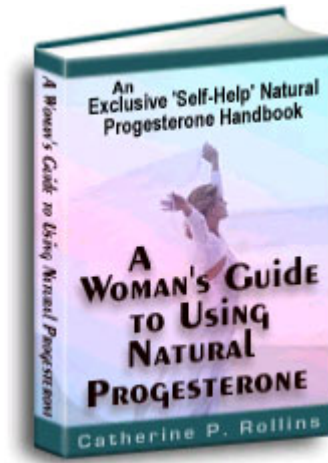


In association with Making Plans Pty Ltd
is pleased to present:



‘A Woman’s Guide to Using Natural Progesterone’

by Catherine P. Rollins

(Revised Edition - 2005)

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Preamble

About the author

Catherine's Personal Journey

I never intended to go down this road. Yet a severe reaction to HRT in 1996, the loan of a book by Lesley Kenton, a chance audience with Dr. John Lee, and the discovery of natural progesterone changed all that.

Since my enlightenment in 1996, I set out to spread the word to help women make sense of natural progesterone and to inform them of where cream could be purchased.

Let me now share with you a little of my own hormonal health history so that you might better understand why I founded this network and how it can be of tremendous help to you.



Hormone Imbalance and Xenoestrogens - The Problems Begin

I have no memory of “period problems” until around age 18 when mum grew concerned and took me to see a specialist.

Be it coincidental or something more sinister, twelve months earlier I'd started working with a company that manufactured “carbon black” (a substance that is a black, extremely fine, odourless powder). It is found in countless items such as tires and other mechanical rubber goods, pigment in printing inks, paints, and plastics.

Almost daily our plant processed complaints of a “black sooty substance” settling in the neighbours' yards. If this substance was airborne, it's reasonable to expect it could be found in our lungs, on our skin, and perhaps made its way into our bloodstream! But, of course, we didn't think like that back then.

And so it began. The pain associated with menstruation each month was almost unbearable. Bouts of diarrhoea, vomiting and excruciating abdominal pain would take me to the brink of collapse. My specialist prescribed “the pill” to artificially regulate my period, reduce unsightly acne, and hopefully ease my suffering. When it failed to yield results I took myself off all medication.

The suffering continued right up until I left the plant (age 22) and signed on as a lay-missionary, moving to Perth, Western Australia. Hormonally speaking, it was clear sailing the following four years. I married and gave birth to my son, John. I soon found out I was pregnant again... very close after John's birth.

The only employment I could secure was a temporary secretarial assignment at another chemical plant where I worked right up until I gave birth to my daughter, Dominique.

My third child, Cara Faith, was born in '89, healthy in every respect but “special” in that she was born with an extra toe on her left foot!

I note here that my pregnancy carrying Cara was not without problems (bleeding, fluid retention, hernia) and I was subsequently advised not to have any more children.

My Hormones Were Tearing My Life Apart

At age 30, I was admitted for a tubal ligation.

By the time Cara celebrated her first birthday, I was grappling with the onset of chronic Fibromyalgia and a severe hormone imbalance was tearing my life apart. I had no explanation for the hot flashes, missed periods, panic attacks, hair loss, debilitating fatigue, or the alienation I felt. Tears came easily. But,

weird as this may sound, I had absolutely no idea how my body worked, or what took place during my reproductive cycles. So where else was I to go for help but to my local doctor?

She got me started on "the pill" and from there we quickly progressed to estrogen patches coupled with Provera tablets and eventually estrogen and testosterone implants.

During the eighteen months of synthetic HRT, I was screened for cancer of the cervix and uterus. A mammogram was also ordered to investigate a lump discovered in my breast.

By October of 1996, around the time I was hospitalised for a D&C to resolve thickening of the endometrium and to correct cervical erosion, a work colleague dropped a book in my lap titled, "[Passage to Power](#)" by Leslie Kenton. Leslie's book referred constantly to Dr. Lee and a "wonder cream" called natural progesterone.

At that stage, I began to panic. I sensed I was in trouble... that HRT was slowly poisoning my body. I was truly frightened.

In the meantime, I hounded health food stores for a jar of natural progesterone cream. None could be found, but I did learn that Dr. John Lee was in town lecturing on natural progesterone. I made it a point to be in the audience.

As I sat, fidgeting nervously and digesting Dr. Lee's message, I knew I was sitting on a time bomb and there wasn't a damn thing I could do about it. Implants, once stitched into your backside, are not easily removed. Yet my body was telling me it was being slowly poisoned ... and all I could do was watch how things panned out.

In my desperate state I sent up a silent prayer, there and then, promising God that if she'd get me out of this mess I'd help other women avoid my plight.

In no time I sourced natural progesterone cream, began applying it directly to my breasts, changed my diet, began exercising, and went for a mammogram. The results came back all clear. The lump had disappeared!

That Was My Miracle

My end of the bargain was to spread the word. So that's what I did. I jumped on the 'Net to research "real" natural progesterone cream, found a local supplier, and helped to make natural progesterone cream available to other women in Australia. I lectured on the subject when there was a willing audience. I funded a seminar in Geelong featuring Sherrill Sellman, author of "[Hormone Heresy](#)" that resulted in an ever-so-brief moment on prime-time TV.

I put together an info pack and posted these out to women absorbing the cost myself. I ordered a box of Dr. Lee's book, "[What Your Doctor May Not Tell You About Menopause](#)" and sold these wholesale.

Then, once again, fate stepped in. I made contact by phone with Dr. John Lee.

I used our conversations to discuss questions presented to me by other women experiencing serious health problems. Dr. Lee always put aside his private affairs, day or night, to lend an ear and extend his medical expertise to women like me who, I guess you could say, hounded him for information. Indeed, [Dr. John Lee](#) truly was a remarkable man whose legacy lives on through this network beyond his death.

Hormone Disruption ... No Bed Of Roses

By 1991, I lived in pain most of the time. I concluded it must be related to the fact I worked on a keyboard all day so I started exercising more. However, during a WorkCover dispute I was officially diagnosed with fibromyalgia.

To say that the pain that plagues people with fibromyalgia made my life difficult would be an understatement. I lost my job as an Executive Secretary and, to some degree, I lost my identity. This reflected in my demeanour and my body size which, at one point, ballooned to a whopping 95 kilos!

I'm baffled completely by people's inability to empathise openly with another's suffering. I not only had to contend with the debilitating symptoms of Fibromyalgia, day in day out, but I had to brace myself for the

ignorant backlash I invariably received from those who should, during my time of need, be extending emotional and physical support. I became an expert at masking my pain.

Advocating Natural Progesterone

Understanding the differences between a Wild Yam Extract cream and USP grade progesterone has become muddled. In Australia, it was known as the "Wild Yam Scam" which I uncovered in my article "[Freedom to Choose.](#)"

I continued using my own body in the trial of progesterone replacement therapy (PRT). However, since I, like other women, had no recognised dosage and usage guidelines to follow, I somehow accidentally overdosed. I had the appropriate tests done to ensure I wasn't at risk, and used the opportunity to write a paper on my observations & test results. I also wrote to government officials in Western Australia asking to see a pharmaceutical grade progesterone cream (manufactured in WA) introduced into the other states in Australia.

I co-founded the Natural Progesterone Advisory Network (NPAN) for women in Australia. Out of this network grew the Natural-Progesterone-Advisory-Network.com website you see today.

A Guide to Using Natural Progesterone

'*A Woman's Guide to Using Natural Progesterone*' comprises unbiased, uncensored, up-to-date information regarding every aspect of natural progesterone and its use. Specifically, it contains detailed information about what progesterone is, its vital role in a woman's body, it outlines HRT and "bioidentical" HRT - two completely different forms of therapy - and offers suggested dosage & usage scenarios to help ensure women get the best results possible.

Promoting Health & Wellbeing

I continue to conduct research into aspects of natural progesterone, while providing comfort and advice to women worldwide on a daily basis.

I want the women of the world to be taken seriously - even when they have unexplainable symptoms - and to have natural help readily available when they need it.

My goal as director of the Natural-Progesterone-Advisory-Network.com website is not to sell natural progesterone cream, but to provide a safe haven for you - and other women like you - to dramatically improve your life through natural progesterone use. To ensure women everywhere have the resources they need to find it and use it for the betterment of their lives.

In light & love,



Catherine P. Rollins
Director, Making Plans Pty Ltd
www.natural-progesterone-advisory-network.com

Our Vision - bridging the gap in education

The Natural-Progesterone-Advisory-Network.com website advocates women's absolute right to a safer, more natural alternative to the currently prescribed 'synthetic' (unnatural-to-the-body) hormone replacement therapy (HRT) our doctors are forcing on us.

We argue that a 'one size fits all', cookie-cutter approach to HRT is out-dated, dangerous, and invariably falls short of the mark. Rather, we preach a more individualized approach that incorporates human-identical hormones.

We provide women who are FED UP being treated like guinea pigs by multi-national pharmaceutical companies with a platform for validation, empowerment and the sharing of "coal-face" experiences using human-identical HRT. Our information is based on input from a panel of medical professionals - many of them leaders in their field

Our charter [and our PASSION] is to cover the gap in education between female healthcare consumers and their treating physicians. To connect women with collaborative medical professionals skilled in bioidentical HRT and integrative medicine.

Here at the [Natural-Progesterone-Advisory-Network.com](http://www.Natural-Progesterone-Advisory-Network.com) website, we undertake to ensure women everywhere have the resources they need to FIND bioidentical hormones and if it suits their individual needs, to USE them effectively and responsibly for the betterment of their lives.

\$1 of every ebook sold is donated to <http://www.WomenInBalance.org>, a non-profit organization comprised of women, doctors, health care professionals, national organizations and their members dedicated to supporting safe, effective and natural solutions for women's health issues in general and for the menopausal transition in particular. That way we can all keep learning.

What's the purpose of this ebook?

'*A Woman's Guide to Using Natural Progesterone*' evolved out of (a) women's choice NOT to use artificial hormones replacement therapy (contained in The Pill & conventional HRT) but to discover safer alternatives, (b) the confusion between Wild Yam Extract creams and 'real' progesterone, and (c) the general lack of knowledge available on effective and appropriate dosage & usage guidelines using bioidentical progesterone.

We draw heavily on the hundreds upon hundreds of 'personal accounts' reported by women successfully incorporating bioidentical progesterone replacement therapy (BHRT) in their health regime, tempered with input from prescribing GPs embracing BHRT in their practice.

And there are many success stories out there that this Network has been a part of.

This ebook contains "coal-face" knowledge rather than just book knowledge. These real life experiences using progesterone give women a sense of conviction that they are on the right track.

Features

- We decipher and simplify information and empirical evidence as it comes to hand so you're guaranteed to get the most up-to-date and accurate information anywhere online without having to spend countless hours searching... or questioning the source.
- We provide tried, tested, and recommended cream usage & dosage for specific problems.
- We discuss various delivery systems of natural progesterone (pills, patches, troches, suppositories, gel, creams)
- We outline when to start applying natural progesterone cream and when to expect to see results, and we explore reasons why natural progesterone cream may not be working for you.

- We answer frequently asked questions (FAQs) posed by women & their doctors around progesterone's efficacy and safety.
- We talk about artificial HRT as distinct from bioidentical HRT - two completely different forms of replacement therapy.
- Women openly and freely discuss their medical concerns and their own experiences with natural progesterone use.

Benefits

- Women learn about their reproductive cycles, how to interpret hormone imbalance, and what contributes to estrogen dominance.
- Women can make a more informed choice once they understand what bioidentical hormone replacement therapy is and what makes it safer than artificial HRT.
- Women learn what to look for when buying cream, how to source a premium cream, and how to apply it safely.
- In learning the various stages of progesterone's action in the body, women can monitor and adjust their dosage to ensure full benefits and protection against estrogen-driven cancers.
- They come to learn what symptoms are treatable with progesterone supplementation, and those that are not.
- Women learn how to approach their doctors, what to do if their doctors refuse to support their choice of BHRT, where to order a premium cream, and in which country a doctor's prescription is required.
- Readers gain new insights into the experiences they may encounter in the beginning, when they start applying progesterone cream and 'estrogen dominance wake-up' hits. Based on anecdotal evidence, we help women make sense of natural progesterone so they can use it safely and with confidence.

We have compiled this wealth of information with women and their healthcare professionals in mind; to deliver a no-nonsense, non-medical exploration of women's collective experiences using natural progesterone successfully over several years.

This ebook is filled with insightful and 'balanced' information about progesterone usage you won't find anywhere else. This knowledge helps women gain a better understanding of the uses of progesterone, what progesterone is, and its vital role in a woman's body.

Women learn about progesterone's action in the body and how to apply cream with a degree of confidence; how much progesterone is required to keep estrogen dominance symptoms under control and protect against some forms of cancer

The information we make available changes women's lives. We educate women on hormone imbalance, how to administer progesterone, and how to distinguish situations that require dosage change and alterations.

Our readers learn what signs and symptoms of hormone imbalance to look for, and what types of things to avoid while taking progesterone cream. They learn how to use natural progesterone cream to regulate their cycles and control [if not eliminate] their symptoms.

Please note, we are NOT doctors, and strongly urge you to work in consultation with your own healthcare professional. Nonetheless, we feel qualified to compile this publication because we, along with our 'sisters' in Australia and around the globe, have used our bodies over many years in the 'unofficial' trial of natural progesterone.

How come natural progesterone is such a secret?

"Twenty years ago a doctor asked me why I wasn't on progesterone and I responded, "nobody told me I should be." Within 3-4 days of commencing progesterone cream, I felt so much better about myself - more confident, more in control of my life. I've been taking progesterone and feeling the benefits for twenty years without any side effects.

"During this time doctors tried to take me off the cream but I refused. I have suggested that maybe these doctors listen to the women who are taking progesterone and getting well. Many times I have shared my experience on progesterone cream with women but their doctors argue they don't need it. Such a pity! I personally wouldn't be without it." (Marjorie Amyot, St Petersburg, FL, USA).

Natural progesterone has been around since the 1940s. The late [Dr John Lee](#) bravely championed its use despite the medical fraternity's inability to embrace his theories. Millions of women around the world continue to be eternally grateful to him having discovered the benefits of its use because of his indefatigable stance. Thank you, John.

So, why are doctors reluctant to prescribe it? Why do doctors refuse to honour a woman's choice of natural progesterone? Why does mainstream medicine remain sceptical? Why IS it the world's best kept secret?

Perhaps resistance is due largely to the lack of published clinical trials and scientific evidence made available to doctors on natural-to-the-body hormones like progesterone. So what's hindering test trials that can change all this? Simply put - lack of funding. Pharmaceutical companies, in the interests of self-preservation, flatly refuse to inject millions and millions of dollars into research and development of a drug that cannot be 'owned' under a patent.

Meanwhile, the pharmaceutical industry is guilty of a massive campaign of misinformation in regards to the less 'natural' hormone replacement therapy drugs they manufacture and push doctors to prescribe.

There is growing evidence that synthetic HRT is perhaps not all it's cracked up to be. Clearly some medical claims are based on myth and not fact. The effect on heart disease is just one example. The dangers of synthetic HRT, especially on breast cancer, are only now being given any exposure as more and more women demand answers to their health questions.

Let's not fool ourselves here. What's best for women's health is NOT very high on the agenda. It's about patents and profits, and chemically-altered drugs that ineptly replace our natural hormones. It's about over-shadowing responsible information on hormone replacement therapy with test trials and data, in some cases funded by the multi-national pharmaceutical companies who manufacture these drugs.

Women globally are angered by this conspiracy. One has to ask why this information is buried so deep even the medical profession cannot find it?

As things now stand, women literally stumble upon natural progesterone by accident. And, in so doing, they struggle every step of the way to bring 'the world's best kept secret' to the light of day.

Women like us around the globe seek to break the bonds of limited choices in HRT and replace them with the freedom to be treated individually and more safely. For is it not a woman's birthright to feel and celebrate her wholeness of mind, body and spirit?

'A Woman's Guide to Using Natural Progesterone' demonstrates, time and time again, why natural progesterone - our essence hormone, so vital to women's hormonal health - is the world's best kept secret.

2

Get to know your hormones

What is natural progesterone?

Progesterone is a steroid hormone, often referred to as a sex hormone. The word 'steroid' is a generic name for dozens of body regulators (hormones) made from cholesterol.

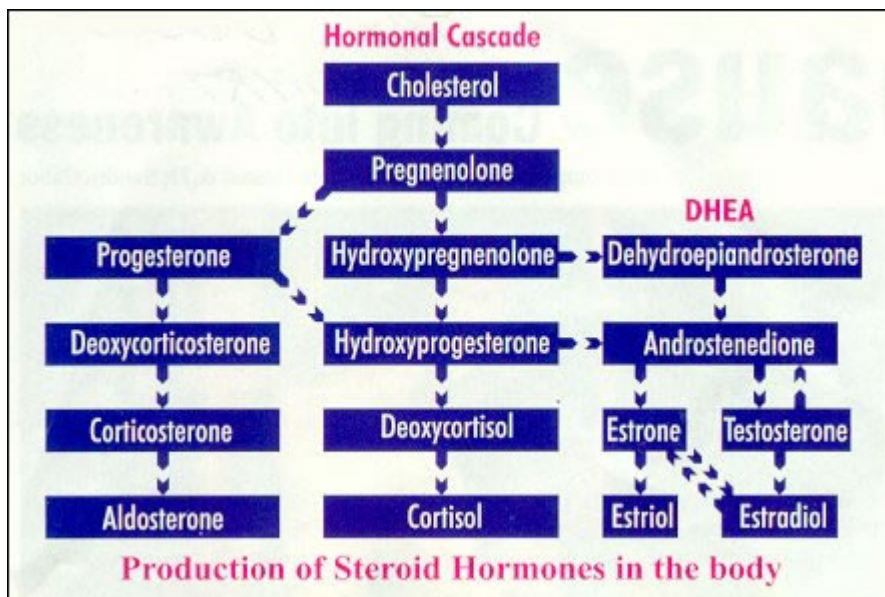
Cholesterol, the basic building block for the steroid hormone, gives them all a similar structure. Switch a few atoms around and the role of the hormone can change dramatically. Without sufficient cholesterol, we can't make sufficient steroid hormones. Some of the more familiar steroids are estrogen, progesterone, testosterone, the corticosteroids, and DHEA.

Progesterone is one of two main reproductive hormone groups, the other being the estrogens, made by the ovaries of menstruating women. It is primarily a hormone of fertility and pregnancy.

The three major functions of progesterone in our body are:

- to promote the survival and development of the embryo and foetus
- to provide a broad range of core biologic effects
- to act as a precursor (building block) of other steroid hormones

Progesterone is also made in smaller amounts by the adrenal glands in both sexes and by the testes in males. Progesterone is a precursor of other hormones such as estrone, estriol, estradiol, testosterone, and all the important adrenal cortical hormones.



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Progesterone is also made in mammals. In fact, progesterone was obtained from the ovaries of pigs and later from human placentas. Both these methods were expensive and only yielded small quantities of progesterone - therefore uneconomical to market.

In the 1940s, however, Dr Russell E. Marker discovered a chemical process by which he could economically manufacture progesterone from saponins harvested from the Mexican Wild Yam and Soy plants.

The levels of progesterone in a woman's body rise and fall dramatically with her monthly cycles. At ovulation, the production of progesterone rapidly rises from 2-3mg per day to an average of 22mg per day, peaking as high as 30mg per day a week or so after ovulation. After ten or twelve days, if fertilisation does not occur, ovarian production of progesterone falls significantly. It is this sudden

decline in progesterone levels (as well as estrogen levels) that triggers a period/menstruation, and another menstrual cycle will begin.

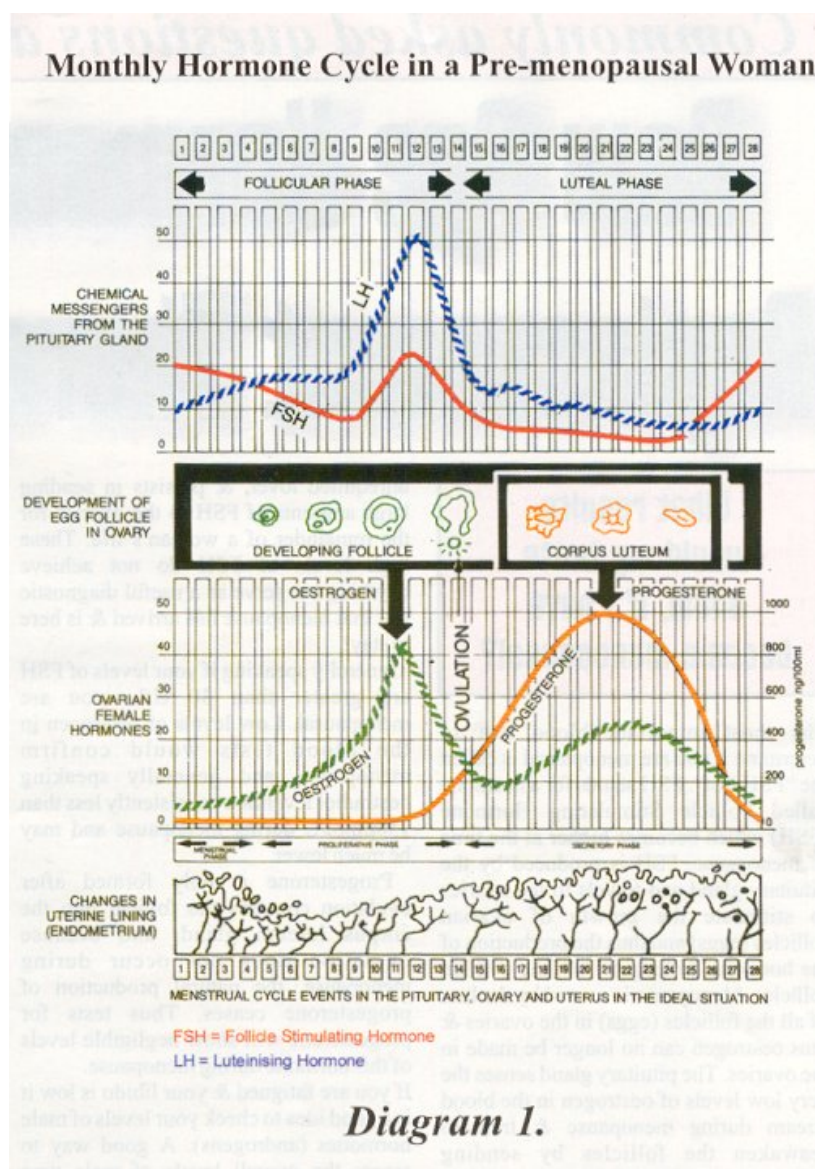
If pregnancy occurs, progesterone production increases and the shedding of the lining of the uterus is prevented, preserving the developing embryo. As pregnancy progresses, progesterone production is taken over by the placenta, and its secretion increases gradually to levels of 300-400mg per day during the third trimester.

If, however, a woman fails to ovulate during her cycle the result would be too little progesterone in her body, and estrogen dominates the hormonal environment. For your understanding, progesterone is manufactured by the empty sack left behind by the released egg. This sack is known as the corpus luteum. Unless ovulation takes place and the egg is released, progesterone will not be manufactured.

A fundamental key to hormone balance is the knowledge that when estrogen becomes the dominant hormone and progesterone is deficient, the estrogen can potentially become toxic to the body; thus progesterone has a balancing or mitigating effect on estrogen.

Progesterone is the body's natural anti-estrogen.

The diagram below demonstrates what actually take place in a women's body during her 28 cycle.



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What is a progesterone receptor?

It is a physical structure on the cell membrane that attracts the progesterone molecule / hormone, and responds to its effect at that receptor site.

Because there are literally hundreds of progesterone receptors (sites) throughout the body, progesterone will have a major impact on your body as each receptor relays a specific message.

Why do women need progesterone?

Progesterone has a comprehensive role in a woman's body. And when levels drop, your body is going to react in a big way. We now know that if we allow estrogen to dominate the hormonal environment, there is significant risk of breast cancer and reproductive cancer. So one of progesterone's most important roles is to balance or negate the effects of estrogen.

At menopause, a women's estrogen level will drop by 40-60% (or can be lower in cases involving thin women). Just low enough to stop the menstrual cycle. Progesterone levels, however, may drop close to zero in some women.

This wouldn't have bothered a woman at the turn of the 20th century who rarely lived beyond her reproductive years. But these days a woman can expect to live to 85 years and beyond. She needs to give some thought to how she's going to rejuvenate her 'ageing' endocrine system. Natural hormone replacement will become a vital anti-ageing tool for both men and women, and progesterone supplementation is a good place to start.

At menopause, the adrenals and other organs take over the manufacturing of hormones, particularly testosterone and estrogen, and some progesterone. However, in cases of adrenal exhaustion and other health problems, the body often cannot compensate adequately, thus causing further hormonal havoc to the body.

Progesterone is a precursor (or building block) to many other steroid hormones such as cortisol, testosterone and estrogen (estriol, estradiol, estrone). Because it is a modulator, its use can greatly enhance overall hormonal balance. Progesterone supplementation will stimulate bone building and help protect against osteoporosis, not overlooking the numerous positive roles it plays in the body. For women who suffer hormonal imbalance but are not necessarily menopausal, progesterone is equally important. Even young women in their 20s and, on occasions, teenagers may need progesterone if they are not ovulating regularly and present with an array of estrogen dominant symptoms.

During pregnancy, rising progesterone levels prevent the premature shedding of the uterine lining (pro-gestation). If progesterone levels drop due to inadequate progesterone production, then a premature delivery could result, or bring about a miscarriage in the early trimesters.

In fact, feedback from women suggests progesterone is very effective in opposing estrogen dominance symptoms of all ages.

Progesterone benefits include the following:

- Maintains the secretory endometrium
- Protects against fibrocystic breasts
- Helps use fat for energy
- It is a natural diuretic
- Natural anti-depressant / mood enhancer
- Facilitates thyroid hormone action
- Normalises blood clotting
- Restores sex drive
- Normalises blood sugar levels
- Normalises zinc and copper levels
- Restores proper cell oxygen levels
- Prevents endometrial (uterine) cancer
- Helps prevent breast cancer
- Stimulates osteoblast for bone building
- Restores normal vascular tone
- Necessary for the survival of the embryo
- Precursor of corticosteroids and other hormones
- Modulates other hormones helping to restore balance

- Promotes sleep
- May help improve libido
- Contributes to reducing anxiety and panic attacks
- Reduces estrogen dominance symptoms

Why do men need progesterone?

Progesterone in men is vital to good health. It is the primary precursor of their adrenal cortical hormones and testosterone. Men synthesise progesterone in smaller amounts than women do but it is still important.

The metabolic actions of the prostate gland are determined in large part by hormones, especially estradiol, progesterone, and testosterone, which are made by the testes. These, in turn, are mediated by pituitary hormones, especially FSH and LH, just as ovarian function in women is.

Both the prostate gland and the uterus develop from the same embryonic cells, and both respond to the same hormones - estradiol, progesterone, and testosterone.

Adding progesterone back into the body helps restore normal inhibition of 5-alpha-reductase, thus preventing testosterone from changing into dihydrotestosterone (DHT), which stimulates proliferation of prostate cells.

What is estrogen?

Estrogen is a group of sex hormone secreted primarily by the ovaries. It is responsible for female characteristics such as the development of breasts and female curves, as well as for menstruation. There are several types of estrogen and the main ones that we know are estradiol, estrone and estrinol. These naturally occurring estrogens are found in the blood and in the body.

Too much estrogen in the body:

- Builds up uterine lining
- Stimulates breast tissue
- Increases body fat
- Salt and fluid retention
- Depression, headaches/migraines
- Interferes with thyroid hormone
- Increased blood clotting
- Decreases libido
- Impairs blood sugar control
- Increases risk of endometrial cancer
- Increases risk of breast cancer
- Slightly restrains bone loss
- Reduces vascular tone

What are estrogen receptors?

Like progesterone, it is the physical structures on the cell membrane that attract estrogen and respond to its effect. There are many estrogen receptors throughout the body.

There is only one progesterone receptor which means there is only one type of progesterone, but there are several types of estrogens.

Testing your estrogen levels

Estrogen status is an important diagnostic tool for various symptoms and conditions in both men and women.

Testing facilities can assay the three naturally occurring estrogens to provide a more complete hormonal profile of you as a patient.

Estrone (E1) is the second most powerful human estrogen compared to E2, and is commonly associated with an increased level of subcutaneous fat or the use of synthetic HRT i.e. Premarin. [Therefore it is a useful marker for monitoring patients taking Premarin or patients with significant subcutaneous fat.]

Estradiol (E2) is the most potent human estrogen. It is easily converted to E1 sulphate. Together E1 + E2 contribute the bulk of estrogen activity.

Estriol (E3) is the least potent estrogen. E3 is important for protection against estrogen dominance because it competes for the same receptor as E1 and E2 but has lower activity.

Mr Colm Benson, Health Services Manager for Analytical Reference Laboratories (ARL), Melbourne kindly provided a sample of ARL's new Salivary Hormone Test Report detailing reference and target ranges for the various hormones.

Estrogen Dominance Linked to Cancer

Breast cancer is a major health issue. It is the most common cancer-related cause of death in women in Australia. One in twelve Australian women will develop the disease and each year many women die from it.

World-wide about 1,670,000 women have breast cancer. And in North America, a woman dies of breast cancer every 12 minutes!

Your risk of surviving malignant breast cancer is just about the same as it was 50 years ago, when the only treatment was mastectomy; about one in three. The incidence of breast cancer is steadily rising and the numbers are appalling. Between 1973 and 1998, the incidence of breast cancer rose by over 40%.

Ovarian cancer is particularly scary because by the time it's detectable, in 70 to 80 percent of women it has already spread to other parts of the body and thus has a high mortality rate. It accounts for nearly 20 percent of gynaecologic cancers, and it ranks fifth in cancer fatalities in women. Most ovarian cancer occurs in menopausal women around the age of fifty.

Uterine cancer, also known as endometrial cancer, is not as common as ovarian cancer. Generally, endometrial cancer develops during the pre-menopausal years when high levels of estrogen and low levels of progesterone are present. The only known cause of endometrial cancer is unopposed estrogen.

Cancer of the cervix is the second most common cancer in women worldwide and is a leading cause of cancer-related death in women in underdeveloped countries. Worldwide, approximately 500,000 cases of cervical cancer are diagnosed each year.

Oral contraceptives have been linked to both endometrial and cervical cancers.

Prostate problems are the fastest-growing health concern among men in Western countries, and the rate of prostate cancer is increasing steadily.

The initiation of normal cells turning into cancer cells is the same for both the breast or uterus and the prostate gland. In these organs, cancer initiation is due primarily to estrogen dominance combined with lifestyle factors and/or toxic insults that predispose estrogen to become oxidised.

The incidence of prostate cancer increases with age. The majority of men in the US will acquire prostate cancer if they live beyond 65. It is a slow-growing cancer (more rapidly growing in younger men, however). For men over 65, the doubling time of a prostate cancer nodule is usually about 5 years. Compare this with the doubling time of a breast cancer nodule, which is about 3 to 4 months. If left untreated, prostate cancer tends to eventually metastasize to bones.

Some of the risk factors for cancer, such as race, age, and family history, are out of your control, so the bottom line in minimising your risk of cancer is to lead a healthy lifestyle, use your common sense, and avoid excess estrogen, whether it be from pesticides, synthetic HRT, or oral contraceptives.

What is estrogen dominance?

We are now learning that many of these cancers are all known to be a result of hormonal imbalances. Specifically they are a result of excess estrogen or estrogen dominance

Estrogen dominance is a term coined by the late Dr John Lee in his first book on natural progesterone. It describes a condition where a woman can have deficient, normal, or excessive estrogen but has little or no progesterone to balance its effects in the body. Even a woman with low estrogen levels can have estrogen-dominance symptoms if she doesn't have any progesterone.

And how do we become 'estrogen dominant'?

All too often our food chain is laced with toxic pesticides, herbicides and growth hormones - a sea of endocrine-disrupting chemicals that mimic estrogen in our body. If we are overweight, our body's store of excess fat can be converted into estrogen. Insulin resistance leads to estrogen dominance. A visit to our GP for the odd hot flash, missed period or PMS discomfort can result in a prescription of estrogen pills, patches or implants.

And yet unopposed estrogen in our bodies results in all sorts of hormone-related health problems such as PMS, endometriosis, uterine fibroids, infertility, weight gain, increased blood clotting, thyroid dysfunction, even cancer, in both men and women.

Our men-folk are equally at risk. Estrogen gradually rises as men age, while saliva levels of progesterone and testosterone gradually falling. Thus, with aging, estrogen dominance occurs. A clear sign of estrogen dominance in aging men is their tendency to develop breasts. This indicates these men are low in progesterone and testosterone.

Where does progesterone fit in?

Estrogen is the hormone that stimulates cell proliferation, or the growing phase. In other words, estrogen causes cells to divide and multiply. Progesterone, on the other hand, is the hormone that stops growth and stimulates ripening. It induces cell maturation and programmed cell death (called [apoptosis](#)).

Although cells in different parts of the body may look and work differently, most repair and reproduce themselves in the same way. Normally, this division of cells takes place in an orderly and controlled manner. If, for some reason, the process gets out of control, the cells will continue to divide, developing into a lump which is called a tumour. Tumours can be either benign or malignant. Doctors can tell whether a tumour is benign or malignant by examining a small sample of cells under a microscope. This is called a biopsy.

Whilst not a cure for cancer, progesterone can dramatically decrease cell multiplication rates, providing women with a degree of protection against estrogen-driven cancers. Normal levels of progesterone in the body can, therefore, actually help protect you against some forms of cancer.

We know now that progesterone deficiency is linked to an increased risk of cancer. Uterine cancer, for example, is known to be caused by unopposed estrogen. That's why women who have an intact uterus and take estrogen replacement therapy must also be given some form of progesterone to oppose estrogen and reduce this risk. This is generally given in the form of synthetic progestin which, incidentally, is not the same molecule as bioidentical progesterone, but is designed to block estrogen effects.

The evidence against estrogen is stacking up

According to Dr Cavalieri, Professor at the Eppley Institute for Research in Cancer and Allied Diseases at the University of Nebraska Medical Centre in Omaha Nebraska, he and his team are at the brink of discovering that almost all the important human cancers that we get in Western civilisation, have the same origin, which is estrogen.

Estrogens, according to Dr Cavalieri, are initiators and promoters of cancer.

They are initiators because they form cancer-causing agents, by metabolising in a specific way. After that they promote cancer via these receptor-mediated processes that increase cell proliferation.

All the evidence, according to Dr Cavalieri, implicated estrogens (including the natural hormones estradiol and estrone), as a major cause of breast cancer ([National Cancer Institute Monograph #27](#)).

[Oxford University Press](#)]. Therefore, if you use progesterone cream and avoid having extra estrogen in the body, you avoid the initiating process.

For women, cancer of the breast and/or in the uterus most often occurs with a progesterone (P) to estradiol (E2) ratio of less than 200 to 1. According to Dr David Zava of ZRT, who has amassed a database of tens of thousands of saliva samples and questionnaires, these cancers occur very rarely in women with a healthy P/E2 ratio.

The Johns Hopkins University conducted a 20 year study, published in 1983 in the American Journal of Epidemiology, showing that women who had good progesterone levels had less than a fifth of the amount of breast cancer, and less than a tenth of all the cancers that occurred in women who were low in progesterone. These outcomes suggest that having a normal level of progesterone protected women from nine-tenths of all cancers that might otherwise have occurred.

Molecular biologist, Dr. Ben Formby of Copenhagen, Denmark and Dr. T.S. Wiley at the University of California in Santa Barbara have researched two genes, BCL2 and P53, and their effect on female-specific cancers and prostate cancer.

Cells of breast, endometrium, ovary and prostate, were grown in the laboratory. Estrogen (estradiol) was added to the cells. This hormone turned on the BCL2 gene, causing the cells to grow rapidly and not die. Then, progesterone was added to the cell cultures. Cell reproduction stopped and the cells died on time (apoptosis).

This methodology was applied to all the above types of cancer. The BCL2 gene, therefore, stimulates the growth of these cells and the risk of cancer. On the other hand, the P53 gene promotes apoptosis or programmed cell death and thereby, reduces the risk of cancer. Estradiol up-regulates or stimulates the production of the BCL2 gene, while progesterone up-regulates or stimulates the production of the P53 gene.

Drs de Lignières and Chang sort to measure the rate at which breast cells multiplied. The breast cells chosen were the milk duct cells since these are the cells where cancer originates in breasts.

Keep in mind that a cancer cell differs from a normal cell in only two ways: (1) it multiplies faster and (2) it hasn't differentiated and become developed into the full mature cell that it is suppose to.

Controlled tests indicated estradiol raised the cell proliferation rate over 200%, progesterone with estradiol brought it back to normal. The ones with progesterone only, lowered the proliferation rate by 400%. The authors concluded that they had shown that estrogen is truly a stimulant of breast cancer and progesterone is a protector of breast cancer.

Therefore natural progesterone decreases the risk for several types of cancer, while unopposed estradiol causes these same types of cancer.

In cases of hormone dependent cancers, it is critically important to maintain optimal levels of natural progesterone and avoid the factors that would promote too much estradiol.

Friend or foe

Just as there is no one apple called apple, there is no one estrogen named estrogen. The word estrogen refers to a class of THREE estrogens as follows:

- Estrone
- Estradiol
- Estriol

Among the three major natural estrogens, estradiol is the most stimulating to breast tissue, estrone is second, and estriol by far the least. And since all estrogens compete for the same receptor sites, it is probable that sufficient estriol impedes the carcinogenic effects of estradiol and/or estrone.

Low levels of estriol relative to estradiol and estrone appear to correlate with increased risk of breast cancer, while higher levels of estriol from endocrine treatment correlate with remission of cancer.

It is now believed that the two major hormones present throughout pregnancy - progesterone and estriol - may well offer protection against breast cancer.

Does progesterone increase my risk for cancer?

According to the late Dr Lee, two studies published in the American Journal of Pathology in 1999 show that estrogen increases breast and prostate cancer, and that progesterone receptors in the breast and prostate are more abundant in cases of more aggressive cancer. Misinterpretation of this type of result is common.

Conventional interpretation suggests that this might indicate that progesterone causes the more aggressive breast and prostate cancers. The truth is that progesterone receptors are made by estrogen. The higher the estradiol/progesterone ratio, the greater are the number of progesterone receptors that will emerge.

This is the tissue's effort to restore proper progesterone function in situations where estrogen dominance is present. Thus, increase of progesterone receptors is evidence of estrogen dominance, and not evidence that progesterone increases the risk of cancer.

When asked by one of our readers how three patients could have developed breast cancer within 3-6 months of using natural progesterone cream, Professor Zava kindly responded:

"If these three women developed breast cancer within 3-6 months of starting topical progesterone cream the cancers were already present and the progesterone may not have been sufficient to stop a runaway train (cancer).

"It would be of interest to know what type of breast cancers these were (in situ or invasive), how fast they were growing (mitotic index or MiB1 (Ki67), and if they contained estrogen and progesterone receptors.

"In cancer cells that contain progesterone receptors, progesterone should slow the growth of cancer and push it towards a more differentiated state. This progesterone-induced differentiation requires cell division so it is possible that progesterone was allowing the cancer cells to proliferate and differentiate (specialize) simultaneously.

"On the other hand it is possible that the breast cancer cells did not contain progesterone receptors, which would prevent them from responding to the anti-estrogenic actions of progesterone (i.e., progesterone down-regulates estrogen receptors and desensitizes tissues to further growth-promoting actions of estrogens).

"A third possibility is that the progesterone cream was of insufficient strength to have full anti-estrogenic effects. Low dose progesterone works in synergy with estradiol to stimulate growth and proliferation. I would question what the estradiol and progesterone levels were in these women who developed breast cancer while taking progesterone.

"Most oncologists and general practitioners that work with natural progesterone find that primary breast cancer, and breast cancer recurrences are less frequent in women using topical progesterone, but it does happen. My experience, in reviewing pathology reports from women who have developed breast cancer while using topical progesterone, is that they usually have tumours that do not contain progesterone receptors, or the receptors are very low.

"When someone claims they know of women who have used progesterone and then developed breast cancer you should get more detailed information. We could then share this with the group and I would be glad to give you my interpretation from a scientist's point of view."

[Dr. David Zava, Ph.D., Hormone expert and Co-Author, "What Your Doctor May Not Tell You About Breast Cancer"]

Synthetic HRT and Cancer

Researchers stopped a large study of synthetic HRT in July 2002 when it became clear the therapy increased the risk of heart disease, cancer and blood clots. A number of studies since then have supported those results.

The Women's Health Initiative study was stopped short one year ago when it became clear that estrogen-progestin increased the risk of breast cancer, heart attack, and strokes. But research using the data from that study goes on, and the latest findings are nothing less than a disaster.

Examining records of more than 16,000 women, researchers concluded that combined HRT tends to make breast cancer tumours more aggressive and harder to detect, reducing the chances for successful treatment.

The [Million Women Study](#), of whom about half used or had used HRT, indicated for the first time that the increased risk started between one and two years of HRT use, dashing any suggestion that increased cancer risk only developed after long-term use. But the risks grew larger the longer the HRT treatment continued.

The biggest blow dealt by the Million Women study, the results of which are published in the Lancet medical journal, was to combination estrogen and progestin therapies, taken by about half of all those on HRT in the study. These doubled the breast cancer risk. They are widely used, because estrogen-only therapies are known to increase cancer of the womb-lining.

Chemically-altered hormones can shut down or reduce our production of natural hormones. Because the molecules have been changed, the synthetic hormones used in the Contraceptive Pill and HRT do not have the same effect on the mind and body as our natural hormones do. In fact, many of the effects of synthetic hormones are the exact opposite to the natural hormone they so ineptly replace.

One prime example of HRT's 'unnatural' molecular makeup is in the case of medroxy-progesterone acetate, a synthetic progestin. If used during pregnancy, this progestin has the potential to cause birth defects.

Natural progesterone, however, being bioidentical to the body, is routinely used in fertility clinics around the globe to help sustain pregnancy in high-risk situations.

Getting progesterone back into your body

A couple of things to consider here. Firstly, statistics clearly tell us that conventional medicines for treating cancer such as tamoxifen, radiation, and chemotherapy just aren't working in the long run. Secondly, new emerging research is providing clear evidence that estrogen without progesterone is a setup for many reproductive cancers. And, finally, if we're going to supplement hormones, we want to keep in mind that our body will respond best to hormones chemically identical to those which the body naturally produces.

That being the case, and all things considered, perhaps identifying and restoring hormone balance might yet offer a logical starting point in fighting these cancers.

And the easiest and safest way to bring our progesterone to estradiol levels back within a minimum ratio of 200-300:1, thereby protecting us against this potentially life-threatening state of hormone imbalance, is by using a premium quality controlled natural progesterone cream in conjunction with regular salivary hormone profiles.

These natural progesterone creams are extremely safe to self-medicate, are non-toxic, and free of side-effects because they contain USP grade micronized progesterone which is essentially the same molecule naturally occurring in the body.

Less estriol, more cancer

The "early days" of estrogen research focused mostly on three estrogen metabolites called:

- Estrone (E1)
- Estradiol (E2)
- Estriol (E3)

We know that estrogens stimulate cell proliferation - specifically unopposed estradiol - is implicated as the cause of some types of cancers.

It is now believed that the two major hormones present throughout pregnancy - progesterone and estriol - could may well offer protection against breast cancer.

Women who are currently on a program of estrogen replacement therapy should perhaps give consideration to estriol cream as a safer alternative in the treatment of vaginal dryness and/or atrophy, severe hot flashes, urinary incontinence, painful intercourse, and other associated symptoms.

We know that estriol does not induce endometrial proliferation to the extent of the other estrogens. However, we do need to include a progesterone cream to balance the estrogenic effect of estriol.

As a treatment for osteoporosis, E3 significantly improved Bone Mineral Density by inhibiting bone resorption and therefore, estriol might be effective for use in HRT in elderly patients.

Estriol is able to be excreted easily from the body in the urine. It is water-soluble and as such does not need to be broken down by the liver; thus it does not build up in the body. For these reasons the safest estrogen to use is estriol applied to the vulva and lower vagina every day (except during breaks).

The reassuring thing about using the weak estrogen called estriol on the vulva is that very little, if any, will be absorbed into the circulation.

It would appear, by all accounts, that estriol is a safe and effective alternative for relieving climacteric symptoms in postmenopausal women.

But how long should we use estriol?

Henry Lemon, M.D. (a women's cancer specialist), came up with an equation that can estimate a woman's risk of breast cancer. He called this idea the estrogen quotient, or EQ, and formally it's the amount of estriol divided by the sum of the amounts of estrone and estradiol. In mathematical terms, it looks something like this: $EQ = E3 / (E1 + E2)$.

If a woman's EQ is low, her risk of breast cancer is higher. Basically, the higher the EQ, the better. Time after time the EQ proved itself.

In 34 women with no signs of breast cancer, Dr. Lemon found the EQ to be a median of 1.3 before menopause and 1.2 afterward. The picture was quite different in 26 women with breast cancer. Their median EQ was 0.5 before menopause and 0.8 afterward.

In another study, Dr. Lemon found that women with higher EQs survived significantly longer after cancer surgery than women with lower EQs.

So, knowing that women need more estriol to boost their EQs, Dr. Lemon also tried using estriol treatments for breast cancer. He asked a small group of women with untreatable breast cancer (because it had metastasized to bones) to take large dose of estriol. By the end of the study, an astounding 40 percent of these women had their cancers go into remission.

Less estriol, more cancer.

After a decade or two of neglect, the EQ and the "estriol hypothesis" of estrogen-related cancer prediction and prevention (and maybe even treatment, like Dr. Lemon's unpublished research) are back! And some researchers are even starting to admit that maybe, just maybe, estriol in its natural form might work as well (even better than) synthetic drugs like tamoxifen.

And as if this news weren't exciting enough on its own, there's another brand new use for estriol and the EQ, which might give some much-needed hope and relief to people suffering from auto-immune diseases, especially multiple sclerosis.

It is recommended that estriol levels be measured when supplementing with a compounded preparation of bioidentical estrogens (e.g. "Biest" preparations contain estriol and estradiol OR "Triest" preparations containing estriol, estradiol and estrone).

We strongly urge women to read *'You're just 24 hours away from discovering-and reducing-your breast cancer risk'* by Dr Wright. This informative article gives us the latest update on "good" and "bad" estrogens.

What are plant estrogens?

Phytoestrogens are plant sterols that come from the plant kingdom which have an estrogenic or female effect on our body. We know that populations who consume abundant and regular amounts of dietary phytoestrogens have a lower incidence of breast cancer and other hormonally sensitive cancers, heart disease, menopause symptoms and osteoporosis.

There is significant research into estrogenic substances found in plants and foods, and their effects upon hormonal disorder and balancing. Indeed, phytoestrogens have been widely used and recognised for their medicinal value and treatment in helping relieve many of the symptoms at menopause.

Foods high in beneficial plant hormones can include alfalfa, apples, aniseed, brewers yeast, barley, beet root, cabbage, carrots, chick peas, clover, corn, cow peas, cucumbers, fennel, linseed, garlic, green beans, green squash, hops, oats, olives, olive oil, papaya, parsley, peas, plums, potatoes, red beans, pumpkin, legumes, peas, lentils, red clover, rhubarb, rice, rye, sesame seeds, soya bean, sprouts, split peas, sunflower seeds, nuts, squash, wheat yams, green beans, cherries.

Some herbs containing beneficial plant hormones are black cohosh, dong quai, hops, sage, red clover, fennel, liquorice root, wild yam, bladderwrack, horsetail herb, sarsaparilla.

The Natural-Progesterone-Advisory-Network.com website certainly does not profess to understand the complexity of phytoestrogens. We simply acknowledge the large majority of women who liaise with our website and appear to understand the value of phytoestrogens in their health regime, and their invaluable usage in hormone balancing.

We acknowledge that phytoestrogens are the silent partner to the success of progesterone therapy. Phytoestrogens have application in progesterone therapy because they actually help reduce the impact of estrogen dominance when progesterone is reintroduced into the body. The reason is simple. Phytoestrogens help tone down the symptoms of estrogen wake up. Phytoestrogens will be taken up by estrogen receptors. This will block the impact of more potent estrogens produced by the body or the environment, and subsequently reduce the impact of estrogen dominance.

All women using progesterone cream or experiencing hormonal imbalance should give due consideration to the benefits of food and supplements rich in phytoestrogens. Their benefits are just incredible. It's why we vehemently encourage young teenagers / women to first try plant hormones to reinstate hormonal balance before they resort to the introduction of hormone therapy to balance their estrogen dominance. This is particularly relevant to women who have intact ovaries and are ovulating. Perhaps they've neglected their diet, maybe they aren't exercising, maybe they are unknowingly exposed to xenoestrogens, chemical agitators, or just plain stress.

While we encourage women to combine phytoestrogens with progesterone therapy, we do caution them to not go over the top with the use of soya products. Some soya products are not fermented, rendering them less effective. Just be wary. These products can interfere with digestive enzymes. Asian countries have learned how to use soya products in balance, in correct proportion, and to always eat them in conjunction with other food combinations.

Other benefits of phytoestrogens:

- Helps keep the skin and mucous membranes more youthful.
- Helps boost dwindling estrogen levels.
- Stimulates estrogenic benefits in the body by stimulating estrogen receptors on the walls in the skin, breast and vagina.
- Stimulates progesterone activity (estrogen and progesterone need the presence of each other to work effectively).
- Helps reduce imbalance of excessive male hormones (androgens) by exerting feminine influence in conjunction with the use of progesterone.
- Helps tone down estrogen dominance.

What is the difference between phyto-hormones and xeno-hormones?

The term phyto-hormones refers to plant substances that, when eaten, can be converted by the body into hormones. Phytoestrogens, for example, found in wild yam, soya, tofu, legumes will go on to mimic estrogen in the body. These hormone-like substances are metabolised in the intestines and absorbed into the blood stream. Soya beans are a good example. Soya beans are one of the richest food sources of phytoestrogens which have a similar biological structure to naturally produced human estrogens. They contain the estrogenically active compounds coumestrol, isoflavones and lignans. Of all the plant estrogens, coumestrol is the strongest and is most plentiful in soya beans.

The term xeno-estrogen refers to a foreign estrogen occurring in chemicals, petrochemicals and foreign substances that can also mimic estrogen in the body. While the body interrupts/identifies it as an estrogen, it is a toxic form of estrogen, that invades the estrogen receptor sites, blocking more natural forms.

Humans have evolved genetically in the context of what we eat. And we've been eating plants for many years. The human body has the ability to bind the less toxic phyto-hormones to proteins thus reducing their effects and making them easier to eliminate more safely. This is not the case with synthetic xeno-hormones.

Xeno-hormones (also referred to as xenobiotics) are foreign to the body and plant kingdom, and tend to have a very potent hormone-like activity in our body. Nearly all xeno-hormones are synthetic petrochemical by-products present in our food, medicines, plastics, clothing, soaps, etc. These toxins build up in our body with disastrous effects.

"Xenobiotics" is a generic reference to substances with a hormone-like effect on the body, and "xenoestrogens" specifically describe those with a estrogenic effect.

Phyto-hormones have a balancing or modulating effect, which means they can protect our cells against over-stimulation from sex hormones that are produced in the body, consumed in our diet or via medication.

How to reduce exposure to endocrine disruptors

Most women living in Western Industrialised countries will experience hormone related problems in their lifetime as a result of their exposure to petrochemical by-products present in their food, medicines, plastics, clothing, soaps, etc.

Too much estrogen in a woman's body without the balancing, protective properties of progesterone may be mirrored in the growing incidences of various cancers, PMS, endometriosis, fibroids, infertility and early menopause.

Humans are not immune to xenohormones and our environmental exposure to these agents is increasing. It would be almost impossible to avoid them in this century and, as our modern technology advances, there grows an ever increasing danger, perhaps in plague proportion. The knowledge of the effects of xenohormones comes primarily from observing wildlife population exposed to chemicals in our waterways and through agricultural spraying. No living creature appears immuned.

There is suggested links between exposure to environmental pollutants that mimic estrogen and the developing baby's tissue. Laboratory experiments, wildlife studies, and the human DES experience link hormone disruption with a variety of male and female reproductive problems that appear to be on the rise in the general human population - problems ranging from endometriosis, testicular cancer, infertility, and in there somewhere is PCOS.

Hormonally active synthetic chemicals can alter the nervous system and brain, and impair the immune system. Synthetic chemicals can derail the normal expression of sexual characteristics of animals, in some cases masculinising females and feminising males. Some animal studies indicate that exposure to hormonally active chemicals prenatally or in adulthood increases vulnerability to hormone-responsive cancers, such as malignancies in the breast, prostate, ovary, and uterus (publication: Our Stolen Future).

It is argued that if a female embryo's ovarian follicles are compromised through exposure to these chemicals, this damage will not be apparent until after puberty.

Pregnant women should do whatever they can to protect themselves and their unborn child from exposure to xenoestrogens during gestation. Children, too, appear highly susceptible as their immunity system is immature. We suggest women avoid buying plastic toys for their children, especially if they are at that age where they are prone to put everything into their mouth. Where possible, don't heat baby's plastic bottles in the microwave. Go back to using glass feeding bottles, and sterilise with boiling water rather than toxic chemicals.

Avoid packaged and/or refined foods, and eat primarily fresh and preferably organic foods, taking care to wash produce thoroughly. Avoid storing food in plastics containers or plastic wraps. Instead store food in glass containers and never microwave or heat food inside a plastic container.

It is imperative to drink clean, filtered water. If you invest in a water filter be sure to change the filter whenever outlined by the product manufacturer otherwise this could create further problems.

One can only assume that pesticides, herbicides, fungicides, basically any substance that is used to kill fungi, plants, or bugs is going to be toxic to our body. Be aware, garden fertilisers, dog flea repellent wash, insect sprays and skin repellents may be highly toxic to you and your family and animals.

If you're particularly susceptible to toxic fumes and are building a new home, do whatever you can to avoid laminated wood or wood veneers, or other materials that outgas chemicals. Glues and adhesives in particular are very toxic as in carpet laying. We have actually had women report severe haemorrhaging and heavy periods following the laying of new carpets.

Perhaps you're supersensitive to vinyls in cars, and vinyls on work benches.

Women in the photography industry have also run into problems, specifically those working in the processing rooms of film laboratories and handling chemicals which are absorbed through their skin. Hairdressers have come to us with cases of fibrocystic breasts, ovarian cysts and PCOS, and we believe there may be a link between the chemicals and the fumes that they are exposed to in this industry.

Rural women who work on the land have displayed thyroid problems such as multi-nodular goitre. Observation suggests there's a link between chemicals used in farm management which may be adversely impacting the endocrine system. Otherwise, these women have lived a very healthy, active and organic lifestyle.

Certain hair dyes and hair products can contribute to xenohormone exposure in the body. We suggest, therefore, women try to use all natural products. If you know you are sensitive then perhaps refrain from dyeing your hair or applying unnecessary chemicals to your skin, eliminating exposure to fumes and skin. A small number of women in the plant nursery industry come to us with hormonal disorders and cyst problems. Could this be the result of exposure to toxic sprays, fertilisers and other substances?

Opt for detergents, soaps and shampoos that are eco-friendly. Avoid solvents and if you must use them protect your skin as they enter the blood stream quickly through the pores. It is also important not to breathe in fumes, to use masks where possible, and avoid exposure to paint fumes, car fumes, nail polish fumes as they can actually cause symptoms like hot flushes, heavy bleeding, and imbalances, as reported by many, many women.

There are certainly solvents in nail polish and nail polish removers used widely among the young teenagers who are vulnerable to reproductive damage. We caution women with hormone imbalance to be wary of the chemicals used to apply & remove false nails.

Our website has observed a couple of women with high levels of estrogen dominance who have undergone breast implants using foreign substances. It's crossed our mind there may be a correlation between their high level of estrogen dominance and a likely reaction to these foreign particles. Of course, there could be other underlying aspects, but there certainly seems to be a very strong link or suggestion that foreign objects implanted in breast cell tissue may lead to xenoestrogen exposure.

We reiterate here that progesterone cannot possibly protect us against the onslaught of xenoestrogens in our environment. Whilst progesterone may help tone down estrogen dominance symptoms and perhaps confer some protection, unless you directly address your exposure to xenoestrogens you'll always be vulnerable to endocrine disruption and associated complications. This is where liver function and support is vital.

For extensive information and references on xenohormones, we strongly urge you to read Dr. Theo Colborn's book, '[Our Stolen Future](#)'. It is a classic on the subject. This book is a must read for anyone concerned about the survival of the human race and the terrible price we are paying by pouring toxic chemicals into our environment without thought for the consequences.



Hormone replacement therapy (HRT)

These days anyway, most women are confronted with the question of hormone replacement therapy (HRT) whether it be a young girl prescribed the Contraceptive Pill to control period problems, cyclic pain, acne or contraception, or whether it's a woman being prescribed synthetic HRT to treat perimenopausal or post menopausal symptoms.

The most important thing to remember here is that you have options. The decision is entirely up to you, based on accurate information, your health requirements and lifestyle.

You need to conduct a little research - don't accept everything you read or hear - and if hormone replacement therapy is a likely choice, think about natural-to-the-body forms of hormone replacement therapy that, if required, includes progesterone, estrogen, testosterone, DHEA, and the corticosteroids (the 'super' anti-aging hormones). These bio-identical hormones are less imposing on the body and kinder on your liver.

We urge women not to blindly accept claims that one form of hormone replacement therapy, be it synthetic or natural, is your only choice. We suggest you do some research which is not at all difficult on the Internet.

There are stacks of publications available on this subject, many of which have been written by doctors and healthcare professionals who support alternative natural therapy or give a balanced view. Books we've found to be very informative and openly recommend can be found in the Resource Section of this Library.

New Age approach to HRT

- Use saliva hormone testing for a complete and individualized hormone profile.
- Supplement hormones only when you have confirmed you are truly deficient in them.
- Use only human-identical hormone replacement therapy rather than synthetic hormones.
- Apply hormone replacement transdermally (through the skin).
- Supplement hormones according to your unique reproductive cycle.
- Use only in dosages that provide normal physiologic tissue levels.
- Take cyclic breaks (from cream) to rest receptor sites, and sustain balance.
- If symptoms of hormone imbalance persist, consult your physician. Your individualized prescription of human-identical hormone therapies may need to be adjusted.

All of the above share something in common ... that hormones should be given in minimal doses.

It is implied, if not stated outright, that synthetic HRT is perhaps overused and overdosed. The Natural-Progesterone-Advisory-Network.com website always endeavours to be as balanced and open as possible. In so doing, we have come to realise that all forms of HRT, if used widely and conservatively, have their place in women's health.

Our fundamental focus is essentially natural progesterone. But we would not be telling women the full story if we failed to admit that there are other factors within a woman's personal hormonal profile and health regime that need to be considered for her ultimate health and success in healing.

One needs to adopt a holistic approach rather than being biased towards any one treatment. We are constantly observing and broadening our knowledge such that what we publish today may be adjusted or expanded upon tomorrow as new information finds its way to our Network. We will always remain open to new findings and women's experiences with natural progesterone.

We believe natural progesterone is quite an incredible and remarkable hormone, discovered by millions of women worldwide. Nonetheless, if any of these women fail to understand the benefits and the interplay of other aspects that can increase the capacity and functioning of this incredible hormone, then they are not getting the best out of their cream ... or experiencing optimal health.

Why a woman might need to supplement progesterone

Research has shown that women's ovaries do not shrink to zero after menopause, in fact they remain pretty much the same size throughout life. Also, far from there being a complete halt in estrogen production, our ovaries and adrenal glands (also skin, & fat deposits) co-operate to produce estrogen at a rate of about 40-60% of previous amounts.

Our ovaries, however, do dramatically slow down their production of progesterone, because former amounts are no longer required for reproduction. This would not be a real problem if our adrenal glands were capable of 'kicking in' and functioning as efficiently as they are meant to do at this time, if we were not burdened with environmental estrogens.

Post menopause, our adrenals should be up to supplying on-going maintenance amounts of our steroid hormones, including progesterone. However exhausted "stressed out" adrenals (abused by modern life) are very often incapable of functioning to any great extent. This means we are left with some estrogen still being produced by our ovaries, plus the ingested 'free-floating' environmental estrogens that clog up our receptors ... but next to no progesterone! This leaves us in an estrogen dominant state, and our hormone ratios way out of kilter!

And estrogen without progesterone is a setup for many reproductive cancers, and this includes breast cancer.

Is bioidentical HRT safer?

The aim of 'hormone replacement therapy' is to put back into the body the hormones that are either missing, or the body is not producing in adequate amounts to offset hormone imbalance.

And women requiring hormone replacement are discovering that bio-identical hormones, like natural progesterone, that are physically and chemically identical to the hormones made in our body, appear to be safe, free of side effects and non-addictive if used wisely and in moderation.

Some women clearly do ok using synthetic hormone replacement therapy. They do not consider these drugs to be a danger to their health because they have not experienced the debilitating side effects of HRT that pushes women to seek out alternative options.

Our website does not see these women who do fine on HRT, therefore, we're not in a position to comment on balanced statistics. We mainly see those women who've had bad experiences, and have nowhere else to go. They have exhausted all their options or intuitive do not want to pursue synthetic HRT.

The internet is jam packed with publications and websites containing information posted by the medical profession and lay persons for and against both forms of hormone replacement therapy. You want to be very aware, however, who is actually funding the research of the data and the trials that are being put forward.

But the confusion does not merely lie with synthetic HRT. The term 'Super Hormones' is used in the USA to describe the group of anti-aging hormones that are becoming increasingly popular in the post-war baby boomer generation to rejuvenate flagging endocrine systems. The hormones that belong to this group are natural progesterone, testosterone, estrogen, pregnenolone, DHEA, thyroid hormone and melatonin in the form of creams, capsules and lozenges.

To load further inconsistency upon women who are searching for answers and some objectivity to arrive at an informed decision, mostly we are bombarded with words like 'precursor', 'natural', 'bio-identical', 'from natural sources', 'wild yam', 'diosgenin', 'saponins', 'plants steroids', 'phyto-sterols', 'phytoestrogens' and the constant interchanging of the word progesterone and progestogen in the same paragraph.

Here's an example of a push for HRT taken from one reputable pharmaceutical company's website: "Fact - Progestogens are hormones similar in action to the progesterone produced by the ovary." Similar does not mean 'the same'. If this were the case, why do progestins cause birth defects whereas progesterone does not?

Some drug companies DO include natural-to-the-body estrogen in their HRT, usually combined with a synthetic progestin. How do you know the difference? This is usually the scenario that catches women off guard because the drug companies CAN advertise their HRT drugs as 'natural' because PART of that

combination hormone may contain natural-to-the-body estrogen. What they omit to state is that the combination progestin IS NOT natural-to-the-body, although originally derived from 'natural' plant sources.

Natural estrogens are estrone, estradiol and estriol. Premarin which most women are familiar with is not a natural estrogen. Actually the drug 'Premarin' comes from PREgnant MARes urINE.

Learn to familiarise yourself with the words that are going to be constantly thrown at you via crafty advertising. Then learn to be more discerning. Just remember, the body sees as 'natural' that which has the same molecular configuration (bio-identical). 'Natural to the body' is what you need to regard as most important when you are contemplating hormone replacement therapy.

The dangers of chemically-altered hormones

Take a closer look at a comparison of the artificial progestin drugs against the human-identical progesterone creams below and it becomes fairly obvious these NOT-natural-to-the-body progestin drugs carry the risk of serious side-effects when the body react adversely.

Chemically-altered hormones can shut down or reduce our production of natural hormones. Because the molecules have been changed, the synthetic hormones used in the Contraceptive Pill and HRT do not have the same effect on the mind and body as our natural hormones do. In fact, many of the effects of synthetic hormones are the exact opposite to the natural hormone they so ineptly replace.

One prime example of HRT's 'unnatural' molecular makeup is in the case of medroxyprogesterone acetate, a synthetic progestin. If used during pregnancy, this progestin has the potential to cause birth defects. Natural progesterone, however, being bio-identical to the body, is routinely used in fertility clinics around the globe to help sustain pregnancy in high-risk situations. Further, recent research suggests natural progesterone may yet prove to be a major player in supporting pregnant women with a history of premature births.

Let's review the list of potential side effects and adverse reactions to a progestin drug:

Progestin Drugs

Warnings:

- If taken in the first 4 months of pregnancy, may cause birth defects
- May cause partial loss of vision
- Dangers of progestin in breast milk is unknown

Contraindications:

- Cerebral apoplexy
- Known or suspected malignancies of breast or genital organs
- Undiagnosed vaginal bleeding
- Known sensitivity
- Liver dysfunction

Reported Adverse Reactions:

- Breast tenderness
- Sensitivity reactions such as oedema (water retention), rashes, and others
- Acne, alopecia (loss of scalp hair, baldness), hirsutism (excess facial & Body hair)
- Weight increase or decrease
- Changes in cervical secretions, and erosions of the cervix
- Cholestatic jaundice
- Mental depression, pyrexia (fever) insomnia, somnolence (acute allergic reactions)
- Nausea & vomiting
- Headaches
- Thrombophlebitis & pulmonary embolism (blood clots in heart & lungs)
- Breakthrough bleeding, spotting, amenorrhea (absence of periods) or changes in monthly cycle.

Human-identical progesterone

Contraindications:

Progesterone should not be used by women with any of the following conditions:

- Severe active liver disease: cholestatic jaundice, hepatitis, Rotor syndrome or Dubin-Johnson syndrome
- Any unexplained or abnormal vaginal bleeding
- History of herpes gestationis, jaundice of pregnancy
- Known sensitivity to progesterone creams or any of their individual components

Use in Pregnancy:

Progesterone is the hormone essential for promotion and maintenance of pregnancy. Ovarian output of progesterone in the non-pregnant state is 25-30mg daily during the luteal phase. The placental output during the third trimester of pregnancy is 340-400mg per day.

Whereas progestins are contraindicated in pregnancy, progesterone exhibits NO adverse effects on the growing foetus.

Possible risks and side effects of The Pill and HRT

- Allergic reactions
- Birth defects
- Breakthrough bleeding
- Decreased immune system function
- Disturbances in liver function
- Eye disorders (double vision, swelling of optic nerve, contact lens intolerance, corneal inflammation)
- Facial and body hair growth
- Fatigue
- Fluid retention and bloating
- Fungal infections and tinea
- Infertility increased with The Pill
- Irritable bowel syndrome
- Hair loss
- Hay fever, asthma and skin rashes
- Loss of Libido
- Lumpy and tender breasts (fibrocystic breasts)
- Migraines and headaches
- Nausea
- Nutritional deficiencies especially zinc, B6 and magnesium
- Psychological and emotional disorders, depression, mood changes
- Secretions from breasts
- Skin discolouration
- Higher rates of suicide
- Weight gain
- Systemic Candida infection
- Urinary tract infection
- Venereal warts
- Vaginal discharges (increased incidence of vaginal thrush)

More serious effects of The Pill and HRT

- Disturbance of blood-sugar metabolism (contributing to diabetes and hypoglycaemia)
- Increased incidence of thrombosis (stroke)
- Increased incidence of hardening of the arteries and high blood pressure
- Increased risk of blood clots
- Increased risk of gall bladder and liver disease
- Increased incidence of cancer of the breast, endometrium, cervix, ovaries, liver, lung and skin

- Increased risk of heart attacks
- Increased incidence of MS

Possible risks and side effects of natural progesterone

Because progesterone creams contain the hormone identical to that produced by the human ovary, side effects are usually minimal. If experienced, these may include breast tenderness and swelling, fluid retention or slight vaginal bleeding. Dizziness, nausea, fatigue, headaches and light headedness have been reported occasionally and usually disappear with adjustment of dose.

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Types of HRT regimes that might be offered by your doctor

- estrogen only - usually only recommended for women who have had a hysterectomy (can be natural or synthetic)
- estrogen + progestogen - usually recommended for women with intact uterus to protect the endometrium (lining of the uterus)
- sequential or cyclic treatments - estrogen taken 7-14 days followed by progestogen 10-14 days, resulting in a period after the progestogen dose is taken. Usually recommended for perimenopausal women to control menopausal symptoms and to regulate bleeding whilst protecting the endometrium.
- Continuous combined - estrogen and progestogen continually to prevent the thickening of the lining of the uterus without incurring a bleed. Usually for women 2 years post-menopause who do not wish to have a period in their therapy.
- progestin - oral pill or injection, combination varies for specific purposes and treatment such as contraception, perhaps endometriosis, PCOS.

How is synthetic HRT usually taken?

- tablets
- skins patches - (can include natural estrogen or natural testosterone), combination patches have natural estrogen but synthetic progestogen)
- creams and gels (natural estrogen)
- implants
- injections
- pessaries
- associated treatments

HRT cops more BAD PRESS

February 2005 - Rare, head to head European Study comparing HRT combos

Most epidemiological studies have shown an increase in breast cancer risk related to hormone replacement therapy (HRT) use. A recent large [cohort study](#) showed effects of similar magnitude for different types of progestogens and for different routes of administration of estrogens evaluated. The study assessed the risk of breast cancer associated with HRT use in 54,548 postmenopausal women who had never taken any HRT 1 year before entering the E3N-EPIC cohort study (mean age at inclusion: 52.8 years); 948 primary invasive breast cancers were diagnosed during follow-up (mean duration: 5.8 years).

Results of this study suggest that, when combined with synthetic progestins, even short-term use of estrogens may increase breast cancer risk. Micronized progesterone may be preferred to synthetic progestins in short-term HRT.

The only epidemiological study comparing the impact of progesterone and synthetic progestins on the breast was the PEPI trial, in which the authors assessed differences between placebo and several HRTs on the change in mammographic percent density. A result of breast cancer risk significantly greater with HRT containing synthetic progestins than with HRT containing micronized progesterone, at least for short durations of use (< 4 years), is therefore new.

February 2004 - Rise in breast cancers halts Swedish HRT study

Swedish researchers stopped a study examining the impact of hormone replacement therapy (HRT) in women with a history of breast cancer because of an unacceptably high risk of recurrence of the disease.

The study, originally planned for five years, was halted after only two because more than three times as many women taking HRT had a recurrence or new breast tumour compared to women who received other treatments to relieve symptoms of the menopause.

"We thought we found an unacceptably high risk for a new breast cancer event in women taking HRT," said lead investigator Lars Holmberg, of the University of Uppsala in Sweden.

"Patient safety must be first. We felt the risk was too high," he added.

After two years of follow-up, 26 women in the group allocated to receive HRT had a recurrence or new cancer, compared to seven in the other group not on hormone treatment.

More than 345 women who had had breast cancer took part in the study. They were randomised to receive either HRT or a non-hormonal treatment.

"Women on active treatment have been advised to discontinue," said Holmberg, whose findings were published online by *The Lancet*.

Millions of women have used HRT to relieve hot flashes, mood swings and sexual problems linked to the menopause and to stave off osteoporosis or brittle bone disease.

The Swedish decision followed moves by American and British scientists who also stopped HRT trials after learning HRT may increase the risk of breast cancer, stroke and blood clots.

An analysis of four major studies into the effects of HRT by scientists at the British charity Cancer Research UK supported the US findings.

The review showed that women who took the treatment for five years had a higher risk of breast cancer, stroke and blood clots in the lung but were less likely to suffer from bowel cancer or hip fractures.

September 2003 - FDA launches hormone therapy campaign

WASHINGTON (Reuters) - The U.S. Food and Drug Administration launched an education campaign about hormone replacement therapy, saying women are confused about recent warnings showing it should only be used in the lowest possible doses for the shortest possible time.

The therapy, once prescribed to millions of women to ease the immediate symptoms of menopause and to prevent osteoporosis and heart disease, has been found to increase the risk of heart disease, cancer and blood clots.

"Menopausal hormone therapy is a major personal decision for women and they need to be armed with the latest facts," FDA Commissioner Dr. Mark McClellan said at a news conference.

It is very important that women realize that this beneficial therapy also carries significant risks. Our recommendation is that if you choose to use hormone therapy for hot flashes or vaginal dryness, or if you

prefer it to other treatments to prevent thin bones, take the lowest dose for the least duration required to provide relief," McClellan added.

Researchers stopped a large study of HRT in July 2002 when it became clear the therapy increased the risk of heart disease, cancer and blood clots. A number of studies since then have supported those results.

"In January 2003, based on the findings of the ... study, FDA advised women and health care professionals that menopausal hormone therapy -- estrogen and estrogen with progestin -- is associated with an increased risk of heart disease, heart attacks, strokes, and breast cancer," the FDA said in a statement.

"The warning emphasized that these products are not approved for heart disease prevention."

But the specific risks vary from woman to woman and hormones are the only drugs that can relieve symptoms such as hot flashes and vaginal dryness and irritation. So the FDA has advised that HRT can still be used -- but at the lowest dose that works and for the shortest possible length of time.

The FDA devised the education campaign after a request from a House Appropriations subcommittee.

Many women became confused when they learned about the dangers of HRT, said one subcommittee member, Connecticut Democratic Rep. Rosa DeLauro.

"Suddenly, millions of women didn't know what to do about hormone therapy," she said. Many, including DeLauro, immediately stopped taking HRT, she said.

The FDA has set up a Web site [<http://www.4woman.gov>] to provide information and the agency has planned a broadcast campaign to educate women, McClellan said.

August 2003 - HRT and breast cancer: results of the Million Women Study

Doctors and women on hormone replacement therapies are being advised to review the use of treatments following powerful new evidence that they increase the risk of breast cancer.

An unprecedented study of the medical histories of nearly 1.1m British women who were cancer-free as they entered the national screening programme revealed that those on some types of HRT were twice as likely to develop breast cancer as those who had not used it.

The so-called Million Women Study, of whom about half used or had used HRT, also indicated for the first time that the increased risk started between one and two years of HRT use, dashing any suggestion that increased cancer risk only developed after long-term use. But the risks grew larger the longer the HRT treatment continued.

Researchers, medicine watchdogs and HRT companies last night sought to dispel any sense of panic at the latest findings, which arose from the biggest single study of women's HRT use and breast cancer. But the results dealt another huge blow to the reputation of the drugs, used by an estimated 1.5m women in the UK and responsible for 6m prescriptions annually in England alone.

These were once extolled for their power not only to treat the symptoms of the menopause, such as hot flashes and night sweats, but to make "new women" of those entering their 50s and 60s.

But in the past two years researchers worldwide have questioned how effective HRT has been in preventing many illnesses, and whether the long-term benefits outweighed risks.

The biggest blow dealt by the Million Women study, the results of which are published in the Lancet medical journal today, was to combination oestrogen and progestogen therapies, taken by about half of all those on HRT in the study. These doubled the breast cancer risk. They are widely used, because oestrogen-only therapies are known to increase cancer of the womb-lining.

But oestrogen-only therapies, taken by four in 10 HRT users in the study, only increased breast cancer risk by 30%, leaving a difficult dilemma for women and their GP advisers about what to do now. Breast cancer is far more common than cancer of the womb. However, more reassuringly, the extra risk disappeared within five years of giving up treatments.

Other emerging evidence from the study suggests that women still using HRT have a 22% extra risk of dying from breast cancer, for which survival rates have greatly improved in recent years. But so far,

according to researchers, this result is of "borderline" statistical significance, and it is too early to estimate extra cancer deaths due to HRT.

However the researchers, funded by Cancer Research UK, the NHS breast screening programme, and the Medical Research Council, calculate that during the past decade HRT use has resulted in an extra 20,000 breast cancers in women aged 50-64, combination therapy accounting for three-quarters of these. In this age group, 15,000 new breast cancers are diagnosed yearly.

Lead author Valerie Beral, director of the Cancer Research UK epidemiology unit at Oxford, said: "Since our results show a substantially greater increase in breast cancer with combined HRT, women need to weigh the increased risk of breast cancer caused by the addition of progestogen against the risk of uterine cancer. Comparing the risk is by no means simple, and women may well want to discuss options with their doctor."

Press release on HRT and breast cancer - Cancer Research UK Summary of the Million Women study - The Lancet (free registration) Department of health.

Breast cancer is a major health issue. It is the most common cancer-related cause of death in women in Australia. One in twelve Australian women will develop the disease and each year many women die from it. World-wide about 1,670,000 women have breast cancer. And in North America, a woman dies of breast cancer every 12 minutes!

July 2003 - HRT cops more BAD PRESS!

The Women's Health Initiative study was stopped short one year ago when it became clear that estrogen-progestin increased the risk of breast cancer, heart attack, and strokes. But research using the data from that study goes on, and the latest findings are nothing less than a disaster.

Examining records of more than 16,000 women, researchers concluded that combined HRT tends to make breast cancer tumours more aggressive and harder to detect, reducing the chances for successful treatment.

A spokesman for Wyeth Pharmaceuticals (the makers of Prempro, the brand name for estrogen-progestin) told the Associated Press that hormone therapy remains "an appropriate therapy when used at the lowest possible dose for the shortest possible time." Is that an absolute gem of drug company double-speak? That's about as close as you can get to saying, "Stop using it." Which may be the best advice for the 3 million U.S. women who still are.

July 12, 2002 - Urgent call on HRT

It's official. Synthetic hormone replacement therapy (HRT) is no longer considered 'safe' when used long term, and perhaps increases the risk of cancer and heart disease. Links of HRT to breast cancer, stroke and other diseases has caused widespread panic to the 600,000 Australian women on some form of HRT, inundating the Cancer Council Australia's hotline.

While health authorities urged women not to panic, the Therapeutic Goods Administration's (TGA) decision to appoint a taskforce was considered a measure of urgency of the situation.

Parliamentary secretary to the Health Minister, Trish Worth, said the US research should be taken seriously. "It is important that Australian women feel confident about the medications that they use," she said.

While women are being urged not to panic, that there is "no suggestion of any short-term toxic effect of combination hormone replacement therapy requiring immediate cessation", the Australian Division of General Practice has drafted a fact sheet, which will be distributed to GPs today, to help them answer questions from patients.

It is recommended women who have been using oral estrogen plus progestin (not to be confused with bio-identical progesterone) for less than five years should not be concerned, but should have their therapy reviewed each year.

On Tuesday, the US study on the risks of combined estrogen-progestin was called off because of fears for its participants. The trial was cut short after five years because it was found one in 100 women taking

the HRT combination suffered health consequences, including breast cancer and heart disease. The US findings could have legal implications for the manufacturers of HRT drugs.

According to statistics from the Health Insurance Commission, Australian women spent more than \$22 million on the suspect HRT drugs in 2000-01. More than 164,000 prescriptions for Premarin were processed in Victoria in 2000-01 and 95,000 for Provera.

Up to 50 per cent of Australian women used it to alleviate symptoms of menopause in the short term. A much smaller percentage took it to prevent chronic diseases such as osteoporosis over the longer terms, defined as five years or more.

Women should heed warnings that hormone replacement therapy can cause serious illness, and export medical committee found last night (July 12, 2002).

The urgently-convened panel ruled that combined HRT should not be used by women in the long term. It backed US findings that combined estrogen and progestin increases the risk of heart disease, breast cancer and stroke. The expert committee also recommended a review of the use in Australia of combination HRT in long term prevention of osteoporosis. However, the expert taskforce, set up by the TGA, also concluded combination HRT was an appropriate treatment option for symptoms of menopause. Victorian president of the Australian Medical Association Mukesh Haikerwal renewed calls for women to seek individual advice from their own GPs. However, the Nation Health and Medical Research Council was under fire last night for failing to update its HRT guidelines in six years.

Australia's peak medical advisory body yesterday announced plans to fast-track a review of its guidelines for HRT. Those currently on the NHMRC website state HRT may cut heart disease by up to 50 per cent despite medical professionals fearing the opposite for several years.

"Although there may be an increased risk in developing breast cancer, this risk seems to be more than offset by the enormous benefits in preventing coronary heart disease and osteoporosis," it reads.

Australian Consumers Association spokeswoman Nicola Ballenden said it was another blow to women already unnerved by this week's alert. "Women are understandably feeling like guinea pigs," Ms Ballenden said.

HRT - Why weren't we told sooner?

The Australian Consumers' Association said that it was understandable that many women would be extremely worried by recent research findings that HRT can increase the risk of heart disease and breast cancer.

"Many women are feeling like they have been treated like guinea pigs. HRT has been widely promoted as a safe panacea to the uncomfortable symptoms of menopause, now we are finding that sometimes it is not safe at all" Nicola Ballenden, a Senior Health Policy Officer with the Australian Consumers' Association said today.

Ms Ballenden said that the revelations had the potential to undermine consumers' trust in their doctors' advice, which could be very damaging.

This story highlights the fact that pharmaceutical companies are the main source of information for many doctors. Pharmaceutical companies have an interest in selling their products and they do this by heavily promoting drugs, including HRT to doctors. The question is whether doctors are getting balanced information or just promotional material from the pharmaceutical companies.

Also muddying the waters are the mixed 'expert medical opinions' that abound. "What consumers, and often doctors, don't understand is that frequently medical experts have a financial relationship with pharmaceutical companies, so their expert opinion might be influenced by this arrangement" Ms Ballenden said.

Consumers are right to wonder why they weren't given the full picture earlier. As long ago as 1997 British Medical Journal review of 22 studies concluded that there was no evidence that post-menopausal HRT prevents heart and blood vessel problems. Until recently women weren't given this information, but were told that HRT could protect them from heart disease.

Consumers are right to ask "Why weren't these products tested more thoroughly before they were prescribed so broadly and why weren't we told of the possible risks earlier?"

Is bioidentical HRT addictive?

Do women experience any side effects coming off bioidentical HRT? Based on observation, "no". Women who stopped using natural progesterone cream were not bothered by drug-related 'withdrawal' symptoms. Rather, they reported a resurgence of their estrogen dominance symptoms indicating their body genuinely required natural progesterone supplementation to support their hormone balance.

Synthetic HRT is another story entirely. We've seen women seek out doctors other than their own GP who will surgically insert a replacement estrogen and/or testosterone implant long before replacement due date. They claim that as time went on, their implants became less and less effective, and they experienced withdrawal symptoms even though blood tests indicated normal to high levels.

We suspect the medical profession recognises the potential to become addicted to, or reliant on implants.

Women who withdraw from HRT do experience very distressing side effects as a result of estrogen levels dropping and the brain being conditioned to what our website refers to as "an estrogen conditioned threshold". The body appears to be conditioned to these high levels of estrogen, and variance appears to trigger a re-emergence of symptoms with a vengeance. Depression and anxiety surface, often peaking at around 3 months after discontinuing estrogen.

This is one reason why long term estrogen users need to 'wean' off estrogen slowly in order to allow the biofeedback mechanism in the body to adjust, and allow for adequate time for natural progesterone to saturate the body and to buffer this huge ratio difference. Women who go off estrogen therapy 'cold turkey' find it a very uncomfortable experience, and may return to HRT despite all their previous side effects purely because they are unable to cope with the inevitable withdrawal and associated menopausal symptoms which appear to be far worse than those faced by women going through a difficult menopause 'naturally'.

Interestingly, many women who stop taking synthetic progestogen tablets after experiencing negative side effects usually feel instant relief, especially if they replace progestogens with bio-identical progesterone. We have not seen evidence of actual withdrawal symptoms coming off synthetic progestogens other than the thickening of the uterine lining, particularly if estrogen is continued.

Whilst a woman continues to use estrogen therapy, estrogen will dominate the hormone environment allowing the potential problem of uterine build-up to occur whilst that woman is being weaned off estrogen. This is when initial high levels of natural progesterone (10%) may be called for until there is a balanced ratio between estrogen and progesterone.

A reduction program of progesterone is required in accordance to the reduction of estrogen levels in the body. And it's only when a woman has totally weaned off estrogen and is asymptomatic for 4 months will she then be able to establish her true physiological dose of progesterone (around 20-32mg). There have been cases where, after 4 months, symptoms have not abated and a very small dose of natural estrogen was required.

Use hormone blood profiles to ascertain levels. It's important to make sure that your progesterone is actually opposing uterine build-up. So work closely with your doctor, and have the required tests that keep a check on this.

Important: As you wean off estrogen you must take a break from estrogen at the same time you take a break from progesterone, otherwise estrogen dominance will reside which has the potential to cause uterine problems.

Coming off estrogen replacement therapy

We'd like to warn women who have been on estrogen therapy for a long time that it's not wise to go "cold turkey" and stop their estrogen as their body is conditioned to a high threshold of estrogen. A sudden drop in estrogen can actually cause hot flushes and can contribute to rapid bone loss as the body tries to adjust.

We suggest you begin by cutting your estrogen dose in half, and then again by half in a few months time, until you find the lowest possible dose that keeps you free of symptoms.

If you are using natural progesterone in conjunction with an estrogen reduction program, remember to take your break from estrogen at the same time as you break from progesterone.

Just be aware that progesterone will up-regulate estrogen receptors, that's why we suggest you initially halve your dose of estrogen when introducing progesterone back into your body. In effect, the body still interpreting estrogen at high levels. As progesterone becomes more effective and your body adjusts so, in turn, will the body synchronise with the gradual reduction of estrogen.

Some women do go "cold turkey" and feel great for 2-3 months, and then fall into a hole. The reason being, they are initially over-riding estrogen dominance symptoms with progesterone and also they have reserves of estrogen in their body fat. The sudden slump comes about because when they have used up all their body's reserve of estrogen. Symptoms such as hot flushes, teariness, anxiety, palpitations, insomnia, bladder infections, cystitis, may surface.

If this occurs it is perhaps advisable to re-introduce a small amount of estrogen to restore equilibrium to the body and to abate symptoms. Then, if inclined, a gentle reduction program using your symptoms as a guide.

Some women can come off estrogen altogether, whereas some cannot. They may require a small amount along with their progesterone. Many women prefer to try phytoestrogenic formulations and high intake of plant foods containing phytosterols and find this sufficient without the need to take estrogen replacement therapy.

If progesterone alone does not abate symptoms of hot flushes and vaginal dryness after four to seven months (incorporating phytoestrogens), it's usually an indication that some form of estrogen is required. Best you get your hormone profile checked out.

A small number of women find the patch form of estrogen delivers too high a dose, dumping in body fat. These women prefer to take transdermal estrogen where they can control dosage at low levels. And, of course, there are those women who successfully take low oral doses of estradiol (0.25 - 0.5mg per day three out of four weeks) or 2-4mg of oral estriol along with their progesterone cream as opposed to Premarin that is reported to be less kind in side-effects for a lot of women.

A more popular form of natural estrogen therapy emerging is the Triest combination incorporating the three estrogens in proportion, compounded by a select few pharmacists (all forms of estrogen require a script in Australia).

Alternative therapies

Drug companies (via your doctor's surgery) scare women into believing that diseases such as osteoporosis and heart disease are inevitable consequences of menopause.

They advocate that while alternative therapies may relieve some symptoms of menopause for some women, they are not HRT and do not replace the vital hormones required by the body to function well and prevent diseases.

They claim that many of these over-the-counter medications and products derived from soya beans, wild yam, evening primrose, red clover, etc., are not researched or tested to the same standards as conventional drugs and the effects of these remedies, long term, have not been established.

Not true, according to our website. Many women have shared their success story of how they adopted alternative therapies without the need for hormone replacement.

These over-the-counter remedies (knowledge of which dates back centuries) have provided women with effective alternatives that enhance hormonal health and balance, rejuvenated their energy and stamina, supported their metabolism, aided weight loss, and counter-balanced depression and anxiety, and insomnia.

This has been as simple as incorporating a balanced phytoestrogenic formulation, increasing their essential oils, supporting liver and adrenal functioning through vitamin, mineral and liver formulation, acknowledging their body type, and eating foods that are compatible to their hormonal and metabolic characteristics.



We've also noted in some women a drop in cholesterol, blood pressure and fluid retention. So while drug companies may claim there's no proof, our website certainly has empirical evidence to the contrary.

Let's state up front that not every women approaching or in menopause needs hormone replacement therapy, be it via any of the natural hormones or conventional synthetic HRT. Their diet, exercise and lifestyle can carry them through, disease-free, to old age. These fortunate people are free of disease, have good bones, and maintain hormonal harmony from the foods they eat which contain plant hormones known as phyto-sterols that have a balancing effect upon their cell receptors.

In a body functioning optimally, hormones are manufactured by the ovaries, adrenal glands, fat tissue, thyroid and pineal glands. Only when the sex hormones are out of balance in the body is there a need for hormone replacement therapy. And at this point you would thoroughly consider all your options.

We see so many women entering menopause or post-menopausal who were asymptomatic but were placed on HRT as a preventative measure, only to be faced with a host of new health issues ranging from weight gain, high cholesterol, headaches, fluid retention, irritability, etc., none of which were pre-existing prior to HRT.

Women who are considered low risk and possibly do not require hormone replacement therapy are women who:

- Have good bones - medium to heavy bone structure
- Do not have osteoporosis (or family history)
- Do not have cardiovascular disease (heart, stroke, embolisms) (or family history)
- Do not smoke
- Do not suffer depression
- Do not use drugs that might increase bone loss (steroids, thyroid medication, diuretics, antacids)
- Have an intact uterus and ovaries (no history of tubal ligation)
- Correct weight to height ratio
- Good cholesterol and blood pressure reading, normal functioning thyroid
- Exercise regularly
- Have a healthy diet rich in fresh fruit and vegetables, low-saturated fat diet,
- Enter menopause between 45-45 years of age
- Have no estrogen dominance symptoms or history of PMS
- Have a happy disposition and good relationship

4

General attitude towards progesterone

Escalating hormonal problems

Women are discovering across the globe that progesterone is proving to be the missing link to their hormonal health and wellbeing in general. And this excitement and newfound knowledge is contagious. More and more, women want to share this revelation with their fellow sisterhood.

There is, however, a resistance out there despite the fact symptoms appear to be associated with 'estrogen dominance' - a term coined by the late Dr Lee, where progesterone levels are inadequate and estrogen dominates the hormonal environment. This can be caused by synthetic HRT, obesity, eating habits, fatty liver, lifestyle, or exposure to toxins in our environmental.

Our society has given rise to the 'quick-fix' approach, where we reach for a tablet to rid ourselves of pain or excess weight, get rid of, regulate or halt menstruation, protect against fertility or remove any likelihood of pregnancy the morning after. We are a society that has learnt there are quick, easy solutions which ultimately remove us from the responsibility of dealing with, and perhaps preventing these health problems.

With the advent of HRT, multi-national drug companies have ever-so-cleverly conditioned us to view menopause as a 'disease' we can 'side-step' completely with the aid of a tablet ... and look more youthful into the bargain. In many cases, we're given HRT as the standard form of treatment where no treatment may be required!

What women fail to realise when contemplating this 'one size fits all' treatment of menopause and menopausal symptoms, is that at the end of the day huge health problems continue to plague women. HRT hasn't provided a solution, but rather generated 'repeat sales' for the drug companies and GPs who's business thrives as a result of the follow-up consultations and medication prescribed to treat secondary conditions that exist because women have been encouraged to take HRT in the first place.

If a woman is serious about embracing natural hormonal balancing techniques that include progesterone therapy then she is going to have to do the investigative work. Hormonal health and wellbeing takes hard work, commitment, time and responsibility for the part you play in keeping yourself well. There is no quick fix or magic bullet on the immediate horizon.

What about our teenage children?

Mothers contact our website looking for answers. Acne, irregular and/or painful periods or the absence of periods, sudden weight gain, daughters presenting with symptoms that indicate polycystic ovarian syndrome (PCOS) and endometriosis, or who are exhibiting huge androgen effects in their body as a result of their eating habits.

By the time these mums find us, some have already tried putting their daughter on The Contraceptive Pill only to experience further problems. Or they just don't like the idea of giving their child synthetic drugs, especially at such a tender age when reproductive organs are still maturing.

When it's suggested these symptoms may indicate hormone imbalance, it comes as an absolute shock to the mother and her daughter, and the following comments are not unusual, "but I've had her tested out", "the endocrinologist says she is fine", "there is no reason for her to be going through all this".

When women approach this website with a history of migraines and PMS, we suggest it may be a peri-menopausal symptom, perhaps estrogen dominance, or the result of hormone imbalance subsequent to a tubal ligation, etc. Or, if a menopausal woman comes to us after HRT failed to provide relief, or she is actually suffering debilitating side effects because of HRT, she'll turn around and say, "This isn't right, my doctor said that I wouldn't have to go through menopause", or perhaps "I thought I was through menopause".

There seems to be a general lack of awareness and knowledge about our reproductive health. There's a tremendous gap in education that makes it rather difficult to help a woman make sense of the various hormonal changes occurring within her body throughout her life. Bodily changes during puberty are taught in sex education classes at school. It's now common practice for a mother to teach her daughter all about the developmental stages of her young life - getting her period, the rounding of her body shape, growing boobs, having babies and contraception - but no one out there teaches a woman that the ebb and flow of her hormones will continue throughout her lifetime. And can be markedly influenced by the chemicals and toxins in her environment, her eating habits and poor nutrition, her state of mind, her sedentary and somewhat stressful lifestyle, all of which can create endocrine disruption to the body.

It is little wonder then that when we mention the word 'menopause' or 'hormonal imbalance', women automatically make the association, "Oh my God, that doesn't happen until you're in your fifties and sixties", drawing the conclusion that it's some form of unwanted disease or unwanted stage of life to be avoided at all costs. In some people's mind, it's a barometer that they are over the hill and heading down the pathway of osteoporosis and redundancy.

There seems to be this pervading sense of embarrassment and social myth surrounding women's hormonal health that we suspect is driven by big drug companies to keep women in the dark for monetary gain. Sadly, we wait until we are met with a health crisis in our life before doing something about it. It usually takes some life threatening situation or confrontational issue before we'll actually change our life or change our style of living and with it, our eating patterns. And for this to occur, it usually takes a tragedy rather than from being generally well informed. What smoker doesn't know about the risk of lung cancer, and yet may wait until she has emphysema or a life threatening disease before she actually considers giving up the cigarettes. We find hormones are very much similar to that. Women generally contact our website at the point which they have exhausted all options and have got nowhere else to go.

Over a period of time we have witnessed some fantastic, remarkable things occurring throughout the network that connects women with friends and relatives. Women are helping women. They are educating others purely by spreading the word gently. Often women ask the Natural-Progesterone-Advisory-Network.com website, "How can I get my mother or how can I get my sister to use progesterone?" The

fact is, you can't. All you can do is make the information available and leave it with her. Because when the time is right, when she needs it, she will come back to it. The seed is sown. The only thing a woman needs to do is offer her mother, her sister or her friend an 'opening' to learn more beyond what they are currently aware of.

One of our greatest joys and challenges has been to advocate natural progesterone to every woman we come into contact with such that each has an opportunity to embrace a more natural, safer form of hormone replacement therapy.

We jump at every opportunity to help educate young teenagers because it is the younger generation we are most concerned about. More and more, we are seeing problems emerge where girls and boys are entering puberty earlier, where they are battling uncontrollable weight gain and in some cases severe hormone problems. Cases of infertility are doubling, there seems to be a growing risk of breast cancer, endometriosis, ovarian dysfunction. Menstrual problems that require synthetic HRT (The Pill) are on the rise. Basically, adolescents are suffering hormonal imbalance like never before in history.

We've seen hormone disruption across all age groups, not just the aged. We have seen it from as early as 9-10 years of age, right through to 80, but unfortunately the problem seems to be accelerating. There appears to be a correlation with our fast-paced lifestyle and reliance on fast foods, refined sugars and carbohydrates. We have been trained to accept that there's a drug out there to fix all our problems. But there is always a high price to pay for quick fixes.

So, if someone is resistant to your suggestion of progesterone, don't be offended by it or put off. Pat yourself on the back and say, "I've paid it forward". When these women are ready, the right information will present itself, or they'll come back to you asking for more details.

Let your own good health speak for itself. It will be your own results that shine through. It will be your renewed hormonal health that will be the proof of the pudding, not your words. In effect, "Walk the talk". Don't make the mistake of lecturing in the blind hope you'll reform the world. Instead, just take responsibility and reform yourself. Take some action in protecting your environment, your immediate health and family, and news will spread. And when there are enough women out there doing this, a paradigm shift will occur. But we cannot instigate change until we make the change within ourselves.

Every day, we see more and more women making this internal change, which gives us faith and hope that the future might yet promise optimal health for our grandchildren.

Picking up the pieces

Judging by the small sample of emails we publish below - and we have hundreds more like these - you cannot help but feel overwhelmed by the hard choices these women face.

More troubling still is the fact these poor ladies are forced to make life-altering judgement calls concerning their health without any suggestion of support, particularly should they challenge, and refuse to comply with their treating physician's recommendation of synthetic HRT.

Some, you will read, have been set totally adrift without even the basic understanding of what's happening to their bodies post hysterectomy ... while their life spirals out of control.

Hi, I need your help!!! I am 39 years old. I had a surgical hysterectomy July 1, 2002. Both ovaries were removed. I am scared to death to take the HRT my Dr. has prescribed. The many instant menopause symptoms have started to really hit me hard. I am concerned that I can not endure all of them. I tried the estra ring to reduce the vaginal atrophy. I had an awful reaction. I wanted to crawl out of my skin. I went to the Dr. had a yeast infection and removed the ring. The Dr. wants to try me on estrogen and testosterone combination pill. I am afraid to start them. The Dr. wants me to take them for 4 weeks and return for a visit to evaluate. At that time he said he might add the natural progesterone cream. Can I take the progesterone cream without the estrogen pill he wants to give me? I was estrogen dominant prior to surgery. I wish I had found your site before July 1. Can you advise me on how to feel good again? I have started to gain weight, I can't think clearly, Hot flashes hit me about 2 - 3 times an hour, insomnia, vaginal atrophy, moody, the list goes on. I am truly afraid of breast cancer. I had no idea that the body has estrogen receptors and how important they are. Please help me soon! ~Judy~

Hi, I am writing in on behalf of a close friend who is absolutely desperate and in need of help. After a lifetime of painful periods and endometriosis (she is 45 and perhaps perimenopausal) she has been advised that the only solution for her is a hysterectomy. She cannot bear this and is currently on her 3rd set of synthetic progesterone to stop a bleed (due to the endometriosis) and is in constant pelvic and lower back pain. I really need to get her to see a sympathetic doctor who is willing to try natural progesterone as a solution before she takes this major step. I don't know if this comes into what you do but I would really appreciate any suggestions as to someone in the Sydney area if at all possible before she takes this drastic step. -Libnan-

I am 43 years of age. When I was 40, I had a complete hysterectomy including removing both of my ovaries due to endometriosis on both ovaries and in uterus. We have one daughter. I was 30 when she was born. When I was 32 my husband and I decided to try for another child, but it never happened. I guess you could say that was the beginning of my ordeal. I had two laparoscopies, took depolupron shots, fertility drugs (Clomid)... and so lot's of pain, lot's of disappointments. We tried for 6 years to get pregnant and it never happened. The Drs wanted me to have a hysterectomy when I was 38 due to the pain I was having ... however, I was hoping for a miracle. (Another child)... but that never happened. So... here I am at 43 years of age... having had both ovaries out and my uterus... I have not been able to take the traditional hormone replacement therapy such as Premarin, or any of the other pills... and that took a year to figure out... I finally started with shots of estradiol however could not seem to get that regulated... I was having to get shots all the time... so I am now on the estrogen patch... .05 strength. I have supplemented with testosterone cream for libido...but I have had palpitations, mood swings, and no energy... sometimes I feel like I am at my wits end. I am beginning to wonder what happened to the joy in my life... I have always been really a happy person. A friend recommended that I try the progesterone cream which I bought the strongest brand that the drugstore makes that they can sell over the counter.. and it just gave me headaches... can progesterone help a person in my situation with no ovaries and cycle? -Steph-

Please help. I have been reading about natural progesterone and need to know if I can use this product. I had a bilateral mastectomy in August, 1999 because of pre-cancer condition in both my breasts. In January of 2003 I had a total hysterectomy. Now I am suffering from night sweat, hot flashes, no sexual desire at all and I'm only 51 and need help badly. I need to know if natural progesterone is like estrogen. I can't take any product with estrogen, but I truly need help. So can you tell me if there is any estrogen in your product. I would truly like to try natural progesterone to see if can help me. All my doctors say take estrogen, but going through what I have with my mastectomies I can't even think about taking any product that might help my body to develop any form of cancer. -Lois-

After visiting my doctor, he took me off of the progesterone and has kept me just on estrogen. I had a total hysterectomy 4 years ago and my doctor slapped a patch on me while I was in the hospital. After many talks with my GP, (telling him I felt in a fog, etc) I went to my pharmacist who filled a prescription for a natural hormone. My doctor insists that I don't need the progesterone part of my prescription. He sites that "since I don't have a uterus, I don't need the progesterone", he also felt it would increase breast cancer and heart disease. I've gained weight even though I watch my diet, I exercise but find myself tearing up at stupid things. Could this be attributed to my lack of progesterone? My pharmacist says yes, my doctor doesn't want me to be back on progesterone. Any suggestions? I'm seeing my doctor today to discuss this. -Mary Lou-

I had a partial hysterectomy 1 and 1/2 years ago. I am 35 and still have one ovary. I am confused about how the cream would work for me because I don't know what my cycle is because I don't have a period, but I am not menopausal????? I check off almost every symptom on the list of symptoms that can be helped with the cream so I am excited to try it if it will work with someone like me. -Rebecca-



Getting a doctor on side

Practitioners remain cautious

Certainly, we can appreciate why doctors remain cautious and wary of a drug (like natural progesterone) that doesn't show up in their manual, and does not appear to have any credibility attached to it at this point in time.

Being an unpatented drug, there is little clinical evidence to support its usage. But change is in the wind. A 2005 European [cohort study](#) demonstrated that micronized progesterone may be preferred to synthetic progestins in short-term HRT.

There are no drug companies, other than Wyett and Ayerst who have already patented their pure progesterone vaginal gel (which we will see more of in the future), who present strong evidence to weigh its usage. That is, until any one of these multi-national drug companies can devise a patentable delivery system of natural progesterone. Beyond that, women unfortunately stand alone in their fight with their GP for recognition of a treatment that they want and have the right to request.

Some doctors, on the other hand, mistakenly believe they are already prescribing progesterone to women when, in fact, they are issuing a prescription for artificial progestins. These doctors have been fed a lot of mistruths, compounded by misrepresentation on the part of the drug companies who are leading doctors to believe their particular brand of progestogen is a 'natural' progesterone or derived from 'natural' compounds. This is stretching the truth somewhat because they have failed to explain to doctors how these natural ingredients have been molecularly tampered with and are no longer 'natural' or bio-identical to the body.

Little wonder confusion reigns out there. And little wonder doctors are even more confused when a woman arrives in the surgery demanding a script for natural progesterone.

We have women who come back to us in tears stating that their doctors were adamant that they are already prescribing natural progesterone, and that the women are the ones that actually are misinformed and/or confused. That the women do not exactly understand what they are asking for, despite the fact that they have their information, books, tapes, and supportive evidence on progesterone. Doctors still dismiss them, make light of the issue, perhaps write out a script for some form of progestogen or blankly refuse altogether, then instruct them to stop being so silly.

It is standard procedure for drug manufacturers to provide your doctor with a Standard Product Information Leaflet on all prescription drugs he can legally prescribe or his patient might request. You now have access via this website to an 'sample' of the information your GP would reference when prescribing natural progesterone provided by a pharmaceutical company. In this instance our information is provided by Lawley Pharmaceuticals who specialises in alternative and mainstream health care, focusing on natural progesterone as an adjunct to traditional hormone replacement therapy.

Many doctors don't understand the difference between progesterone and a synthetic progestogen, so therein lies a problem to start with. The second problem lies in the fact doctors do not take kindly to being told they might be wrong. They don't appreciate their patients turning up with more information on a drug like progesterone which they have failed to research. This deflates their ego and/or threatens them. Thirdly, a doctor is trained a specific way and has developed a certain mind set.

One suggestion would be, don't go into your doctor's surgery with a know-it-all attitude intent on ruffling feathers or upsetting egos if you genuinely want to help your GP become aware of your needs. You are, after all, asking him/her to support an alternative hormone replacement therapy that may or may not work, and to provide you with informed choices rather than drug propaganda.

Unfortunately, because most doctors are on very tight schedules, and are very busy people, they often don't listen correctly to their patient's needs. They sometimes don't hear what is really being said or fail to read the information on progesterone that the women leave behind. These female patients are doing their utmost to meet their doctors half-way, yet, sadly, their doctor will have none of it. As a result, so many women turn to the black market to source their cream and self-medicate, or seek out alternative medicines.

Therein lies another problem, because a good many naturopaths won't embrace progesterone purely on the basis they are not 'authorised' to sell an S4 drug (here in Australia).

Occasionally, we learn of naturopaths who acknowledge progesterone and encourage women to use it. But again, we come back to the common hiccup - if a woman needs to obtain a doctor's prescription how does she obtain a script from her doctor? How do women break this rigid mind set? How do we get our doctors to understand what we are really asking for? Get our doctors to recognise our needs and to understand that perhaps his/her form of treatment or prescription drugs hasn't really worked for us.

So many times women have recounted how they just couldn't find the nerve to go back to their doctor because they'd have to admit that they didn't go through with the prescribed HRT. That perhaps they threw the drugs down the toilet, or didn't want to own up to the many side effects that caused them to stop HRT. In the absence of such negative feedback, these doctors go on to assume that synthetic hormone replacement therapy is a successful form of treatment.

On the other side of the equation, these women who are taking progesterone successfully, getting well again and realising a renewed quality life, don't feel the need to go back to their GPs to report the excellent results. So, to be fair, their doctors are none the wiser.

Our organisation has always encouraged women to work closely with their doctors, and for doctors to draw closer to their patients. We feel the Women's Guide to Natural Progesterone website has been like the 'go between', bringing natural alternatives into the domain of the doctor, and medicine into the domain of alternative therapy. That which is in the best interest of the patient is what matters most ... not which side of the fence it is offered.

Now that progesterone has been tagged an S4 drug here in Australia, it is always going to remain under this classification. Therefore, we have to learn how to bring our doctors up to speed. Learn how best to demonstrate to doctors that what we are doing with natural progesterone is not dangerous but rather is proving to be a successful form of treatment for a majority of women, if used and managed correctly. Egos aside, we seek to break down the mind set, to be open to the possibility there is a safer form of hormone balancing available.

Women in some countries cannot purchase progesterone readily over the counter or through distributors. They can, however, lawfully purchase 2-3 tubes for personal use over the internet provided it is not used outside your immediate family.

Keep in mind, generally speaking only sick women return to their doctors. Those women using progesterone and realising fantastic results rarely report back to their doctors. Those healthy women who have enthusiastically returned to share with the GP their renewed hormonal balance have been met with comments such as, "It's just placebo" or "we don't know the long term effects". This reaction by some of the medical fraternity is very discouraging and hurtful, especially if they profess to hold their patient's best interest at heart (which bears further discussion at a later stage).

Doctors who embrace natural hormone replacement therapy perhaps feel more comfortable working in higher dosages, again because they don't have the appropriate evidence to support the effectiveness of topical absorption and its effect on the endometrium at physiological doses. Nor are there trials/studies to back it. Of course, there are no trials or studies with troches or lozenges that we know of. Perhaps with the higher levels doctors feel they are conferring endometrial protection, and believe because they are following traditional hormone replacement therapy guidelines they will not be accused of negligence.

Women using troches need to be monitored by their doctor for symptom relief and to ensure their troches are tailor made. The catch here is that in order to get troches, lozenges or pessaries you need to have a doctor on side ... and there are very few out there willing to write a script.

We have observed a few doctors raise their consultation fee for women seeking NHRT. If you are visiting a doctor who prescribes natural progesterone, make sure that doctor really is working with you, listening to you, and keeping an eye on your symptoms; monitoring your progress rather than sending you back to other doctors to oversee.

If a doctor is specialising in this area/niche in the market place, then that doctor ought to have you as a total patient not just the hormonal patient. This is a holistic approach and a holistic event. Your doctor needs to know what other forms of treatment have been prescribed to you. So often we have seen doctors who are willing to prescribe progesterone, hand out a hefty bill at the end of the consultation (maybe because they're the only GP in town writing scripts) only to send that woman back to her family GP for tests and other forms of follow-up treatments.

Many bad situations have occurred. Here are a few (of many):

- a woman prescribed a cortisone injection for pain in her shoulder which totally negated the use of progesterone;
- the doctor prescribing progesterone refuses to tell the endocrinologist that the patient is on progesterone and the patient then having to cover her doctor's tracks.

This is not on. If a doctor is going to take responsibility, he or she should be in there boots and all. None of this semi-commitment based on outcome. Be comfortable with your doctor and make sure it feels right.

Doctors are human beings and are not always ethical. It is sad that a small percentage of doctors recognise women's desperation as a business opportunity. Perhaps their interest isn't as much in the belief and benefits of the progesterone as getting bums on seats.

Unfortunately, but it's a fact, women who need a script will get it any way they can, including a visit to these types of doctors who take their money but offer no support and/or education. This really is concerning because women are all too often left on their own to self-medicate. They've had to sneak behind their own doctor's back, accept treatment that may be contraindicative of progesterone usage, maybe they're unable to tell their doctor the full story ... all of which has the potential to end badly.

Try and work with your own doctor. Be strong, courageous and assertive. Doctors provide a service; they are there to serve you. You pay the bill and they are accountable. Ultimately, it's up to you to be the person who instigates what you want. Stand up for your values and beliefs, no matter how hard it may seem at the time, and no matter how intimidated you might feel. If you believe this is an opportunity you would like to explore, you have the right to do so. After all, what you are asking of your doctor is to have the unaltered, unpatentable form of progesterone that he/she is already prescribing; the progestogens such as Provera etc. , are formulated from natural progesterone.

How can hundreds upon hundreds of women be wrong? There is a revolution going on, driven by women around the globe. It's momentum is building. But it has to start with each and every individual woman. For change to occur we must be daring and willing to take it upon our own shoulders.

It only takes a second to change a mind set but we just don't know how many women it will take to change the way the medical fraternity views natural progesterone. The trials that doctors require to be convinced may have to come from us. We are the walking, talking evidence.

Our stories and painstaking journals are living proof. We must go back to our doctors and keep gently referring to our good health, our improvement and quality of life, rather than avoiding the issue and feeling ashamed that we are taking something without their blessing.

We are the ones that have the power and control so why do we keep handing it over to our doctors? And why do we abandon ourselves, our true self, to gain approval or to place some other person's needs or opinions above our own. We only get one body, one chance, one time here on earth. If we allow ourselves to be guinea pigs and manipulated by trends, drug companies, or greed, then we really have lost an opportunity to claim a part of our magnificence.

Approaching your doctor

We suggest women go with information in hand. Take your book, information and, if possible, a Drug Sheet showing contraindications and indications which really blows these doctors out of the water because they can see that it has indications, use, dosage, guidance.

Visit our website and download the following report to hand to your GP:

<http://www.natural-progesterone-advisory-network.com/PDFs/BreastCancer.pdf>

Australian women who previously had difficulty getting their doctors to write a script for natural progesterone can breathe a little easier. Pro-Feme is now listed on their doctor's computer as a recognised prescription drug with dosage clearly defined. This DOES NOT lock you into buying Pro-Feme. What cream you end up purchasing is entirely up to you! It simply means you have fulfilled your legal obligation to obtain a doctor's prescription.

Tell your doctor you have done your research and you would like the opportunity to try this form of hormone replacement therapy. Remember it is hormone replacement therapy - it is not natural

alternatives. Tell him you are aware it is a form of human-identical hormone therapy, and that throughout the British Commonwealth (Australia, New Zealand, Canada, UK) it is deemed an S4 drug available on prescription only. This means it is illegal to buy or import [for personal use] natural progesterone cream without a script. This will impress the doctor because you have done your homework and are not asking for some herbal preparation. You are asking for human-identical progesterone supplementation. Be firm in the way you ask, but don't TELL him. Doctors hate being told how a woman expects to be treated. It is almost a stroking procedure.

Explain how you are fully aware this is not test trialed, that there is little supporting data, and people believe it is only one man's opinion yet to be proved. However, tell him how your research states that because it is a natural occurring molecule in the body it has a huge safety margin and the body does not react as it does to the altered synthetic progesterone version. The body can assimilate it better because it recognises this molecule as already existing in the body, rather than introducing a foreign derived molecule that has the potential to cause serious side effects, health risks, and is harder on the liver.

Natural progesterone, given topically, is more absorbable, more effective, bypasses the liver, and doesn't have the same metabolic end result as synthetic HRT. This has strong data back-up. You are stating to your doctor the reasons why you would prefer to take this form of progesterone. Perhaps you've had a bad experience on HRT. You should point out that you are not referring to wild yam or synthetic progesterones. You are asking for something that will be safer to use and promises better end results than the synthetic variety. If you have, in the past, reacted to the contraceptive Pill, have a family history of blood clots, breast cancer or stroke, or HRT has caused you to become depressed, gain weight, retain fluid etc., one would expect your doctor to embrace your decision to trial natural progesterone.

The next approach to take with your doctor is to explain: "I recognise that, as my treating physician you need to err on the side of caution when there is no listing of this drug in your manual. However, as your patient, I take full responsibility for this form of treatment and I'm prepared to sign a disclaimer (which some doctors have insisted their patients undertake here in Australia). I would like to involve you in the progress of my treatment, and to that end I'm willing to chart my symptoms and report back to you if there are any problems".

How can they argue when you are taking responsibility and over-riding all their objections? If the doctor then proceeds to tell you that you don't know what you are talking about or that he wants to prescribe you progesterone for endometrial protection etc., you restate that before you go down that track you want to at least have this opportunity to trial natural progesterone. That all you are asking for is six to twelve months (of your time), and you will be receptive to synthetic hormone replacement therapy if the proposed natural hormone replacement therapy doesn't go according to plan.

We find that this approach often works. You are a woman on a mission. Your mission is to get your script. Get your doctor to respect your choice and listen to what your needs are, not tell you what you ought to have. A good many women who go in with this expectation walk out with that script.

If you failed to get your progesterone script and walked out with another doctor's bill wondering what went wrong, we suggest you re-evaluate why you allowed yourself to be (a) intimidated, (b) made feel insignificant such that your needs were not worthy of acknowledgement, (c) disempowered by your doctor's presumption of knowledge on natural progesterone, and (d) why perhaps the approval of your GP was more important than your right to have a say in what goes into your body.

There are occasions when a woman seeking natural progesterone can be 'out foxed' by her doctor. By asking for progesterone, the doctor may see an opportunity to impose synthetic HRT on you regardless of your request. Because you have stated you need hormone supplements, you've exposed your vulnerability and been cornered. You have unwittingly strengthened your doctor's position to administer HIS/HER choice of HRT - not yours. We've seen women walk out of the surgery with HRT scripts instead of natural progesterone, submitting to their doctor's wishes - and been billed for it.

Often women will bend to pressure purely because they feel uneducated (comparing themselves to their doctor), wrongly believing they have no right to question their doctor or state their needs. In fact, many women don't even tell their doctors the full story in fear their doctors will think they are hypochondriacs. Some doctors have absolutely no idea the extent to which these female patients suffer or how many symptoms they actually experience, purely because they modify their list. Often women fail to get their script because they sense their physician will refuse to treat them. We hear way too many stories of emotional blackmail, particularly involving specialists (breast cancer).

Women have basically been told that if they elect to take natural progesterone, particularly if they have had mastectomies, they will be encouraging the regrowth of cancer. Any refusal to follow their doctors' recommended treatment justified a discontinuation of his/her services. Another example of medical

practitioners being behind the times is the usage of Tamoxifen. Evidence can be found in recognised medical journals that progesterone actually does confer endometrial protection, especially in the usage of the drug Tamoxifen - as Tamoxifen can promote endometrial cancer.

Progesterone, on the other hand, offers protection by opposing estrogen activity in the body. Indeed, progesterone IS the body's natural anti-estrogen.

We encourage women to do their homework. Be firm. Be sure. Often women fail to get a doctor's prescription purely because they are not quite sure themselves. They allow confusion to reign and their doctors to take control of the situation. Many women are not comfortable taking control of their lives, so this is a huge step for some of them. We implore you to have courage, be persistent and believe in yourself. After all, it is your body and your birthright to become well again.

Walk into your doctor's surgery with a list of suggested guidelines. Once you've got your doctor on side and the script has been written, we suggest you ask your doctor to help you begin charting your progress immediately by ordering tests to establish baselines. These would include for example a blood profile, blood pressure reading, a bone mineral density reading and, if you suspect or have had a history of cervical hyperplasia, a pap smear and an ultrasound if you have a history of endometrial hyperplasia, fibroids or poly ovarian cystic syndrome. Take these tests and any other tests your doctor may suggest. This is acting intelligently and with your doctor's help and assistance.

There is a place for integrative medicine and there is certainly a place for very sophisticated diagnostic tools. We don't say run into your surgery, get your script and run out the door. Rather, be intelligent and sensible about this. Make the most out of it. Your doctor is not your enemy. Unfortunately we have put doctors on pedestals and made them God. However, doctors often don't feel like Gods. They are open to litigation and probably have more to lose than you. Medicine is like any profession where you seek out and respect expertise. It's like bringing in a painter to paint your house. You want the best job done but you may want a colour scheme that he doesn't feel suits. Do you allow the tradesman to paint according to what he wants? No, you expect him to follow your instructions if he wants to get paid. It is the same principle when you go to the doctor and ask for a natural progesterone script. You are allowing him to offer advice, which we hope you listen to and take on board because GPs have a much to offer. But you are also suggesting that maybe you would like a treatment (which you have thoroughly researched) that meets your needs rather than his.

Is it harmful to withhold information?

The short answer is "yes". Natural Progesterone is not natural to Nature. This must be understood. It is a human hormone that can be safely introduced into the body because it is identical to the progesterone molecule found 'naturally' occurring in your body (ovaries).

Just remember, it is a hormone and any hormone used incorrectly can create an endocrine disturbance in the body.

It is definitely wise to work cooperatively with a doctor who knows exactly what you are using, otherwise, if he doesn't have the full story, how can he treat you correctly?

If your doctor refuses to support you, it may be wise to change to a doctor who will. Ask your doctor for a copy of your complete medical history and test results so that you can take your file along to your new doctor. Some women continue on with their doctor out of obligation, or perhaps because of family / peer pressure.

Over and above being detrimental to your health, withholding information is a disservice to your GP and yourself. Even though natural progesterone is a relatively safe hormone, out of balance or outside physiological dosages it has the potential to disturb the ebb and flow of other hormones.

Further, your doctor may prescribe a treatment that is not recommended in conjunction with progesterone therapy. In other words, it may be contraindicative of your progesterone.

This has happened in many, many situations with our women. For example, your doctor may put you on the Contraceptive Pill or implant into your body a synthetic progestin, or give you a cortisone injection, all of which basically negate the effectiveness of your natural progesterone. We have seen this happen many times over, simply because women withheld information. They very quickly discover they have become severely hormonally imbalanced once the actual drug administered negated progesterone's

positive impact on the body, and consequently compromised the benefits of progesterone over many months.

A woman may go to her doctor complaining of fluid retention in the first few weeks of progesterone use, not understanding that sodium retention is a result of estrogen build-up/estrogen dominance which can be exacerbated with the reintroduction of progesterone. As we have stated previously, when progesterone is reintroduced into the body, it can actually increase the symptoms of estrogen dominance, purely because it is sensitising estrogen receptor sites. Progesterone 'wakes up' estrogen receptors, encouraging estrogen to work more effectively. Progesterone stimulates estrogen, and estrogen stimulates progesterone. Each hormone is intrinsically linked to the other, but out of balance they can cause havoc in the body. When estrogen receptors wake up, often women will find they have increased headaches and intracellular oedema (sodium moves through the cells into the inner cell, bringing water with it). Your doctor, seeing this problem and not knowing you have just started progesterone, could prescribe a diuretic that can not only create electrolyte imbalances, but also retard progesterone efficiency in the body.

We have seen women prescribed anti-depressants after they became teary-eyed and depressed on progesterone supplementation, not realising that these symptoms are part of estrogen dominant wake-up. In prescribing anti-depressants, the doctor has inadvertently stalled an opportunity for progesterone - a mood enhancing hormone - to relieve hormonally induced depression naturally once the body has had time to adjust, and estrogen dominance has been defeated.

The Natural-Progesterone-Advisory-Network.com website has contacted by many women experiencing increased intensity of joint and muscle pain at some stage of their progesterone therapy. One such case was Susan who reported significant discomfort around the seventh month. Susan went racing off to her rheumatologist who wanted to put her on cortisone-based anti-inflammatory drugs which would have counteracted progesterone benefits long term and perhaps impaired her hormonal health.

We now believe, based on women's collective input that the incidence or exacerbation of joint and muscle pain while taking progesterone is a result of receptor activity in those areas. When women complain of this insidious yet common theme, we encourage them to "hang in there" because it is an experience a good many women connected to our website have gone through.

It occurs on different levels at various stages (7-8 months average), however, more importantly, the incidence of pain and increased discomfort does not appear to be suggestive of progressive degeneration of any pre-existing disease. Rather, we have to conclude based on women's experiences that it's an indication cell receptors are waking up; in most cases, a sign the body is responding favourably.

Many women with arthritic or inflammatory problems find that after about two years on progesterone they are reporting significant joint and muscular mobility, and their pain has dramatically reduced, allowing them to resume physical activities that were once restrictive or beyond them.

We encourage women who are arthritic, battling autoimmune problems, or residual joint damage and subsequent long term pain to avoid pain killers that are harsh on the liver. Instead we suggest they take a premium bone and joint supplementation formula that will nourish joints, bones, cartilage and muscles with essential minerals to compliment progesterone therapy to ensure they derive the full benefits from their hormone balancing.

We have a case which we would like to share with you here. June approached us after being diagnosed with breast cancer and her mastectomy was scheduled in 3 weeks time. June was referred to the Natural-Progesterone-Advisory-Network.com website seeking information on natural progesterone by a concerned friend. She began progesterone replacement therapy along with nutritional supplementation with her husband's full support. Progesterone therapy began immediately on prescription from a local GP without her endocrinologist's consent. This was contrary to any advice provided by the Natural-Progesterone-Advisory-Network.com website. In fact, we suggested she go back to the doctor whom we knew had written the progesterone script and, incidentally, was operating a woman's clinic. It was up to her doctor, in our opinion, to liaise with June's specialist and relay this vital information. This did not happen. And June was too frightened to open her mouth, perhaps intimidated by both doctors.

Prepping herself for surgery, she started applying progesterone in high doses to saturate her body prior to her mastectomy. She had read a medical article supporting the theory that if women ovulated (producing progesterone) prior to surgery that the likelihood of metastases would be reduced. June wanted to cover all her options. Following surgery she underwent chemotherapy. Her doctor, however, was concerned because her periods had remained cyclic, with no signs of hormonal disruption after completing her course of chemo. This demonstrated to the Natural-Progesterone-Advisory-Network.com website the

positive impact progesterone was having on June's body under extreme conditions, possibly supporting and/or protecting ovarian function.

Tragically, to June's detriment, she did not inform her specialist that she was still using progesterone. In response to this unusual occurrence, her specialist scheduled June in for more chemotherapy because, in her opinion, June's periods should have stopped. Her justification for this decision may have been based on the premise that while June continued to menstruate, her estrogen levels were too high which could jeopardise further risk of cancer. This would have been a high probability without progesterone in the equation to oppose estrogen.

Had June been upfront with her specialist, or had the GP who prescribed progesterone (who to this date still continues to treat her with progesterone) informed the endocrinologist that she was treating June in such a manner then perhaps the second lot of chemo may not have been necessary. And June may not have entered menopause so abruptly. If this information had been revealed at the onset, perhaps the endocrinologist would have been forced to look at the possibility that the second lot of chemo may not have been warranted. And possibly viewed progesterone's place in June's treatment, recovery and outcome more favourably.

We last heard that June was continuing Tamoxifen against her better judgement while also continuing with progesterone therapy in secret. June's doctor continues to keep this information from her specialist. June's case demonstrates the plight of women not only here in Australia, but around the world.

So, we say, if you are going to go to your doctor and withhold information, make sure you understand the symptoms of estrogen dominance and the progression of progesterone therapy before your doctor starts treating you, if only to avoid unnecessary conflict of interest. And we advise women to undergo any tests your doctor may recommend to rule out anything sinister.

Freedom to choose a safer form of HRT

While drug companies, politicians, doctors and health gurus argue what's in the best interest of women's health, women themselves are rarely given a voice in the hormonal health debate, an arena that sees women the casualties of exploitation and victims of political agendas.

Women are big business in the healthcare industry. Which explains why female baby boomers are led to believe menopause is a disease that requires synthetic hormone replacement therapy (HRT) for the rest of our lives. Rarely is it clarified that these drugs carry significant side-effects, all too often negating any benefit.

If we're to offer our bodies to science in the trial of any drug, synthetic or otherwise - as is often the case - it should be with our consent upon full disclosure. We're told synthetic HRT dosage is safe when individualised, based on a woman's tolerance to the drug. Nevertheless, HRT makes some of us quite ill. We need and demand a more natural-to-the-body alternative when it comes to hormone replacement therapy.

Excess estrogen

Estrogen dominance is a term coined by the late Dr John Lee in his first book on natural progesterone. It describes a condition where a woman can have deficient, normal, or excessive estrogen but has little or no progesterone to balance its effects in the body. Even a woman with low estrogen levels can have estrogen-dominance symptoms if she doesn't have any progesterone.

And how do our estrogen levels become excessive?

All too often our food chain is laced with toxic pesticides, herbicides and growth hormones - a sea of endocrine-disrupting chemicals that mimic estrogen in our body. If we are overweight, our body's store of excess fat can be converted into estrogen. Insulin resistance leads to estrogen dominance. A visit to our GP for the odd hot flash or missed period can result in a prescription of estrogen pills, patches or implants.

Men are not excluded here. Estrogen gradually rises with age, while saliva levels of progesterone and testosterone gradually fall with age. Thus, with aging, estrogen dominance occurs. A clear sign of estrogen dominance in aging men is their tendency to develop breasts. This indicates these men are low in progesterone and testosterone.

And yet unopposed estrogen in our bodies results in all sorts of hormone-related health problems such as PMS, endometriosis, uterine fibroids, infertility, weight gain, increased blood clotting, thyroid dysfunction, even cancer, in both men and women.

Dr Cavaliere, Professor at the Eppley Institute for Research in Cancer and Allied Diseases and his team at the University of Nebraska Medical Centre in Omaha Nebraska are on the brink of discovering that almost all the important human cancers that we get in Western civilisation have the same origin - which is estrogen. Estrogens, according to Dr Cavaliere, are initiators and promoters of cancer.

For women, cancer of the breast and/or in the uterus most often occurs with a progesterone (P) to estradiol (E2) ratio of less than 200 to 1. According to Dr David Zava of ZRT Laboratories, who has amassed a database of tens of thousands of saliva samples and questionnaires, these cancers occur very rarely in women with a healthy P/E2 ratio.

We know that the micronized progesterone in a jar or tube of cream is human-identical to the progesterone molecule found in our body, making it extremely safe to self-medicate, it is non-toxic, and has no recorded side-effects. It's the drug of choice for women (and men) looking to offset estrogen dominance which, as we're learning, can represent a potentially life-threatening state of hormone imbalance.

The politics of progesterone

The Australian Therapeutic Goods Administration (TGA) some years ago classified Progesterone an S4 drug, available only on prescription. Anyone using progesterone, whether in cream form, troches, drops, pessaries or orally, and doing so without a doctor's prescription, is using it 'illegally'.

Regardless of its good safety record and extremely low toxicity, and its uses in women's cosmetics and moisturisers in the United States over many years, progesterone is tagged an 'S4 poison' because of the category it falls under rather than its drug characteristics.

Problems arise when women are forced to track down a collaborative doctor who's willing to write a prescription ... and then track down the source of our premium cream.

For example, Lawley Pharmaceuticals, located in Western Australia, manufacture a high-grade progesterone cream that is, paradoxically, only available to women within the state of Western Australia. Any woman ordering cream in from the Eastern states, even with a doctor's prescription, is breaking the law!

Women in all Eastern states of Australia must be content with creams formulated by a compounding pharmacist, only a handful of which have cultivated the skills and training in compounding customised medicines using traditional skills, advanced techniques and specialised knowledge.

While regulatory laws on natural progesterone exist in the UK, Canada, New Zealand and Australia, a doctor's prescription is NOT required in countries such as the USA. Natural progesterone creams can be legally sourced through whatever channels available - over the counter, via marketing distributors, or on-line over the internet. So, for the time being anyway, a US drug law does not apply to progesterone usage.

There were rumblings, however, that America's Food & Drug Administration (FDA) will, in the next five years, impose changes to current drug law, restricting ad-hoc marketing of creams. This hasn't happened yet. A new law titled "Anabolic Steroid Control Act of 2004" passed by Congress Friday, October 22, 2004 adds 18 steroid precursors to the list of anabolic steroids that are currently classified as controlled substances. In spite of critics who would have included progesterone and DHEA, both of these supplements have been left off the list. That doesn't mean that they won't be targeted in the future, but for now they're safe.

Whether we order cream in from overseas or via a local compounding pharmacist, the retail price per tub of cream is prohibitive at roughly AUD\$50 per unit. But this wasn't always the case. Prior to seizure of all commercially distributed progesterone creams in Australia in December 1997, the price of a tub of cream was at least AUD\$20 cheaper. This considerable price hike pushed cream further out of reach of so many women who relied on progesterone to maintain optimal hormonal health. Once again, women lost out big time!

Here's the rub, though. Women require a doctor's prescription to get access to bioidentical progesterone replacement therapy but our doctors flatly refuse to prescribe it, despite empirical evidence collected over decade suggesting it's a safe, non-toxic alternative to synthetic HRT.

It's unfortunate, but a fact nonetheless, women who need a script will get it any way they can, including a visit to doctors who take their money but offer no support or education. This is a real concern when women sneak around behind their own doctor's back, accepting treatment that may be contraindicated of progesterone usage, perhaps unable to tell their doctor the full story, all of which has the potential to end badly.

Wild Yam Scammers

Pharmaceutical companies and politicians aren't the only ones guilty of exploitation of women. A good example would be the growing popularity of Wild Yam Extract creams. Word has caught on that progesterone, derived from Wild Yam Extract (*Dioscorea Villosa*), is restoring women's health.

Manufacturers of Wild Yam creams, unable to get access to USP (United States Pharmacopeia) grade or BP (British Pharmacopeia) grade progesterone, have sold women the notion that diosgenin, in its 'natural' Wild Yam state, can be converted into progesterone in the body. These claims fly in the face of the facts that this is physically impossible because there's no enzyme in the body to take up diosgenin. Diosgenin first needs to be 'synthesised' in the laboratory to render it identical to the human hormone. (Many of our modern steroids are manufactured from diosgenin extracted from them. Drugs like birth control pills are affordable due to this genus).

These Wild Yam creams that contain absolutely NO USP progesterone are sold through health food outlets and by naturopaths as complying with Dr John Lee's protocol and research on progesterone. This simply isn't true.

According to the publication 'Herbal Medicine, Principles and Practice of Phytotherapy, Modern Herbal Medicine' "claims have arisen in the popular literature that the female body can manufacture progesterone from diosgenin, particularly if a wild yam cream is applied to the skin. No evidence exists for mammalian enzymes which are capable of effecting what is a difficult chemical conversion. The evidence that does exist strongly disputes the possibility of this conversion. In fact, diosgenin appears to have estrogenic properties in mice and lacks progesteronic effects."

Kerry Bone, an experienced Australian researcher and industrial chemist, and practising herbalist writes in Modern Phytotherapist Vol.3, No.2 1997 that "any progesterogenic activity of plants due to their content of progesterone can be discounted as insignificant ... that when women were administered Wild Yam cream or tablets, saliva analysis found that their progesterone levels were no different from untreated women." He goes on to conclude "plants (such as Vitex) exhibit significant progesterogenic activity only by stimulating luteal phase progesterone in the premenopausal women. Despite the rhetoric and the controversy, there is no solid evidence for any other kind of progesterogenic activity from plants."

In short, bioidentical, natural-to-the-body progesterone is not produced anywhere in the plant kingdom. Bioidentical progesterone is manufactured in a laboratory with the aid of an enzyme. The substance diosgenin, found in the Mexican Wild Yam or Soy plants, has to undergo a series of chemical changes whereby it is synthesised or converted from its raw state into pharmacopeia grade progesterone.

And this confusion is not limited to lay women. Members of the medical fraternity, when arguing vehemently against the efficacy of progesterone, constantly make reference to homeopathic Wild Yam creams containing diosgenin.

Natural progesterone creams are referred to as 'natural' because the end result represents the same molecule naturally occurring in the body. It is chemically identical to progesterone of ovarian origin.

Doctors Don't Want to Know

The question is whether doctors are getting balanced information or just promotional material from the pharmaceutical companies.

As a patient, I know that a Wild Yam Extract cream containing 'diosgenin' is not a precursor to progesterone in the body. And that a synthetic progestin analogue such as Provera (medroxyprogesterone

acetate) is a molecular modification beyond bioidentical progesterone. But most physicians do not. They derive their knowledge of drugs from pharmaceutical companies who, for obvious reasons, focus their marketing pitch on patented products only - such as synthetic HRT and the contraceptive pill.

Natural progesterone is referred to as 'natural' because it represents the same molecule naturally occurring in the body. It can be introduced into the body with relative safety and minimal side effects because the body recognises it.

And it's because progesterone is classified a naturally occurring medicine, drug companies cannot slap their logo on it, brand it as their own 'exclusive' product, and generate commercial application.

This lack of financial incentive for drug companies to inject millions and millions of dollars into research, development and marketing of a drug they cannot 'own' means progesterone is then overshadowed by its synthetic cousin - progestin - not because it's less effective but because, to these multi-national drug companies, biological progesterone represents a dodgy investment.

The 1995 PEPI (Postmenopausal Estrogen/Progestin Interventions) trial, a three-year multi-centre, double-blind, placebo-controlled trial sponsored by the National Institutes of Health (NIH), clearly demonstrated that natural progesterone actually works better than synthetic progestin in terms of protecting the heart, and that natural progesterone can protect against uterine cancer as well as synthetic progestin. Yet, inexplicably, this message has not yet reached the medical community.

Chemically-altered hormones can shut down or reduce our production of natural hormones. Because the molecules have been changed, the synthetic hormones used in the Contraceptive Pill and HRT do not have the same effect on the mind and body as our natural hormones do. In fact, many of the effects of synthetic hormones are the exact opposite to the natural hormone they so ineptly replace.

It's quite obvious some doctors really struggle to come to grips with what exactly bioidentical HRT is, and why incorporating salivary hormone profiles offer more accurate results than blood tests. A flow on from this is that women often cop a 'dressing down' when they approach their GP requesting a prescription for progesterone and that a baseline hormonal profile be established using salivary assays.

Doctors are encouraged to prescribe a potentially harmful drug (which may cause and promote cancer), but see absolutely no reason why they ought to remain open-minded (at least!) to a safer alternative - bioidentical progesterone - which may actually prevent cancer!

Some of us may manage to convince our GP to write a script, and go so far as to order a saliva hormone profile kit, but then our doctor leaves the interpretation of symptom relief and saliva assays reports, dosage adjustment, etc., up to us - the patient! We may as well revert back to the days when we sourced our cream through health food stores or MLM distributors which, of course, did not include hefty GP consultation fees and a 50% hike in the price of cream!

Technically, we're not self-medicating. We've elicited the cooperation of our GP required to legally obtain progesterone thereby meeting the guidelines set down by the TGA. But why aren't these same doctors monitoring our progress? Are they capable of monitoring our progress? In some case, it's evident they are not.

Most doctors want nothing whatsoever to do with 'bioidentical' hormones, preferring instead to stick to tried and tested drugs they're more familiar with, resulting in a 'stand-off' between women and their family doctors.

Many women are feeling like we have, and continue to be treated like guinea pigs.

In light of the recent European, US, UK and Swedish findings that conventional HRT, once prescribed to millions of women to ease the immediate symptoms of menopause and to prevent osteoporosis and heart disease, has been found to increase the risk of heart disease, cancer and blood clots, and perhaps has legal implications for the manufacturers of HRT drugs, doctor would be well advised to embrace every opportunity to actually listen to the women who are using natural progesterone and who are not only getting well, they're remaining healthy (and happy) long term!

A woman's dilemma

"My name is Susanne and I just joined your network and read parts of your ebook. First let me thank you, Catherine, for what you do for all the women around the world who have to fight for education and support in their search for health.

"I am 42 and live in Canada (my husband and I moved here 6 1/2 years ago from Switzerland). At age 33 I had a hysterectomy (I still have my ovaries) and ever since I am battling with a non-existent sex drive.

"At first I was told that my body needed time to adjust to the changes after the operation. I accepted that. Then we moved to Canada and I had to come to terms with some things like finding a GP and language problems before I was able to talk to my new doctor about my problem. He didn't seem to care too much for my symptoms and it took me 3 years to finally get him to react.

"Based on at the time 2 years old test results on testosterone and estrogen he gave me a prescription for 40 mg of testosterone saying that my levels were within a normal range and he didn't think this would help me. And it didn't. So after 2 months he didn't renew the prescription and then tried some other things like Viagra (!). He also offered me some prescription strength anti-depression medication. In all cases stating that he didn't think this to help. He didn't say it but made me feel that he thought that my problem was strictly in my head. He denied me a referral to a specialist until half a year ago when I told him that now my husband was starting to suffer from the situation too. This was what it took to finally get him to send me to a gynaecologist.

"My hopes were up - but only to be crushed last week when I had that appointment.

"After my last visit at my GP's I started searching the internet for answers. I did some 20 plus hours of research starting with the search for a laboratory which would do testing for me without the involvement of a physician as I knew that my GP wouldn't order any tests. He had stated that he didn't think it necessary to spend money on tests (in Ontario health care is government funded)! When I finally found ZRT Laboratories in Oregon USA I read about progesterone for the first time. I ordered tests for testosterone, progesterone, estradiol and DHEA. The results confirmed what I had suspected: my progesterone is only about 35 % of what the minimum level should be. The estradiol/progesterone ratio is even worse: only about 9 % of what it should be. The other hormones are within normal ranges. So last week when I had my appointment at the gynaecologist's I told him about the tests. He didn't even look at the results. He didn't hear me out and kept cutting me off whenever I tried to say something. Instead of answering my questions he held me a one-hour lecture in testosterone and after a 3-minute examination dismissed me with a prescription for the same testosterone my GP had given me half a year ago and the diagnosis that everything was just fine with me.

"You can imagine how I felt when I came home!

"The next morning my husband woke me with the announcement that he had found a web site I would be interested in (we are self-employed and he is an early riser while I like to sleep in). I must say that he has been a tremendous help in the whole thing. Always supportive and understanding he helped me all those years, never complaining about a thing.

What he had found was your web site. I read it and signed up for your ebook the same day. By now I've read a big part of it and am more than ever convinced that natural progesterone is the answer to my problems.

"Thank you so much for your advice. If you don't mind I will keep you posted on my progress in this matter." ~ Sincerely, Susanne ~

How will a doctor's examination benefit me?

Certain tests will determine whether there is an absence, or presence of any underlying problems. If everything looks good, you can begin progesterone therapy.

A pap smear, for example, is advisable. This will detect cancerous or pre-cancerous cells, or changes in cell structure of the cervix.

A mammogram can detect early signs of breast cancer, lumps or abnormal cell changes (although regular self-examination is encouraged).

A bone mineral density (BMD) test can detect osteoporosis.

Your doctor can order a screening of blood sugar levels, and cholesterol LDL/HDL ratios.

Other specific tests such as liver function and thyroid function may be beneficial. Comparisons can be obtained through both blood work and saliva assays.

A blood count and salivary hormone profile will determine estrogen, progesterone, the follicle stimulating hormone (FSH), testosterone and DHEA levels. Abnormalities will indicate any sign of metabolic disorders and, where a woman is in her menopausal, peri menopausal or post menopausal stages, it will also show whether she has an absence of progesterone.

Urinalysis will show signs of any kidney disease, signs of infection, or even detect signs of glucose which indicates diabetes or pre-diabetic conditions.

A pelvic ultrasound will determine diseases of the uterus and the ovaries, and is useful for women where a pelvic examination may be uncomfortable, difficult or inconclusive. It also gives us a good picture of what is happening on the ovaries and also the state of the pelvis in general.

Some women also have a bladder function test to determine the amount of urine they can hold, and we have had lots of women who have required bladder hitching surgery, and others, bladder stretching on a regular basis. We believe this is hormonally linked and often women report improved bladder capacity 12-18 months after using progesterone on a regular basis.

The doctor's physical examination should include:

- blood pressure: detect whether you run any risk of cardiovascular disease, hypertension (high blood pressure) and risk of stroke
- weight: determine whether you are underweight or overweight (very indicative of hormone imbalance, particularly estrogen dominance and Syndrome X)
- thyroid: detect if there is an abnormality, growth, enlargements, lumps; a thyroid function to determine overactivity or underactivity such as hypothyroidism (blood spot testing now available for TSH, FT4, FT3).
- breast examination: check the breast tissues and see that there are no abnormalities, puckering or presence of lumps or multiple cysts, changes occurring in texture / colour of tissue or nipple
- abdomen: check for any tenderness, lumps or swelling / distension particularly over the pelvic area or around the liver area
- pelvic examination: check your pelvic organs, the condition of your ovaries and whether they are tender or if there is any hardness, lumps, any enlargement, signs of cancer
- uterus: is it prolapsed
- vaginal tissue: signs of atrophy or whether the vaginal tissue is in good order and healthy skin colour and texture
- bladder: is it prolapsed, investigate problems such as discharge, thrush, stress incontinence or cystitis, and other related problems
- urethra: may be inflamed, doctor may also want to do a pap smear and bladder tests if you repeatedly complain of urethritis or vaginal itching and so forth, which can indicate low grade infection that may need a culture
- liver: evaluate the body's ability to detoxify both exogenous and endogenous compounds via functional liver detoxification profile (FLDP)
- full blood profile: check haemoglobin reading (anaemia), B12 deficiency, and so on.

Because most GPs appear to be running to a very tight schedule and often under pressure, we recommend women take along their list to remind them of the things they would like checked out to ensure they get value for money, and book a double appointment if you feel you need more time.

It sounds pretty daunting doesn't it? However, if you go in armed with knowledge, reasonable expectations, and your list, chances are the doctor will take you seriously, and know that you are not there to waste his time. That you have specific needs and requirements of his service to you.

Ultimately (we hope) your GP will respect you for having done your homework and for being a person of clarity. You are there for a specific purpose ... to elicit the support of your GP in achieving optimal physical and mental health.

If your GP is uncooperative, then perhaps it's time to change doctors.

Finding a healthcare professional

One of the best ways to source a GP in your region is via a compounding pharmacist. These pharmacists maintain a current database of local doctors prescribing bio-identical HRT.

International Compounding Pharmacists

International Academy of Compounding Pharmacists - Referral Service
http://www.iacprx.org/referral_service/index.html

USA, Canada & International

American College for Advancement of Medicine
http://www.acam.org/dr_search/index.php

American Association of Naturopathic Physicians
www.naturopathic.org

American Holistic Medical Association
<http://www.holisticmedicine.org/ahma/public?action=findDoctors>

Professional Referral Network
www.healthreferral.com

American Academy of Environmental Medicine
<http://www.holisticmedicine.org/ahma/public?action=findDoctors>

Institute of Complementary Medicine
<http://www.i-c-m.org.uk/brcp/pracsearch.asp>

Professional Compounding Pharmacists
www.pccarx.com/contact.asp

The Natural Hormone Institute of America
www.womens-medicine.com

Menopause Clinician List for Canada
www.menopause.org/clinicianscan.pdf

Menopause Clinician List for USA
www.menopause.org/cliniciansus.pdf

United Kingdom

Institute of Complementary Medicine
<http://www.i-c-m.org.uk/brcp/londonsearch.asp>

Natural Progesterone Information Service
<http://www.npis.info/consultadoctor.htm>

Australia

Australasian College of Nutritional & Environmental Medicine
http://www.acnem.org/referrals/referral_service_main.htm

American Academy of Environmental Medicine
http://www.aem.com/referable_physicians.htm

International Academy of Compounding Pharmacists
http://www.iacprx.org/referral_service/index.html

Redwood Australia
www.redwoodhrt.com.au

Analytical Reference Laboratories
<http://www.arlaus.com.au>

Dartnell's Pharmacy
<http://www.dartnellsphy.com.au/searchDoctor.htm>

The Mortar & Pestle Pharmacy
<http://www.mortarandpestle.com.au/doctorref.html>



Buying a premium progesterone cream

What is a compounding pharmacist?

A compounding pharmacist is a term used to describe the art of preparing medication to a specific formula.

A compounding pharmacist has the freedom to work with therapeutic drugs, scripts, scheduled poisons and also the freedom to work with natural herbs. He is licensed to tailor make drugs to the needs of the individual. When a doctor orders a script, the pharmacist can make up that formula according to that requirement. This is the original art of the pharmacist.

Over the years this art has all but disappeared from the dispensary, replaced by mass produced products from huge multinational drug companies. Many pharmacists are not equipped with the modern technology to compound. In the days before the giant pharmaceutical companies began to patent their products en masse, each and every pharmacist was a custom compounding pharmacist. The doctor instructed the pharmacist to formulate /tailor-make the medication required in the treatment of a patient's illness. Modern pharmacists can still do this, however, only custom compounding pharmacists have the day-to-day experience with the method of treatment, equipment and training.

When it comes to compounding a natural hormone into a cream, only a handful of pharmacists have cultivated the skills and training.

Pharmacists who are members of the [Professional Compounding Chemists of Australia Pty Ltd](#) specialize in the compounding (or making) of a wide variety of customized medicines by using traditional skills, advanced techniques and specialized knowledge. Customised medications can include preparations for HRT using only bio-equivalent hormones - ones with chemical structures exactly the same as the hormones our bodies produce.

What is an herbalist?

An herbalist is one who studies, collects, and prepares plants useful for health and healing. Herbal medicine, sometimes referred to as Herbalism or Botanical Medicine, is the use of herbs for their therapeutic or medicinal value.

In a sense, the herbalist has basically taken over the role of the pharmacist, prescription drugs excluded. A pharmacist will meet the script of a doctor while an herbalist can tailor make for the individual but does not necessarily have to meet the requirements of a doctor. An herbalist is licensed to make herbs and use natural remedies, not S4 drugs, and he cannot make therapeutic claims.

There are many talented herbalists out there who can balance a woman's hormones specifically through herbs. And herbs are something that cannot be underestimated. The power of herbs is unique and incredible, and dates back many centuries. In the right combination, they can do some miraculous things in our body.

Many women realise remarkable results with hormone balancing without the need of progesterone replacement therapy.

Often we do suggest a woman try an herbalist, particularly if she is ovulating and is not showing severe estrogen dominance. We know from experience that herbs such as Vitex can often bring a woman's hormones back into balance, in some cases increasing her fertility, without the need for natural progesterone treatment. This approach treats hormonal imbalance by stimulating the pituitary, in turn getting the body to regulate, stabilise and normalise its messages rather than putting the progesterone molecule back into the body.

In the British Commonwealth where progesterone is classified a prescription drug, herbalists are NOT permitted to incorporate micronized progesterone into their preparations. To imply otherwise is bending the truth. If, however, he or she is adding micronized progesterone to your cream, it would be illegal. Moreover, it is highly unlikely the insignificant levels of progesterone (often referred to as homeopathic) would be of benefit to a woman suffering severe progesterone deficiency.

It should be understood that if your adrenals are functioning optimally, they will produce small amounts of progesterone but maybe not at the levels required to offset the fact you are no longer producing progesterone month to month via ovulation. Once you enter menopause, your adrenal glands will provide minute amounts of progesterone, however, not nearly enough to oppose the effects of high estrogen levels.

Are all creams created equal?

In other words, is there a difference between micronized progesterone cream and micronized, standardised progesterone cream?

It depends on what standardised means. All compounding pharmacy creams are not standardised because no analysis of batches is performed.

Analysis includes active ingredient assays, preservative assays, preservative efficacy testing, impurity testing, mixing validations, cleaning validations, in-line weight validations, testing of raw materials, certificate of analysis documentation, etc., etc.

We would assume that standardised means each and every batch is tested for all or most of these things and therefore there will be no variation between batches.

Very little of this is done with the US creams made by the cosmetic manufacturers because these are not requirements in the US. We know they are not done by compounding pharmacies.

If someone is saying their cream is standardised ask them to show you some of the above documentation - a Certificate of Analysis would probably be enough to stump them if they are not legitimate.

Also the degree of micronisation of the progesterone is vital to the effectiveness of the cream. If the particle size is too large then it won't work.

Micronisation is a process where the progesterone is milled to a particular size. The degree of micronisation is dependant upon the process used to mill the progesterone. The smaller the particle size the easier it will be for the progesterone to pass between the intercellular spaces of the skin's stratum corneum - the skin's physical lipid barrier to prevent substances/chemicals entering the body.

Any progesterone cream manufacturer or compounding pharmacy should be able to inform the user of the degree of micronisation of the progesterone that they use. They should hold on file a particle distribution profile for each batch of progesterone which they utilise.

In general the absolute maximum particle size should be no greater than 20 microns.

Once incorporated into the cream, it is very difficult to accurately determine what particle size has been employed.

The onus is for the manufacturer to provide documentation for their product especially if they use "micronisation" as a selling point.

How do I know if a cream is a reliable, high quality cream?

Quality progesterone cream, whether mass-produced and quality controlled batch to batch, or compounded by your local pharmacist, needs to meet certain criteria if it's going to work. We mentioned in a previous chapter that not all compounding pharmacists understand, or are sufficiently skilled at compounding progesterone. Your cream must contain micronized BP progesterone/US Pharmacopeia grade progesterone, in a stable fat soluble base [not a mineral oil base] otherwise it won't absorb and assimilate in to the body.

Too many women are rubbing on progesterone yet fail to derive the full benefits, largely because it's not compounded correctly, or, possibly it does not contain micronized progesterone. There are different grades of micronized BP progesterone. If it's gritty, oily or greasy it often indicates that cream quality is sub-standard.

Batch control is especially important. We have recorded cases where women accidentally overdosed on locally compounded creams simply because they increased their dosage when cream failed to provide

relief of symptoms week in, week out. It's why we recommend women purchase creams that are quality controlled and batch manufactured.

Even when you are bringing cream in from overseas, a good quality cream would have all the ingredients and the batch number, etc recorded on it. Ensure that you buy a pure progesterone cream with no other additives. You also should be aware of the physiological dosage your progesterone cream is delivering.

Be careful of creams that have been enhanced with essential oils and fragrances, and other unknown additives, as we don't understand the interactive behaviour these substances can have on the effectiveness of progesterone or skin sensitivity. For genuine progesterone benefits, don't play around with inferior creams. Your cream manufacturer should support the benefits of all ingredients and ensure progesterone quality is not compromised.

Don't give up on progesterone supplementation simply because you are experiencing a 'reaction' to your cream (itching). We recommended you swap brands, perhaps opting for a cream that is free from additional hormones, herbs and alcohols.

We have found from experience and women's feedback that a high quality cream displays the characteristics of being readily absorbed, non-greasy, odourless, and doesn't stain or leave a greasy residue on the skin.

It's important these features exist so that the micronized progesterone molecule can be readily absorbed through the pores of the skin and not be stuck on the surface trapped in a greasy base.

We've come to believe that quick absorption of the cream over a small area is indicative of a superior cream.

Quality Control

If there is a down' side to this 'easy access' scenario in the USA it's the lack of quality control imposed on progesterone cream manufacturers.

In the United States progesterone in a cream base is classified as a cosmetic as long as the manufacturing company makes no therapeutic claims for their products. This is why most commercially produced creams are called body creams or lotions. Any claims about effects on menopausal symptoms tend to be very generalised and "grey" so as not to incur the wrath of FDA . Third party claims via websites or advertising material is at arms length from manufacturers and therefore claims often represent progesterone as being the "magic bullet" for all types of ailments.

Because of the cosmetic status of commercially produced creams adherence to Good Manufacturing Practice (GMP) is not regulated in the same way and the pharmaceutical industry and to a lesser extent the "compounding pharmacy" industry. Labelling requirements on cosmetics is also variable and the amount of progesterone actually in a preparation does not need to be stated.

Labelling on some preparations available in the USA can often border on deception.

USP or BP grade progesterone means that the progesterone used is of United States Pharmacopeia or British Pharmacopeia standard which is extremely high quality.

In general, a good quality compounding pharmacy will only use USP or BP standard active ingredients. Dr John Lee highlighted the variation of products on the US market in his original book (page 269-272) *'What Your Doctor May Not Tell You About Menopause'*. He expanded on the original list in subsequent editions and books.

IN general, if a company cannot give written confirmation of the amount of progesterone in their preparation then you might have serious doubts about the quality of the product.

Another important issue in progesterone cream production is the base in which the progesterone is dispersed. Different bases will "release" at different rates and the skin is a natural barrier to permeation of drugs. Different compounded products may vary in effectiveness depending upon the type of base used in the manufacture. If purchasing a cream from a compounding pharmacy it is best to enquire with the pharmacist as to the type of base being utilised.

An oil-in-water base will provide a far more effective delivery system than an aqueous moisturizing base in terms of achieving a systemic effect.

Stages of conversion from wild yam to synthetic HRT

Broadly speaking, there are three stages of conversion from wild yam to synthetic HRT.

Stage 1 of conversion ~ Wild Yam Extract

The substance called 'diosgenin' is chemically extracted in a laboratory using wild yams, soya beans and other plants from the tuber family. Diosgenin is used as the active ingredient in Wild Yam creams. However, there is no proof that diosgenin can be converted by the body into the hormone progesterone. Though it is reported to have estrogenic properties. Since it is not classified a drug, it is not regulated by therapeutic governing bodies. You can buy wild yam creams and tonics in virtually any health food store.

Stage 2 of conversion ~ USP Progesterone

Back in the laboratory, diosgenin is then converted (with the aid of an enzyme not present in our body) into United States Pharmacopeia (USP) grade progesterone, rendering it a hormone that is bio-identical to the progesterone made by a woman's ovaries. Bio-identical, USP progesterone has a good safety record and extremely low toxicity. It is a regulated prescription medicine (S4 poison) in some countries like Australia, New Zealand, UK and Canada.

Stage 3 of conversion ~ artificial HRT

Major pharmaceutical companies 'tamper' with the molecular structure of USP progesterone to produce progesterone's synthetic cousin - progestin - that the body no longer sees as bio-identical. Typically, this is the artificial HRT that our doctors insist on prescribing despite new emerging evidence that these unnatural-to-the-body drugs ineptly replace our natural hormones, and have been found to increase the risk of heart disease, cancer and blood clots.

Bottom Line: Wild yam creams that contain no progesterone cannot do the work of progesterone in the body.

Can you get a rebate on cream?

In countries like Australia where progesterone is classified an S4 Drug available with a doctor's prescription, there are private health insurance schemes that offer a rebate, Medibank Private being one of them.

In our experience, women with insurance can expect a rebate of around AUS\$20 with proof of purchase & duly marked receipt verifying their physician's Provider Number.

Some women, however, get quite shrewd and break their order for cream down into smaller lots per receipt. Instead of accepting one receipt for two or three tubes of cream, they'll ask for individual receipts for each tube or jar of cream. This then entitles them to claim the AUS\$20 against EACH RECEIPT submitted!

It has yet to be substantiated that receipts for progesterone creams ordered through overseas distributors (online) are 'official' enough for private health insurances to attract a rebate.

Where to buy natural progesterone

Here at the Natural-Progesterone-Advisory-Network.com website, we undertake to ensure women everywhere have the resources they need to FIND bio-identical hormones and if it suits their individual needs, to USE them effectively and responsibly for the betterment of their lives.

Our website is privately funded so we don't sway to the influences of cream sponsors or censors. We tell it like it is when it comes to the best uses and sources of natural progesterone. That's precisely how we've been able to expand this community and help so many women around the globe.

Believe it or not, our goal is to NOT sell progesterone cream directly from this website. Our goal is to provide good information that leads to good choices.

We have, therefore, compiled a list of premium natural progesterone creams [below] that meet the correct formulation. We also include information relating to international compounding pharmacists should you prefer to have your cream tailored to suit your individual needs, in consultation with your treating physician.

International Creams

Dispensed in a Custom Pump Bottle

Beyond Fertility.com, P.O. Box 201, Heber Springs, AR 72543, (866) 762-2858, website, www.BeyondFertility.com, e-mail lori@beyondfertility.com. They sell Happy PMS progesterone cream.

Alternative Medicine Network, 601 16th St., #C-#105, Golden, CO 80401, toll-free (877) 753-5424, www.altmednetwork.net, e-mail sales@altmednetwork.net. They make Awakening Woman Natural Progesterone Cream which contains only progesterone as its active ingredient.

Arbonne International, Inc., P.O. Box 2488, Laguna Hills, CA 92654, (800) ARBONNE, web-site www.arbonne.com, e-mail customerservice@arbonne.com. They make PhytoProlief and Prolief Natural Balancing Creams.

Life-flo Health Care Products, 8146 N. 23rd Ave., Ste. E, Phoenix, AZ 85021, (888) 999-7440, e-mail care@life-flo.com, website www.life-flo.com. They make Progestacare cream.

Matol Botanical International, Quebec, Canada, (514) 639-3347, www.matol.com, makers of Botanelle Progesterone Cream.

Pure Essence Labs, Inc., 1999 Whitney Mesa Drive, Suite A, Henderson, NV 89014, (888) 254-8000 ; www.pureessencelabs.com. Makers of FemCreme.

Restored Balance Inc., 42 Meadowbridge Dr. SW, Cartersville, GA 30120, (800) 865-7499, www.restoredbalanceusa.com, e-mail restoredbalance@adelphia.net. They make Restored Balance PMS/Menopausal progesterone cream.

Vitamin Research Products, Inc., 3579 Highway 50 East, Carson City, NV 89701, (775) 884-1300, (800) 877-2447, makers of HerBalance Cream. www.advancedmenopauserelief.com

Women Living Naturally, 4200 University Avenue, Suite 2100, Madison, WI 53705; (608) 231-3906; www.womenlivingnaturally.com. They make Progensa 20 progesterone cream.

Women's Medicine, Inc., The Natural Hormone Institute of America, 1891 Beach Boulevard, Suite 100, Jacksonville, FL 32250; Toll free (866) 628-6337; www.womens-medicine.com; Dr. Randolph's Women's Progesterone Cream contains only progesterone as its active ingredient, and no chemicals.

Dispensed in a Tube

Emerita, Pro-Gest, 621 SW Alder, Ste 900, Portland, OR 97205-3627, (503)226-1010 or(800) 648-8211. A Division of Transitions For Health, Inc., website www.emerita.com.

International Health, 8704 E. Mulberry St, Scottsdale, Arizona 85251 Makers of EssPro'Leve Plus Progesterone Cream with Essential Oils. 1-800-481-9987 or (480) 874-1419 Email: nopms@doitnow.com

Kevala, a division of Karuna, 42 Digital Drive #7, Novato, CA 94949, 888-749-8643, website, www.kevalahealth.com, e-mail info@kevalahealth.com. They make PureGest Lotion which is free from additional hormones, herbs and alcohols.

Natural Pause Company, 16044 Maricopa Hwy, Ojai, CA 93023 (888) 267-5032, www.naturalpause.com, makers of Natural Pause cream.

Nature's Sunshine Products, Inc., www.naturessunshine.com, 75 E. 1700 S., Provo, UT. 84606. (800) 223-8225m, e-mail, questions@natr.com; Pro-G-Yam 500 Progesterone Cream with wild yam extract.

Neways, 150 E. 400 North, P.O. Box 651, Salem, UT 84653, (801) 423-2800. They make Endau cream.

Springboard, 3115 Stoney Oak Drive, Spring Valley, CA 91978, Toll Free Phone (866) 882-6868, or (619) 670-3860, fax (619) 670-4149, website www.springboard4health.com or www.naturalprogesterone.com. They make ProBalance progesterone cream.

Sarati International, Rt. 3, Box 385, Ted Hunt Rd., Los Fresno, TX 78566. (800) 900-0701. They make Natural Progesterone Cream, website www.sarati.com. Online distributors: www.sunrisewd.com, www.heranswer.com, www.resonancedirect.com, www.progestnet.com.

Vivace Health, PO Box 36496, Merivale, Christchurch, New Zealand, (6403) 355 1557, fax (6403) 355 2764, www.womens-health-solutions.com. They facilitate orders for Serenity for Women progesterone cream after providing information to the customer.

Dispensed in a Jar

Ambrosium, Na Vysluni 19 / 235, 362 63 Karlovy Vary - Dalovice, Czech Republic; www.progesteron.cz, e-mail info@ambrosium.cz.

Bio-Nutritional Formulas, 106 E. Jericho Tpke, P.O. Box 311, Mineola, NY 11501, (800) 950-8484. Fem-Gest cream.

Broadmoore Labs Inc., 3875 Telegraph Road/294, Ventura, CA 93003, (800) 822-3712. Makers of Natra-Gest progesterone creams.

Crazy Woman Lodge, Inc., 936 B 7th Street Ste 247, Novato, CA 94945 USA (866) 366-3699, www.resonancedirect.com, e-mail customerservice@crazywomanlodge.com. They make Resonance natural progesterone botanical cream.

Easy Way International, 5340 Commerce Circle, #E, Indianapolis, IN 46237, (800) 267-4522. They make Gentle Changes progesterone cream.

Elan Vitale, P.O. Box 13990, Scottsdale, AZ 85267, (800) 527-5898, (602) 483-5650. They make BioBalance progesterone cream.

Health and Science Research Inst., 661 Beville Rd., Ste. 101, Daytona Beach, FL 32119, (888) 222-1415, fax (904) 267-9005, www.health-science.com, www.whs.net.nz. Serenity for Women progesterone cream.

Helen Pensanti, M.D., P. O. Box 7530, Newport Beach, CA 92658 (714) 542-8333, www.askdrhelen.com, e-mail info@askdrhelen.com.

Kokoro, LLC., P.O. Box 597, Tustin, CA 92781, (800) 599-9412, (714) 836-7749, website www.kokorohealth.com. They offer Kokoro Women's Balance Crème.

Products of Nature, 54 Danbury Road, Ridgefield, CT 06877, (800) 665-5952. Maker of Natural Woman progesterone cream. www.pronature.com - Connecticut, www.prodnature.com - Texas.

Vitality Lifechoice, Carson City, NV, (800) 423-8365. They make Balance Cream.

Organic and Artificial Preservative Free

Botanical Alternatives, Inc., PO Box 563 Yamhill, OR 97148; email info@botanicalalternatives.com; website www.botanicalalternatives.com; they use no synthetic preservatives or known carcinogenic chemicals.

Oasis Advanced Wellness, 9842 Pinehurst Street - Baytown, TX 77521 - 29N44, 94W59, (281) 303-0707, website www.oasisserene.com. They offer Oasis Serene progesterone cream - completely organic and artificial preservative free.

United Kingdom & Europe (tax free)

Institute of Well-Being, P O Box 493, St Peter Port, Guernsey, GY1 6BY, Channel Islands; www.pro-gest.co.uk. They sell (tax free) Pro-Gest progesterone cream by Emerita.

Wellsprings Trading Ltd., PO Box 322, St Peter Port, Guernsey, GY1 3TP, Channel Islands; www.progesterone.co.uk. They sell (tax free) Serenity for Women progesterone cream by Health and Science Research Inst.

International Pharmaceutical Companies

Lawley Pharmaceuticals
www.testosterone.com.au

Testosterone Products Australia (TPA) is a site dedicated to the online ordering of topical testosterone and progesterone creams manufactured by Lawley Pharmaceuticals.

Andromen®, Andromen® Forte, Andro-Feme® testosterone creams provide testosterone for men and women. Pro-Feme® progesterone creams provide progesterone for women.

The products are manufactured to international pharmaceutical grade Good Manufacturing Practice standards.

USA Compounding Pharmacists

Medical Park Tower Pharmacy, 1301 West 38th Street #135 Austin, Texas, 78705; tel: (512) 454-5626. These compounding pharmacists sell USP micronized progesterone cream over the counter, with counselling, scooper, and information packets included.

International Compounding Pharmacists Referral

One of the best ways to source a GP in your region is via a compounding pharmacist. These pharmacists maintain a current database of local doctors prescribing bio-identical HRT.

International Academy of Compounding Pharmacists - Referral Service
http://www.iacprx.org/referral_service/index.html

Importing creams into Australia

Australian women will need to hold a current doctor's prescription to legally obtain progesterone cream via importation or through their local pharmacy. It should be understood that importation of natural progesterone cream is permitted for personal use ONLY. Distribution of cream is illegal.

This statement is true of most, if not all countries that are members of the British Commonwealth of Nations (UK, Canada, New Zealand or Australia).

Australian Manufactured Creams

Lawley Pharmaceuticals, 672 Beaufort St, Mt Lawley, Perth, Western Australia 6050, 1800 627 506, e-mail lawleyph@arach.net.au, website www.lawleypharm.com.au. They make Pro-Feme progesterone cream, Andro-Feme testosterone cream (for women), Andromen® and Andromen® Forte (testosterone for men), and Natragen estradiol cream.

Burrendah Pharmacy, 10/61 Apsley Rd, Willetton, Western Australia, 6155. Phone: 08 9457 1777 Fax: 08 9457 1589, website www.burrendahpharmacy.com. They sell above listed creams manufactured by Lawley Pharmaceuticals.

Australian Compounding Pharmacies

All pharmacists listed below are members of the Professional Compounding Chemists of Australia Pty Ltd. Members of this association specialize in the compounding (or making) of a wide variety of customized medicines by using traditional skills, advanced techniques and specialized knowledge. Customised medications can include preparations for HRT using only bio-equivalent hormones - ones with chemical structures exactly the same as the hormones our bodies produce.

Redwood Australia
Head Office: Suite 1102, 1 Newland St, Bondi Junction NSW 2022
Phone: 1300 304 638 Fax: 02 9389 4500
Email: info@redwoodnhrt.com.au
www.redwoodnhrt.com.au

West Lindfield Pharmacy
30 Moore Ave., Lindfield NSW 2070
Phone: 02 9416 2642 Fax: 02 9415 6604
www.compoundingchemist.com

The Green Dispensary Compounding
368B Kensington Rd, Erindale, Sth Australia, 5034
Phone: 08 8431 6727 Fax: 08 8431 9540
www.green dispensary.com

Richard Stenlake Comounding Chemist
1st Floor, 76 Spring St., Bondi Junction NSW 2022
Phone: 02 9387 3205 Fax: 02 9389 3821
www.stenlake.com.au

Australian Compounding Pharmacy
16 Saint Mangos Lane, Melbourne Vic 3008
Phone: 03 9670 2882 Fax: 03 9670 9615
www.compoundia.com

Shirley James Strathfieldsaye Pharmacy
32 Blucher St., Strathfieldsaye, Bendigo, VIC
Phone: 03 5439 3513 Fax: 03 5439 3514

Nation Wide Compounding Pharmacy
825 Glenhuntly Rd., Caulfield South, VIC
Phone: 03 9532 8555 Fax: 03 9532 8900

Thompsons Amcal Pharmacy
962-964 Main Road, Eltham, VIC
Phone: 03 9439 0799 Fax: 03 9439 2525
eltham@amcal.net.au

Raju's Pharmacy
Gisborne Village Shopping Centre
Brantome Street, Gisborne, VIC
Phone: 03 5428 2107 Fax: 03 5428 2793
rajupharm@hotmail.net.au

Belvedere Park Pharmacy
284 Seaford Road, Seaford, VIC
Phone: 03 9786 2703 Fax: 03 9785 2420
feldschuh@hcn.net.au

Dartnell's Pharmacy
376 Canterbury Road, Surrey Hills, VIC
Phone: 03 9888 5899 Fax: 03 9888 6911
www.dartnellsphy.com.au

Williamstown Pharmacy
81 Ferguson Street, Williamstown, VIC
Phone: 03 9397 6035 Fax: 03 9397 6093
www.williamstownpharmacy.com.au

Melbourne Compounding Centre
186 Victoria Street, Seddon, VIC
Phone: 03 9689 0833 Fax: 03 9689 0733
www.compounding.com.au

Gooding Drive Compounding Chemist
6/166 Gooding Drive, Carrara, Queensland, 4211
Phone: 07 55305888 Fax: 07 55305888

Chemmart Windsor Pharmacy
142 Newmarket Rd, Windsor, Queensland, 4030
Phone: 07 38575666 Fax: 07 3357 4857
chemmartwindsor@bigpond.com

The Mortar & Pestle Compounding Chemist
PO Box 999 , Pacific Fair, Gold Coast, Queensland, 4218
Phone: 1800 451 072 Fax: 07 5554 6493
www.mortarandpestle.com.au/index.html



Using progesterone cream effectively

What percentage of progesterone is in your cream?

Make sure you know how much natural progesterone is contained in your jar or tube of cream. And how much is delivered per application. Are you are getting the correct dosage into your body?

Mark sure your container of cream contains at least 450 mg of progesterone per 28 grams (1 ounce).

The percentage of progesterone contained in your cream determines how much is administered each application:

- 1.6% ~ 16mg per 1 gram application
- 2% ~ 20mg per 1 gram application
- 3.2% ~ 32mg per 1 gram application
- 4% ~ 40mg per 1 gram application
- 6% ~ 60mg per 1 gram application
- 8% ~ 80mg per 1 gram application
- 10% ~ 100mg per 1 gram application

Cream said to contain 1.6% progesterone would equate to 16mg per application. 3.2% would mean your cream contains 32mg of progesterone per recommended dose. Just try to keep in mind that a 1% cream would equal 10mg, 2% equals 20mg, 10% equals 100mg, and so on.

Incidentally, 16-20mg is Dr John Lee's recommended average daily dose.

Some women, however, opt for the higher concentrations simply because it works out more economical, and they rub on less cream. There are women, particularly the post menopausal group, who find the 32mg an ideal 'maintenance' dosage to balance the symptoms that tend to accompany change of life.

It's important to carefully follow application instructions. Measure your cream according to the dose indicator outlined by the cream manufacturer. For example, if you are using a tube of 1.6% cream the manufacturer might recommend squeezing roughly 2cm of cream onto the skin - 2cm in this case being equal to 16mg of progesterone, 4cm would give you 32mg.

Alternatively, some creams measure their applications by ½ or ¼ teaspoon. Again, you shouldn't have to guess here. All relevant information should come packaged with the cream. If it doesn't, ask for information to be sent to you.

High progesterone doses within the range of 100mg per application are usually prescribed as treatment of estrogen-driven conditions such as endometriosis, PCOS, uterine hyperplasia, fibroids, migraines, severe PMS or severe post natal depression. High dosage typically continues for three or four months before women report a turn around and can start weaning back.

The Natural-Progesterone-Advisory-Network.com website has observed women treating specific conditions with high levels of progesterone beyond six months or more, and it's interesting that they report loss of cream efficiency and their estrogen dominance symptoms reappear. We believe this is due to failure to reduce dosage according to symptom reduction or lack of breaks from cream, leading to receptors 'tuning down'.

Further, increasing dosage and frequency of cream application can lead to progesterone overdosing, which we'll go into in detail in another chapter. A good rule of thumb - least is best. If you have been using high doses of progesterone cream, we suggest you wean back to levels where you are asymptomatic. If you find your cream has become ineffective for reasons listed above, taking a break from cream altogether for a month or so is another way to enhance cream effectiveness.

Another tip we have discovered is changing the route of delivery. That is alternating with intra-vaginal at minimal doses. This will stimulate different receptors and possibly improve cream performance. Women become caught in a cycle where increased body fat raises estrogen levels, and estrogen increases the tendency to accumulate body fat. If you are significantly estrogen dominant, we suggest you consider losing weight thereby reducing your estrogen dominance.

Progesterone dosage will correlate with your degree of estrogen dominance. The worse the symptoms, the more cream you apply. It follows then that your goal should be to reduce estrogen dominance through lifestyle changes, diet, exercise, and making sure that your liver is doing its job, with a view to reducing the progesterone cream back to its absolute minimum.

Progesterone is not the answer to every ailment. We cannot emphasize strongly enough a woman's need to look at other big players in her overall hormonal health (eg diet, nutritional supplements, lifestyle changes). All too often women read Dr John Lee's publications and naively expect all their symptoms to vanish with the introduction of progesterone cream. For the record, John clearly states that hormone imbalance is multi-factorial. That progesterone is not a 'silver bullet'. Chances are you'll have to do more to help yourself than slap on some progesterone cream!

So many women have commented, "But I thought this was going to be easy!" Hormones fluctuate throughout the day, as they do in your lifetime. You need to understand this, and learn to read your body's bio-rhythms.

Are there any side effects using natural progesterone?

The 'Drug Information Sheet' for natural progesterone provided by Lawley Pharmaceuticals reads: "Adverse Reactions ... because progesterone creams contain the hormone identical to that produced by the human ovary, side effects are usually minimal. If experienced, these may include breast tenderness and swelling, fluid retention or slight vaginal bleeding. Dizziness, nausea, fatigue, headaches and light headedness have been reported occasionally and usually disappear with adjustment of dose..."

The Natural-Progesterone-Advisory-Network.com website, whilst aware of this information, rarely sees cases where there is not a logical explanation for the abovementioned side effects. We interpret these symptoms as 'estrogen dominance wake-up crisis' where the introduction of progesterone is 'waking up' and stimulating the estrogen receptors exacerbating the estrogen effects in the body.

These side effects may occur in cases of long-term use at high doses when not indicated and where breaks from cream have not been adhered to, or where inferior creams have been used. We talk about this all throughout our Resource Library, and provide techniques for overcoming estrogen dominance with the use of progesterone.

Like any drug it has side effects, good and bad. However, 'bad' in the case of progesterone does not necessarily indicate 'dangerous'. Progesterone, being bio-identical, has a huge safety margin in the body with which to work within. For argument sake, a woman could apply a dose of 400mg progesterone (similar to levels of a pregnant woman in her last trimester), and perhaps experience a state of relaxation and drowsiness. This dosage would not represent a risk to her health even though the recommended physiological dose is 15-20mg, imitating the output of the ovaries at ovulation. This demonstrates the enormous flexibility of drug dosage levels, and its relative safety factor.

We do not recommend that you slap on 400mg of progesterone cream, we're simply pointing out that should extra cream be necessary to treat your symptoms, it's not going to harm or jeopardise your health, particularly when your body is using the progesterone you are applying.

In Australia, regardless of its good safety record and extremely low toxicity, and being used for years in women's cosmetics, progesterone is still classified an 'S4 poison' because of the category it falls under rather than its drug characteristics.

As previously mentioned it has a huge safety margin, therefore, if you were to overdose you would probably go to sleep. In earlier years they used to use progesterone to control epilepsy with children so we know it has natural sedation effect.

Long periods of progesterone use without breaks can actually tone down the receptors and make the progesterone sites ineffective, creating estrogen dominant symptoms again. If the situation has occurred where progesterone has become ineffective, a break may be advisable for a month or two to restore and freshen the receptor sites.

When you first start using Natural Progesterone cream you can start getting estrogen dominant symptoms (eg headaches, breakthrough bleeding because it is waking up the estrogen receptor sites). These will usually pass once your dosage becomes more normal. So don't worry too much if that happens the first month or two. It is your body re-acquainting itself with progesterone. It is also stimulating the estrogen. Estrogen's activity in the body is more 'pronounced'.

We suggest this is a time to take a lot of phytoestrogens to counteract the estrogen wake-up period. This also can happen when you have had a break. It is a good sign that things are working, that the estrogen has been stimulated again and that progesterone is taking some effect on your body. We remind you that progesterone and estrogen sensitize each other thereby maximising their impact on the body. Either hormone out of balance will cause the other to tone down.

Possible side effects of progesterone:

- Lethargy/sleepiness: Probably an effect of allopregnanolone, a by-product of progesterone on the brain.
- Oedema (water retention): Probably caused by excess conversion of deoxycortisone, a mineral corticoid made in the adrenal glands.
- Bloating: Excess progesterone slows gastrointestinal (GI) transport, and with the wrong kind of gastrointestinal flora such as Candida this can lead to bloating and gas.
- Lowered libido: Excess progesterone blocks an enzyme called 5 alpha reductase which normally causes conversion of testosterone to DHT. Testosterone is good for libido in both women and men. Excess may also down-regulate progesterone receptors.
- Mild depression: Excess progesterone down-regulates estrogen receptors and brain response to estrogens is needed for serotonin production.
- Symptoms of estrogen deficiency: Too much progesterone will down-regulate estrogen receptors and desensitize tissue to estrogen. Too little estrogen and you won't get the benefit of progesterone because progesterone receptors are primed by estrogen receptors.

Recommended cream dosage for specific problems

The use of progesterone is not the only form of treatment for the following conditions and must be used in conjunction with medical supervision. Progesterone often kick starts other treatments, but has to be worked in with diet, vitamins, stress management and other environmental aspects.

These are the dosages we have observed to be effective. It is unfair to put too much emphasis on progesterone as a miracle hormone to resolve metabolic imbalance.

Progesterone used intelligently has brought wonderful results for many women providing it is embraced holistically and diligently.

Menopause

Women who have already entered menopause prior to their hysterectomy will benefit from 20mg of progesterone (delivered by a 2% cream) taken three (3) weeks in each calendar month, making sure they break from cream for a period of one (1) week.

This break from cream each month is important to ensure your progesterone receptors do not down-regulate from incessant application of cream. If you do not break from cream for at least 5-7 days each month, you will begin to lose the benefits, requiring more cream to be applied to get half the benefit.

Incidentally, breaking from cream each month shouldn't give cause for concern because once you've established adequate levels of progesterone in the body, this will carry you through the seven day break without incident.

Pre-Menopause

If you've had a hysterectomy and managed to keep your ovaries, and they are healthy, chances are you will not experience any significant changes to hormone fluctuations post surgery. At least, not for a

number of years anyway. In these circumstances, hormone replacement therapy is generally not required.

If, however, your ovaries have been inadvertently damaged during surgery, they may not continue to produce adequate amounts of hormones which could lead to hormone imbalance shortly afterwards.

You will need hormone replacement therapy (HRT) to help resolve the immediate loss of hormone production resulting from the removal of your ovaries.

As stated above, progesterone can be converted in the body into estrogen and testosterone, so supplementing with just 20mg of progesterone (2% cream) three (3) weeks out of four (4) each month might be enough to put things right again. But, for some, maybe not.

In order to get a handle on your hormone fluctuations post surgery, you may need to apply 20mg of cream 4-5 times A DAY, which adds up to a dosage of roughly 100mg daily (10%). If this is what your body needs initially, then stick with it.

If, inside three months, high levels of progesterone are not resolving hot flashes, vaginal dryness or flagging libido, then reduce your progesterone dosage gradually back down to around 40-60mg a day as you begin to introduce very small amounts of estrogen and/or testosterone.

Some women need maintenance doses of 40mg+ to remain symptom free, some do not. Therefore, don't be afraid to experiment. If you notice an improvement when you apply more cream then stick with what works. Your objective ought to be achieving a dose that's right for you that sits as close to physiological levels (20mg) as possible FOR YOU.

What you don't want to do is create a state of 'progesterone excess' in the body. You are attempting to mimic nature. If your body's not utilizing the available progesterone circulating in your body - determined by salivary hormone profiles - then reduce your dose.

As a general rule, you have a considerable safety margin with progesterone, making it almost impossible to accidentally poison yourself. For the record, the only known 'side effect' of bioidentical progesterone supplementation is increased sleepiness.

Uterine fibroids / heavy bleeding

We are recommending conservative doses here. However, many doctors may prescribe more, or less. Use between 64-100mg for 4-7 months under supervision. Overall, an average of 7 months on high levels seems to be an effective timeframe to get some measure of control. Your barometer is reduced bleeding and reduced clotting along with other symptoms such as regulated cycles that may have been present. Adjust dosage accordingly.

High doses 100-200mg (suppositories) under strict medical supervision gradually reducing over a few weeks have been incorporated with successful outcomes (documented in literature). However, the Natural-Progesterone-Advisory-Network.com website does not work with doses exceeding 10%, and has no experience with suppositories.

We find that women with a history of fibroids tend to sit on a maintenance average dose of 4% (40mg). When stabilised, work 2 weeks on, and 2 weeks off. In some cases, a 12 day break is too long, and needs to be adjusted.

The depletion of progesterone reserve (be it through stress or imbalance) will not be detected until the second month / second menstrual period, indicating a need to increase dosage temporarily until symptoms settle.

When treating uterine fibroids, it's imperative that you master estrogen dominance as fibroid growth is influenced by estrogen. See our section on 'How can I reduce my estrogen dominance naturally?'

Hysterectomy

We urge women who have been informed they need a hysterectomy to hang on to their ovaries regardless, unless life-threatening. Even though a hysterectomy will interfere with the blood supply

resulting in complete dysfunction of your ovaries over time, leaving them where they are will benefit your overall hormonal health ... providing they are healthy.

Surgical removal of ovaries in the case of an a hysterectomy will mean your body is not manufacturing adequate, if any, progesterone required to oppose estrogen dominance brought about through exposure to xenoestrogens.

Given that your body can convert progesterone into estrogen AND testosterone, supplementing physiological doses (2%) of bio-identical progesterone has been known to fix many of the problems associated with hormone imbalance post surgically induced menopause. Sometimes women may need to supplement bio-identical estriol and/or testosterone for vaginal dryness, hot flashes and/or loss of libido.

Endometriosis

At commencement of progesterone therapy, initial doses of high levels between 6-10% is often required, usually to compete with high cortisol and pain levels created by this disease. The body is also very deprived of progesterone. It may take 4 menstrual cycles until symptoms begin to abate. Then reduce dose according to pain management. The average maintenance seems to hover around 54mg (5>%) between 4-7 months.

Average out to 54mg, and reduce according to pain levels. Rub onto the ovaries and pelvic ligaments, remembering to rotate the site. A good response is regular and less painful periods. If you are finding that you are bleeding heavily, possibly suffering anaemia, make sure that you work closely with your doctor. All heavy, non-cyclic bleeding should be investigated.

These women don't cope well with long breaks from cream. But ideally, for the younger women, early diagnosed endometriosis, the goal is to mimic nature and aim for a 12-26 day cycle using cream. And eventually return to a 'least is best' dosage. For a young teenager/woman suffering endometriosis, a maintenance dose would range from 2-4% and often she can wean off progesterone altogether for months on end supplementing with herbs. Women with more established endometriosis appear to sit between 4-6% maintenance dose for at least a year, then lower doses may be tolerated as healing progresses. Your barometer of treatment is reduction of pain, a return to regular, pain-free periods, and associated endometriosis symptoms.

Migraines / PMS

Starting from approximately 32mg from day 10-12, gradually increasing to larger doses (up to 10% if necessary) toward the end of the cycle. This gradual increase of progesterone levels peaking at around day 26 will usually control the onset of migraine and PMS. Rub onto your temples, neck, and back at hourly intervals to dislodge the headache or onset of anxiety or mood swings. You will probably find that one or two doses will be enough.

For severe PMS and migraines, up to 10% levels are well tolerated in initial stages. Your maintenance dose is around 16-32mg, your barometer being symptoms relief. PMS and migraines may take months to settle, and usually disappear if managed correctly.

Severe migraines may take up to 12 months to control but, with each cycle, severity, duration and debilitation lessens. PMS is slightly easier to conquer, usually over 4-7 months.

Cervical dysplasia

The normal dose would be 20-32mg for 4 months and usually positive changes are observed in this timeframe, confirmed with another pap smear. For a quicker result progesterone pessaries or lesser dose via intra-vaginal application may be of benefit.

We would expect that you are under the care of a physician and all other tests have been performed to eliminate likely causes such as cancer, STDs, etc. Progesterone is not the only factor here. Nutrition and attention to hygiene needs addressing. You might also consider moving away from tampons (bleaching chemicals) during your treatment.

Progesterone has been reported to correct abnormal cervical cells (atypical) where a pap smear reading indicates the need for further investigation and possible surgery. Get a second opinion and consecutive pap smears following 2-3 months on progesterone therapy.

Adrenal exhaustion

This range depends on the degree of your condition. Begin at 32mg and assess your progress. High levels of 64mg are often required initial 8 weeks or more to compete with the cortisol output because there will be competition for the same receptors and progesterone has to work harder under these conditions. Reduce as your symptoms improve.

Absorption and assimilation of progesterone has been observed to be very poor in these women, particularly when associated with chronic fatigue or fibromyalgia. Intra-vaginal application very gradually has proved far more effective in conjunction with nutritional supplementation aimed at rebuilding their immunity.

These women often qualify for additional steroid hormones. This is why a saliva assay is imperative to assess possible depletion of other hormones to, and fine tune levels.

PCOS

The average dose that most women with PCOS seem to be asymptomatic at is around 54mg of progesterone cream daily from day 12-26 of your cycle (adjust accordingly) for at least the first 7 months if there is a regular cycle. In the initial few months, however, a lot of women take 64mg of progesterone cream from day 5-26 to address extreme progesterone deficiency and estrogen dominance symptoms. And after your body has settled down, you may wish to wean back to a lesser dose or to extend breaks to fall into line with a day 12-26 cycle. Get as close as you can to a 'least is best' dosage, long term, and remain asymptomatic. Some women have reduced dosage levels as low as 2-3%, day 12-26, or 14-28 on a longer cycle, and enjoy optimal health.

It's important that you have regular ultrasounds to assess the condition of your ovaries, and an indicator of treatment progression.

If you are using a regime day 5-26 in the first 4-7 months until symptoms settle, please be aware you are using a program suggested to enhance fertility.

Dosage barometer would be improvement of symptoms such as reduced facial and body hair, no further weight increase, clearer looking skin if suffering acne, less cravings for sugars and refined carbohydrates, regular cycles, absence of ovulatory pain, elimination of PMS and other estrogen dominance symptoms.

Nursing Mothers - postnatal depression

To treat severe depression, doses >64mg uninterrupted for 4 months have been used successfully (depending on the degree of depression), then wean back gradually to 15-20mg physiological dose. Once their period returns, these women have adopted a cyclic 12-26 day regime to maintain hormone balance.

The advisable dose of 15-20mg, based on observation, hasn't affected prolactin levels. If this dose is inadequate, increase gradually until you arrive at a level where you feel relaxed, getting a sound sleep at night, general improved sense of wellbeing and not feeling depressed.

If you wish to use high levels and feel it is necessary, the barometer is your absence of symptoms. If your milk production is effected, it is an indication that progesterone may be interfering with the hormone prolactin (responsible for producing milk). We have not had any reports of this, even at 6% short term use.

Fibrocystic breasts

Physiological dose of 15-20mg, rubbing some cream on to the breast tissue daily and the remainder of cream for that dosage rotated around the body. Your breasts will respond favourably to this dose regardless of what else you do. You can remain on this dose indefinitely (with regular breaks) to maintain breast tissue softness and cyst-free breasts.

Barometer would be diminished cysts. Success of treatment is usually seen within a few months. Women who are highly stressed, or who have a high intake of caffeine may take longer to respond.

Fertility

We have not had hands-on personal experience with fertility. Fertility specialists in America are currently working with a natural progesterone product called 'Crinone Gel 8%'. There may be similar products available in Australia, however, we are unable to name any at this time.

As a general guide, Dr Lee recommends using 20mg of progesterone from day 5-26 for 3 months to rest the ovaries (turn off ovulation). Then the next month which is the fourth cycle use 20mg from day 12-26 or 14-28 if you are on a longer cycle. Should you become pregnant continue to use the cream increasing dosage to 30-40mg in the first month, after which increase dose to 60-80mg. If you are uncomfortable about stopping the progesterone, continue until one week before delivery. If you are going to stop the progesterone never stop suddenly. Cut down by the third month when the placenta takes over making progesterone.

If you withdraw progesterone suddenly it could potentially trigger a miscarriage.

Liver function

If the liver is not functioning properly chances are you will feel very nauseous with progesterone usage in the initial stages. This is the only time we recommend minute amounts of cream (maybe as small as 5mg), gradually increasing as tolerated. Start supporting your liver function with a premium liver formulation and detox regime. Also, if progesterone is not helping you for various problems, one must wonder what other factors are at play here. A liver assay would be advisable in this situation.

The liver is the organ that eliminates ALL the hormones after the body has utilised them. The liver is also where synthetic HRT is metabolised making it available for the body to use. Natural, bio-identical hormones bypass the liver and gut and are taken directly into the blood stream.

Osteoporosis

This is fairly controversial with Dr Lee recommending a more physiological dose, three weeks on, one week off if post menopausal, and if peri-menopausal a physiological dose 12-14 days if asymptomatic.

As there are no firm studies to-date, except Dr John Lee's work with his own patients of 20 years practice, we can only use his guidelines.

However, for the first 8 weeks if you are estrogen dominant, work on the principle of saturation up to 64mg. If you are post-menopausal you can go for 8 weeks without a break and then come back to physiological doses between 15-20mg as a maintenance dose if asymptomatic.

A lot of menopausal women do not show signs of estrogen dominant symptoms, but still need to have high doses initially because the body is so deprived of progesterone. If women are peri-menopausal, still menstruating and have osteoporosis, then the principle of saturation and pulling back to maintenance doses 15-32mg for bone building, depending on their estrogen dominance and other symptoms. Arriving at a physiological dose where you are symptom-free other than treating osteoporosis may take months in adjunct to diet, nutrition, phytoestrogens, etc.

We emphasize more progesterone dosage does not make more bone, in fact it can retard the benefits of bone building, because it can down regulate if it's used in high dosages for long periods of time unnecessarily. Higher than physiological doses of progesterone is only beneficial to the body when it is addressing problems at hand (excluding osteoporosis).

In summary, if you are post menopausal and have osteoporosis you are not going to see immediate results and may not see results for quite a few years. Adopting a 'least is best' approach will still have the same favourable outcome as opposed to high or random dosage.

Barometer is improvement of Bone Mineral Density (BMD) reading - 3 to 4 year comparison of results.

Hot Flashes

From our research and understanding, these are really a marker for estrogen and progesterone deficiency. This results in a huge ratio difference between the estrogen and progesterone levels, sending the body's biofeedback mechanism into 'overdrive' to prompt ovulation (wake up the ovaries).

Initially you can use high levels of progesterone between 6-10% in the first 6-8 weeks, depending on severity and occurrence of night sweats and/or flushing. The body will settle once it understands progesterone in the body to stay. Using the principle of saturation seems to help to override estrogen dominance wake-up crisis quicker. Severe flushes usually indicate radical fluctuation of estrogen so it's important to stabilize the ratio between estrogen and progesterone. Incorporating phytoestrogens ('tricking' estrogens) are imperative in addressing hot flushes successfully. See Chapter 12 on Phytoestrogens.

Hot flushes can range from seconds to minutes, and can be very debilitating. Women often find that regular doses throughout the day and night deliver a more consistent message to the brain and evens out ratio imbalance. Consistent doses are far more effective in the initial stages than a day and night application. It is important to keep you fluids up, and helps prevent dehydration from excessive sweating. Continue with this approach and the hot flushes will gradually subside as the body adjusts to the progesterone input into the body. Once the hot flushes subside, reduce this dose accordingly, working back to asymptomatic doses.

The average dosage most effective to control hot flushing, menopausal or peri-menopausal state, is approximately 32mg, usually achieved around the fourth month. If hot flushes haven't subsided within 4-7 months on progesterone there may be a call for administration of some estrogen.

When should you break from cream

In the first 2 months, a woman can actually go without a break as the body is usually very deprived of progesterone, and a majority of the hormone is being soaked up into fat tissue. This is also the reason why a higher dose is well tolerated.

Not breaking from cream in the first 6-8 weeks will not, in our experience, adversely affect your periods. You will continue to get your period. And it's likely, during this time, you will still be estrogen dominant. In fact, double doses help negate the estrogen wake-up promoted by the introduction of progesterone back into the body which stimulates the estrogen already present in your body and may exacerbate your symptoms.

After 8 weeks, it is advisable to establish a rhythmic pattern in your body. So it's important you begin taking a break from cream (as saturation has most likely been achieved around this time). This is also the time when weaning back to physiological doses can be initiated, as determined by symptom relief and charting.

A break from cream must now be taken to fall into line with your menstrual cycles, i.e., menopausal woman would follow a calendar pattern of 3 weeks on, 1 week off; a cycling woman would follow a program of 2 weeks on cream, 2 weeks off according to her period.

This is the aim - to achieve balance using progesterone on physiological doses ('least is best' principle) such that symptoms are relieved. However, be mindful of the fact you could take many months to a year to achieve hormone balance and maintain the appropriate breaks from cream without feeling the absence and/or deprivation of progesterone.

We remind women that it is so important to have at least a 3 day break in order to restore receptor sensitivity. To do otherwise is to risk losing the full effectiveness of your progesterone cream (down-regulates).

If you cannot achieve lengthy breaks when you first start progesterone therapy, work towards increasing the breaks each month. We always know when a woman is 'progesterone balanced' when she can take 2 weeks break without discomfort.

Should women post menopause take cyclic breaks from HRT?

"It occurs to me," says [Jonathan V. Wright, M.D.](#), a much respected field leader in natural biochemical medical treatments since 1983, "that if something operates on a cycle for 35 to 40 years and after that we start overriding that cycle by taking the hormone progesterone in the same quantity every day with no regard to that cycle and with no break (that break being the functional equivalent of the menstrual period) when there's very little progesterone around, and if we start overriding that cycle that's been going on for several years, there's a very strong likelihood this will cause problems.

"It turns out that one of the estrogen hormones called estriol is generally conceded to be either anti-carcinogenic, or at the worst neutral, but not pro-carcinogenic. And all animal research studies have shown it to be so with the exception of when the estriol is given continuously. The longer the estriol is given continuously the more likely it is to be a carcinogen to that animal.

"We should observe what happens in nature and copy it as well as we can. So not only do we want a molecule with the same size, same structure, the same weight, the same wave length, the same everything. We also we want the molecule on the same schedule as is found in nature. We're trying to mimic individual nature."

Homo sapiens suddenly emerged some 150,000 years ago. Natural selection adapted woman to this unique environment. However, there is little, if any, adaptive evolutionary preparation for menopause. Even though it is normal to have a menopause due to the failure of the ovaries if one lives that long, humans are the only species that lives much past reproduction.

This longevity is comparatively new and comes from our great mental powers that have allowed us to evade the usual things that carry off aging individuals: haemorrhage, infection, birth accidents, and natural predators. Half of our lives happens after reproduction is over, and we have no evolutionary adaptation for this.

Women who go through menopause at 45-55 years of age now live to be 85 or 90 years old.

Based on these life expectancy trends, women face the prospect of spending the last one-third to one-half of their lives in a state of hormonal imbalance. The quality and quantity of life for these women will be determined by how well they (and their doctors) manage hormone replacement.

So what are our options here? On one hand, evidence suggests we need give serious consideration to hormone supplementation to ward off premature ageing, osteoporosis, breast cancer, dementia, heart disease, etc., while, paradoxically, the media has us on constant alert to yet another clinical trial suggesting, if not proving conclusively, that foreign-to-the-body hormones typically used in HRT carry significant health risks and should not be used long term.

In an evolutionary sense, we're sailing blindly (and some might say arrogantly) into uncharted waters.

Of course, we're NOT without a 'road map' to guide us, as Dr Wright points out. Yet, even in light of Mother Nature's template and conventional HRT's bad press, a large majority of doctors continue to align themselves with drug-company-driven HRT protocols that dump pharmacological doses of unnatural-to-the-body hormones into our stomach without adherence to periodic breaks to prevent down-regulation of receptor sites, often without first capturing the patient's baseline hormone levels.

This 'one size fits all', cookie-cutter approach to HRT is out-dated, dangerous, and invariably falls short of the mark.

A safer choice is human-identical hormone replacement therapy which, when administered transdermally, has no known negative side effects.

Here are some suggested HRT guidelines:

- Use saliva hormone testing for a complete and individualized hormone profile.
- Supplement hormones only when you have confirmed you are truly deficient in them.
- Use only human-identical hormone replacement therapy rather than synthetic hormones.
- Apply hormone replacement transdermally (through the skin).
- Supplement hormones according to your unique reproductive cycle.
- Use only in dosages that provide normal physiologic tissue levels.
- Take cyclic breaks (from cream) to rest receptor sites, and sustain balance.
- If symptoms of hormone imbalance persist, consult you physician. Your individualized prescription of human-identical hormone therapies may need to be adjusted.

How to map out an individualized program

Step 1: What is the length of your menstrual cycle?

This can be determined by counting from Day 1 of your period to Day 1 of your NEXT period.

Obviously, this will vary. Some women menstruate on a 28 day cycle, others are on a shorter cycle (eg. 21 days) while it's not unusual for women to have longer gaps between their period (eg. 35-40 days).

If it's been some years since you menstruated, then try to recall your cycle as best you can. You want to determine a functional equivalent of your unique menstrual cycle.

Step 2: When do you ovulate?

Once you have an idea of the length of your cycle, it's relatively straight-forward figuring out when ovulation would have taken place.

While the days leading up to ovulation will vary for each woman, typically menstruation will follow about 2 weeks after ovulation occurs. You would, therefore, chart ovulation by counting back 14 days from the first day of your period.

Why is it important to understand your ovulation phase? Because progesterone production begins to rise dramatically after ovulation, peaks and then quickly falls. Your body actually cycles progesterone production from ovulation until 2-3 days before your next period. If you were to follow Mother Nature's template, you would supplement progesterone for approximately 2 weeks each cycle.

May I add here that this 'common-sense' approach to progesterone replacement therapy has served me well these past nine years.

Step 3: How long do you bleed during menstruation?

Understanding the length of your menstrual bleed is particularly important for women supplementing estrogen. Where medically indicated via salivary profile, estrogen supplementation should be according to your body's output of estrogen (E1, E2 & E3).

Estrogen production is produced by the developing follicle before ovulation. Estrogen levels begin to rise the day after you stop menstruating and peak in mid-cycle at the time of ovulation. Where medically indicated, you would supplement estrogen for approximately 3 weeks each cycle.

Triest is the name for the combination of all three estrogens often use in estrogen replacement therapy. The optimum ratio for the estrogens is:

- estriol / E3: approx. 60-80% of circulating estrogen
- estradiol / E2: approx. 10-20% of circulating estrogen
- estrone / E1: approx. 3-5% of circulating estrogen

Find yourself a supportive doctor

For women entering menopause, erratic periods go with the territory. Some women report intermittent bleeding that goes on for years, others tell of how their period just stopped all of a sudden. Therefore, progesterone isn't really going to regulate monthly bleeding when Mother Nature is signalling the end of your reproductive years. What progesterone supplementation can do, however, is make the going a little easier.

A lot of women benefit immensely by incorporating Vitex into their program, particularly when experiencing extremes of wandering periods. It seems to assist in balancing and regulation, along with many of its other medicinal and traditional benefits.

If you are unsure when to apply progesterone cream, or perhaps you are experiencing menstrual irregularities, you might benefit from a treatment protocol (as outlined above) that mirrors your 'natural' cycle.

May I recommend you work closely with a collaborative physician competent in bioidentical HRT to ensure the best possible outcome while keeping you safe and informed. This is particularly relevant when supplementing estrogen in combination with progesterone and other steroid hormones (eg. DHEA, cortisol, testosterone).

Please also refer to our suggested HRT guidelines above.

An excellent website that can help you understand female reproductive health is the World Organisation Ovulation Method Billings ([WOOMB](#)). I highly recommend the new 2003 edition of '[The Billings Method](#):' Using the body's Natural signal of fertility to achieve or avoid pregnancy by Dr Evelyn Billings & Dr Ann Westmore.

How will your GP determine correct progesterone dosage?

In countries where progesterone is a prescription S4 drug (supposedly monitored by your doctor) problems arise when your GP is asked to write a script for a drug she/he knows very little about. Most GPs err on the side of caution and follow drug indicated usage.

The truth is, women are going to have to improvise, and in some cases rely on the 'coal face' observational data collected to-date to determine their parameters. To tune into their bodies, adjust their doses according to symptoms, initially working with higher doses in the first 6-8 weeks and weaning back to where they are asymptomatic.

We have observed that some doctors who are progesterone 'savvy' have been very quick to reduce a woman's dosage to a physiological dosage well before progesterone has had an opportunity to work effectively in the body, bringing about a rapid return of symptoms or a flare up of a particular disease or condition.

It is a fact the Natural-Progesterone-Advisory-Network.com website encourages each and every woman to take responsibility for herself during progesterone therapy. She might want to include in her personal analysis, our opinions and observational data, and international input from women who have reported excellent results supplementing with progesterone.

We impress upon women not to take our information as gospel. Use our information and experiences and tailor it to your own needs and opinions, or not. Just always remember, the information provided in this publication is not intended, nor should it be construed, as a substitute for professional medical advice. It is intended as a sharing of knowledge and information from the research and experience of Catherine Rollins, experts in the natural progesterone community, and our network of hundreds of women who have been using natural progesterone over the past ten years. We encourage you to do your own research and make your health care decisions in partnership with a qualified health care professional.

Neither should you blindly follow a doctor's instructions if you intuitively feel that perhaps a little bit of extra progesterone could help you in the initial stages.

If you are having an estrogen dominant 'wake up' crisis, increase your cream to double the strength versus what you're on now, providing progesterone concentration remains under 10% [100mg]. If symptoms subside within 24 hours, then you know you are on the right track and should maintain a level where you are progesterone replete. Once you settle, start gently reducing. Usually you will see changes either way within 24 to 36 hours. Therefore, if you feel you need to go up a bit, try it for a few days.

Alternatively, if you're feeling worse on a higher level, try going the other way - reduce your dosage - and see if your symptoms get better. Some women actually need to decrease their progesterone in the first eight weeks purely because it is actually reacting in their body, particularly if their liver isn't functioning optimally or their receptors are very slow to regulate and they just can't cope with high levels. These same women may cope with high levels further down the track.

We urge women to experiment, but keep in mind that at the end of the day your goal is to work to physiological doses, mimicking nature (equal to ovarian output at ovulation of roughly 16-20mg per day).

In the back of your mind remember you don't want to end up having an imbalance through too much progesterone.

You've started taking progesterone and feel awful

Progesterone therapy is complex. Not every woman reacts in the same way.

Every woman's biochemistry and ability to absorb and use cream is different. Most, however, fall into two categories. Those who experience an incredible response almost immediately - they feel fantastic and cannot get enough progesterone cream. Then there are those who feel absolutely dreadful and believe the cream is actually making their condition worse.

If you're feeling euphoric, this will begin to taper off once your body has adjusted to the higher than usual progesterone levels in your body.

Conversely, progesterone can actually 'wake up' your estrogen receptors, initially exacerbating various degrees of estrogen dominance (reports of feeling like a "beached whale", foggy, throbbing head, unable to get going).

Be mindful that progesterone and estrogen are a 'pigeon pair'. One compliments the other. Remove progesterone from the equation and you leave estrogen to dominate the hormonal environment. Eventually your estrogen receptors will compensate by 'tuning down'. This blunted response to estrogen is 'heightened' when progesterone is added back into the body. Progesterone restores estrogen sensitivity resulting in what appears to be exacerbated estrogen dominance symptoms (the Natural-Progesterone-Advisory-Network.com website refers to this activity as estrogen dominance wake-up crisis. This is perfectly normal, a good sign in fact that hormone imbalance is being treated.

Unusual things can happen when you start using progesterone and we suggest you journal it. Take notes (journal) because these signs and symptoms will be idiosyncratic to your hormonal profile.

There have been various reports of itchy ears, breakthrough bleeding, tingling nipples, sore breasts, headaches, fluid retention, heavy periods, sore sinuses, phlegmy throat and more. Anything is possible when progesterone levels are being restored to normal physiological levels. Even accelerated aches and pains can indicate estrogen receptor wake-up symptoms. Give it at least ten days for the symptoms to subside. It can take some women two to three months to restore receptor sensitivity.

Be warned that every woman has her own unique receptor 'wake-up' episode. You might be one of the lucky ones who suffers very little. If, however, the whole experience is becoming quite trying, hang in there. You'll turn the corner very soon ... and your body will definitely thank you for it in a few months time.

Another reason why women may feel awful on the cream is because many women fall into the trap of stopping their cream because they feel great or they forget to take it. They then find themselves back with the recurring symptoms because they haven't taken their cream consistently nor have they incorporated precautionary or maintenance steps to control their environmental estrogens and reduce their own estrogen impact on their body.

To maintain themselves on a stabilised level they need to continue to take their cream on physiological doses according to nature and cyclic events as nature intended, so they have progesterone always in their body to get the full benefits. Otherwise they end up with inconsistent levels and progesterone deficiency. There are certain aspects we can't control such as the impact of our environment. We can, however, control our dose and application of progesterone. Stopping and starting, or random dosage is not the way you use this hormone. It will confuse the body, and may make you feel awful.

Hormone imbalance is not about adding more progesterone and more estrogen. It is about balancing the hormones as nature intended. We are referring to physiological doses here. If your body already has high estrogen levels then you need to address your estrogen dominance separately to the issue of progesterone deficiency. In many cases, women are already ovulating and producing normal physiological progesterone levels that would be enough to keep them well ... if they weren't estrogen dominant!

Simply adding more cream can sometimes be a cop out for taking some personal responsibility.

Feeling nauseous?

The experience reported is likened to morning sickness commonly experienced in the early stages of pregnancy. The reintroduction of progesterone creating hormone fluctuation can bring on this nauseous feeling, particularly in the first few days. If so, cut dosage right back and gently use small amounts until the feeling passes. Then increase as your body adjusts. Usually the feeling of nausea subsides within 10 days.

Nausea, in our experience, nearly always indicates liver dysfunction. You need to support this organ. A dysfunctional liver simply cannot tolerate the introduction of a new hormone. These women usually react quite violently to HRT. Our observation confirms that women suffering poor liver function are candidates for progesterone supplementation after years of deficiency, problems which are compounded by conditions such as FMS, CFS, chronic endometriosis, adrenal exhaustion, other auto-immune problems.

Use progesterone in these cases with sensitivity and a program that incorporates steady increases in dosage over time. We suggest you start with very small doses (<10mg). You can expect to experience in 2-3 weeks time an estrogen dominance wake-up. This is when you may need to increase or double your dose to override wake-up symptoms. The receptors would have been stimulated slowly and have taken their time to respond (usually because the conditions stated above often have slow, sluggish cell receptivity). The small doses have been enough to tickle and tease the estrogen receptors to wake them up but the progesterone doses (tolerated) has not been adequate enough to oppose and over-ride estrogen levels and this hormone's effects in the body.

Some women who have experienced levels of nausea on progesterone are nervous and reluctant to increase their dose. Nonetheless, it is important to emphasize that the dose they are currently sitting on is actually creating estrogen dominance problems like headaches, fluid retention, feelings of PMS. Contrary to what one lady was told, nausea is NOT caused by using cream through a period (she was only 3 weeks into her program suffering from endometriosis).

Favourable outcomes result from going beyond this barrier of estrogen dominance. We suggest you try an extra 1-2% dose and assess how you feel. But pull back if you experience extreme nausea. The objective at the end of the day is to treat your symptoms with progesterone. If low doses aren't resolving your health issues, you need to push forward onto a high dose. With a good liver program in place, women are surprised how well they can now tolerate appropriate doses to treat their problems (achieve saturation) before pulling back to physiological doses.

Why is the liver so important in hormone balancing?

Drugs, artificial chemicals, pesticides, alcohol and hormones are broken down (metabolised) by a 2 step detoxification pathway inside the liver cells. These 2 liver pathways are designed to convert fat-soluble chemicals into water-soluble chemicals so that they may then be easily excreted from the body via watery fluids such as the bile, sweat glands, and urine.

For an efficient detoxification pathway, the liver must have adequate amounts of antioxidants such as vitamin C, vitamin E and natural carotenoids. Carotenoids are the pigment substances which give colour to fruits and vegetables. If antioxidants are lacking, then toxic chemicals become far more dangerous.

For efficient Step Two detoxification the liver cells require sulphur containing amino acids such as taurine and cysteine. The nutrients glycine, glutamine, choline and inositol are also required for efficient Step Two detoxification.

Cruciferous vegetables such as broccoli, cabbage, brussel sprouts and cauliflower, raw garlic, onions, leeks and shallots are all good sources of natural sulphur compounds which enhance Phase Two detoxification. Thus these vegetables and nutrients can be considered cleansing substances for the liver.

If the Step One and Two detoxification pathways become overloaded there will be a build up of toxins in the body. Many of these toxins are fat-soluble and incorporate themselves into fatty parts of the body where they may stay for years, if not for a lifetime. The brain and the endocrine (hormone) glands are fatty organs, and are common sites for fat soluble toxins to accumulate. This may result in symptoms of brain dysfunction and hormonal imbalances such as infertility, sterility, sexual dysfunction, breast pain, menstrual disturbances, adrenal gland exhaustion and early menopause.

There is an increasing incidence of degenerative diseases of the nervous system such as Multiple Sclerosis, Parkinson's disease, Alzheimer's disease and Motor-Neurone disease, which cause severe disabilities.

Accumulation of insecticides, pesticides and petrochemicals inside the cells of the nervous system will damage these cells, increasing the risk of these neuro-degenerative disorders. If the liver is unable to detoxify these deadly toxins they will get past the liver and accumulate in the fatty parts of the brain and other nervous tissue. People generally believe that such terrible diseases will never happen to them and yet we do very little to support liver function because we do not realise that a healthy liver is vital if we are to protect ourselves from these common diseases, let alone hormonal problems.

Cardiovascular diseases such as strokes and heart attacks are the leading cause of death in society today. Most people do not realise that it is the liver that removes excessive dangerous fats from the blood stream thereby preventing fatty blockages of the blood vessels, which cause these diseases.

Many chemicals such as pesticides, petrochemicals, aspartame, etc., are carcinogenic and have been implicated in the rising incidence of many types of cancers. If the filtering and/or detoxification systems within the liver are overloaded or inefficient, this will cause toxins, unhealthy fats, dead cells and micro-organisms to build up in the blood stream.

This will increase the workload of the immune system which will then become overloaded and irritated. The simplest and most effective way to cleanse the blood stream and thus take the load off the immune system is by improving liver function.

As you've read, the liver not only breaks down and eliminates toxins in the body, this process contribute to reducing estrogen dominance by assisting in the removal of excess hormones thus promoting hormone balance. This facilitates more effective performance of progesterone and possibly provides scope to reduce your dose if the body is functioning optimally. On the flip side, a woman with a fatty, dysfunctional liver will require far greater dosage of progesterone perhaps with minimal benefits.

Many women fall into the trap of believing that taking Silybum marianum (St Mary's Thistle) and Taurin supplements are adequate to detox a sluggish liver. The Natural-Progesterone-Advisory-Network.com website always advises women to get their hands on a [premium formulation](#) that contains the necessary vitamins, herbs and essential nutrients to facilitate pathway 1 and pathway 2 detoxification, assisting with the efficient burning of fat from the liver itself.

Weight reduction cannot take place until the liver has cleared itself of all fat deposits, at which point it can then eliminate fat and toxins from the body. This is when women see permanent weight loss as opposed to 'yo-yo' or crash diets that tend to see a women gain more weight.

The www.LiverDoctor.com website and publications will provide a wealth of information, advice and recommendations on how you can improve your liver function using powerful nutritional strategies.

Adjusting your dosage

If you've been on the cream for at least 4-7 months, your charts and your symptoms will determine your dosage. As symptoms are relieved, your dosage should be reduced, working towards the 'least is best' principle.

Reduction should be according to the condition you are treating and how you respond.

If women do not adjust dosage accordingly upon symptom relief but instead maintain a high dose regardless, then the benefits of progesterone may actually wear off and symptoms possibly creep back in.

For the uninformed woman, her automatic response might be to increase dosage seeking to reclaim that initial euphoric state she first experienced on progesterone. Or by not adjusting progesterone accordingly she has either accidentally down-regulated her progesterone receptors or simulated more estrogen production pushing her body back into estrogen dominance.

Once you are asymptomatic, we recommend you use the LEAST amount of progesterone possible to keep your symptoms under control.

Barometers for correct progesterone dosing

Some of the 'hormonal' barometers reported by women indicating the need to make adjustments are listed below. But of course every woman is unique and will have her own hormonal template once she starts charting. The breast is a good example of how to monitor dosage as we explain:

- Breasts are a fantastic barometer to guide you with your hormonal balancing. In fact, many women use sensations in their breasts to assess their progesterone dosage.

If women are using too much progesterone after they have had a period of balance, they may experience itching, tingling, or soreness of the nipples. Breast engorgement, a feeling of fullness, a dull ache, or general breast tenderness appears to be the first indication to women to reduce their dosage.

If symptoms are relieved upon reduction of dosage after 2 days, then you know you're on the right track. Don't confuse these symptoms and reduce progesterone if your period is due.

Clearly, your breasts are extremely responsive to hormone fluctuations, some more than others. If you're one of these women, allow your breast messages to help you fine-tune your hormones. Learn to listen to your body.

Other physical barometers of overuse or under use:

- Period changes - ranging from heavy, or sign of clotting, slight spotting.
- Sinusitis - women complain of sinus or hay fever-like symptoms, often indicating the re-emergence of estrogen dominance.
- Return of headaches - fogginess, tight band around the head, scalp tension
- Fluid retention - puffy ankles
- Re-emergence of sleep disorders - waking at 2am - 4am very common
- Hot flushing
- Vertigo
- Unexplained muscle/joint pain
- Sense of uneasiness - apprehension, anxiety, quick to tears, slight depression

In our experience, because of the need to address so many problems with progesterone supplementation, overdosing inside 7 months is very uncommon providing there is a genuine progesterone deficiency.

Generally, it takes about 12 months for a woman to really master her hormonal profile and achieve balance. For this reason, we urge women to not pre-judge their results on progesterone inside this timeframe. When we talk about the need to reduce dosage, this usually applies to women who've been on progesterone at high levels for 4-7 months and may not have adjusted dosage according to the reduction of their estrogen dominance symptoms.

High doses which might be necessary to oppose estrogen dominance tend to 'frighten' some women in their initial stages of progesterone, and subsequently their dosage is inadequate.

How to know if you need to increase dose

If reducing dosage doesn't help or perhaps increases discomfort, then it indicates the need to increase your progesterone dosage, and pay particular attention to increasing your intake of phytoestrogens to oppose estrogen dominance crisis.

This situation of estrogen wake-up often follows an episode of stress which would account for the shortage of progesterone and the increase of estrogen levels.

Drop progesterone back to your previous dose once balance has been achieved and symptoms have subsided.

You MUST address why you require dosage adjustments. Are you becoming more estrogen dominant or hormonally imbalanced from over use or under use?

One of the biggest players in robbing progesterone supplies and creating hormone imbalance can be STRESS, pulling progesterone down another steroid pathway to create the 'survival' hormones - cortisol and adrenalin.

If there has been stress, high pain levels, shock, trauma, surgery, illness, or unresolved emotional issues, chances are there is a progesterone deficiency in the body requiring higher levels of progesterone cream to help compensate temporarily. When high cortisol is present in the body (our anti-inflammatory hormones) there is a competition between progesterone and cortisol for the same receptors sites, so higher-than-usual levels of progesterone is required (as is the case for PMS).

Progesterone has a calmative effect and anti-stressor influence thus helping to address the stress itself, reducing the need for continued high cortisol production. Reducing stress allows the opportunity for progesterone to work its benefits in the body once again.

You can apply more cream until you reach an emotional equilibrium, that place where you begin to feel an inner sense of wellbeing and calmness, in spite of your physical symptoms (that could take a few days to settle).

But, of course, the most reliable way to ascertain whether you need more or less progesterone is to do a hormonal saliva assay. Particularly if you are struggling to re-establish balance with dosage versus symptoms.

We include here for your benefit an email addressed to the Natural-Progesterone-Advisory-Network.com website that we believe typifies the scenario we commonly face. It highlights many issues.

"... I think the burning sensation is flushes, they settled down for a little while when I first started taking progesterone (13 months ago) they happen if I'm stressed, hurrying or concentrating hard, and always if I have a drink. I usually have anywhere between 18 and 24 day cycles, used to start the cream around day 11 but have started lately around day 7 or 8 so I get enough days in with the cream. I use between 1 and 1.5 cm cream per day applied of an evening. I originally used a little more but used to get teary and emotional and sore boobs, so cut it back a bit. Decided estriol cream would be the go, because after doing some reading it seems the other 2 estrogens are more likely to cause cancers, and from what I can understand estriol doesn't and it also has some cancer protection, so I thought that since estrogen is supposed to stop the flushes, (which it seems to for other women) maybe I might be a bit estrogen-deficient and that it would be the safest one to take, if that makes any sense! So if that was the way to see if it would help, I was wondering if you knew where to get a cream that wasn't synthetic, Dr ... has tubes of estradiol, but I don't really want to use that, because I'm not sure if my problem is that I am estrogen-deficient. Diet hasn't changed much, only that I have given up milk in my numerous cups of tea that I usually drink each day and have limited the amount of cheese and butter to very little - over last few weeks - but the red/purple face has really been an on-going thing for 4-5 years, just become very frequent and severe lately. I am 48. Tubes tied. Never taken pill. Same soap. Skin not itchy, has always been a bit dry. Hormonal health, much better since going on the progesterone, don't have the PMT and long sleepless nights like I used to." ~ Julie ~

Firstly, 'Julie' does not understand 'hot flushes', she hasn't mastered the use of progesterone nor has she completely understood the role of progesterone in her body. Julie probably doesn't realise that progesterone therapy works in stages, and often needs reassessing at 12 months to re-evaluate dosage according to symptoms. We believe, given that Julie is 48 years old with a history of tubal ligation and PMS. She needs to increase her dose because clearly 16-20mg (1.0-1.5cm) per day is not addressing and settling her hormone fluctuations.

We don't believe Julie has incorporated phytoestrogens into her diet which would help stimulate estrogenic benefits and sensitise progesterone receptors. She has attempted to reduce saturated fats from her diet (dairy products) but has not, to our knowledge, increased her intake of essential oils (Omega 3-6). In the past, Julie's experience of estrogen dominance symptoms such as tears, emotional and sore boobs led her to believe she should reduce her dosage. While this may have worked in the past, the dose level is obviously not holding her any longer. She needs to increase her dose, and be prepared to work through the estrogen dominance wake-up barrier until her symptoms abate.

By incorporating nutritional supplements in adjunct with liver work, she will go a long way to restoring hormone balance and fine-tuning her cream dosage to suit her individual profile. Julie can become more aware of these subtle hormonal changes through charting and comparison.

Estrogen supplementation might not be wise until Julie has maximised the benefits of progesterone and, if there is a deficiency confirmed by blood tests and saliva assays, then and only then should she consider estrogen supplementation. Clearly the doctor prescribing and supplying cream has very little understanding and, through lack of support, has left Julie no choice but to self-medicate and seek answers elsewhere.

What is the right dose for you?

Ideally, the least amount of progesterone cream needed to resolve your estrogen dominance symptoms is your correct dose. It's up to you to figure out how you're going to achieve your monthly dosage goal.

Just remember, even if you don't match the daily doses exactly, your body will continue to steadily release progesterone into the bloodstream. So breathe easy ... the sky isn't going to fall if you fail to get it right every time.

But it is important to know how much progesterone is contained in your tub or tube of cream. If you don't know, we can't tell you! Application instructions should be included with your container of progesterone. And one would expect these instructions to include details on how much progesterone is delivered per application. Only with this information can you make sense of the recommendations/observations we outline in this publication.

Just remember, you can have too much progesterone in your body! Balance is the key.

Mr Colm Benson, Health Services Manager for Analytical Reference Laboratories ([ARL](#)), Melbourne kindly provided us with a sample of ARL's new [Salivary Hormone Test Report](#) detailing reference and target ranges for the various hormones.

I'm especially pleased to note the inclusion of a P4:E2 ratio in ARL's Salivary Hormone Test Report.

The ideal treatment ratio between progesterone [P4] to estradiol [E2] is at least 200:1. In healthy women without breast cancer, we find that the saliva progesterone level is routinely 200 to 300 times greater than the saliva estradiol level. Conversely, in women with breast cancer, the saliva P4/E2 ratio is considerably less than 200 to 1.

Using ARL's breakdown of estrone [E1], estradiol [E2] and estriol [E3], you can estimate your risk of breast cancer using the [estrogen quotient](#) (EQ). The estrogen quotient is the amount of estriol divided by the sum of the amounts of estrone and estradiol: $EQ = E3 / (E1 + E2)$. If your EQ is low, your risk of breast cancer is higher. Basically, the higher your EQ, the better.

One size does NOT fit all

Over time, the Natural-Progesterone-Advisory-Network.com website began to identify the need to individualise dosage according to each woman's unique hormonal profile to treat her symptoms.

We concluded that a physiological dose of 15-20mg was an unrealistic 'maintenance' dose for many of the women working within our Network. Ten years on, this continues to be the trend.

Very few women tend to on 15-20mg and remain asymptomatic. The only two categories that fall into the 15-20mg maintenance dose are the elderly taking progesterone for osteoporosis and suffer no symptoms of hormone imbalance, and the younger women that appear to have relatively healthy functioning ovaries. These younger women may or may not need to remain on progesterone once they achieve balance.

Our working range has been from 20mg (2%) to a maximum of 100mg (10%), and found no reason to go beyond this range.

Having addressed ALL other factors that may contribute to hormone imbalance, women clearly do best on an average maintenance dose of 32mg per day once they have achieved balance. Are the every-increasing xenoestrogens in our environment coupled with our very overweight population major players here?

Evidence suggests that there's a growing epidemic of hormone imbalance emerging with the post-war baby boomer generation and their off-spring.

We acknowledge there are probably thousands, upon thousands of women who use progesterone very successfully without the need for direction or guidance. However, there IS a need (upon which the Natural-Progesterone-Advisory-Network.com website was founded) to address the group of women out there floundering and in need of support, information, and direction.

It was these "coal-face" experiences graciously provided by women battling major health and hormonal concerns, and their success using progesterone as an alternative hormone replacement therapy that gave birth to '*A Woman's Guide to Using Natural Progesterone*'.

Where on the body do you apply cream?

For optimal results the cream is rubbed onto thin skinned areas where blood vessels are closest to the skin's surface, rotating application around the body. This allows for optimal uptake and gets the progesterone into your blood stream quickly.

The least effective areas will be the fatty areas of the buttocks, stomach (unless thin), outer thighs and generally where there is a store of fat or poor blood circulation. Why is this? It is a fat loving hormone, and being lipophilic it will go into the fat tissue and be stored until the blood vessels collect the hormone, sweeping it along and taking it to the progesterone receptors to deliver the messages.

If a woman has poor circulation, or poor lymphatic drainage, or is overweight where there may be low capillary density, the hormone's effectiveness is slowed down. For this reason, it is important to apply the cream closest to the blood vessels where it can be transported around the body to latch itself onto receptors to work more effectively.

We have had women who have applied to their buttocks and fatty abdomen and have experienced delayed results with progesterone for months on end, simply because this fat-loving hormone sat in fat tissue, or their very sluggish circulation delayed the uptake. Be aware that areas where you tend to 'store' body fat is not an ideal location for cream application. Where you can see blood vessels - perfect!

We advise, therefore, that you rotate your progesterone application around the body, alternating different locations daily. The larger the area of skin the cream is spread on, the greater the absorption. Rotation allows for rejuvenation of the receptor sites, thus obtaining optimal benefits.

There are areas that are particularly good such as the palms of the hands, soles of the feet, inside of the arms (not the armpit), inside of the thighs, neck, chest and breast where tissue has a high capillary density allowing for efficient absorption. Any area that tends to 'flush' indicates blood vessels are close to the surface.

Other very receptive areas that respond to progesterone are directly over the ovaries, behind the knees, on the temples, back of the neck, back pelvic ligaments, joints and inside of wrists. Save a little extra and apply to areas of pain (except during breaks). A little dab under the eyes for gritty, dry eyes will work wonders. You will be amazed how it will help with pain management, particularly joints, knees, headaches, and stress points.

Do not wash the skin for at least an hour after applying.

When to start using cream

We are constantly learning about progesterone dosage and its usage. In summary, here are some simple guidelines we recommend:

- Menopausal - start straight away, cream usage 3 weeks on, 1 week off.
- Cyclic (regular periods, 28 day cycle) - start cream from day 12 to day 26, day 1 being first day of bleed.
- Cyclic (regular periods, 30 day cycle) - start cream from day 14 to day 28, day 1 being first day of bleed.

- Non Cyclic (no regular period is established) - start immediately, follow pattern 2 weeks on cream, 2 weeks off. This will mimic a cyclic pattern whether you are having a period or not. If a cyclic period emerges, adjust your breaks to fall into line when bleeding starts, resuming cream on day 12 - 26.
- Elderly - start immediately, 5 day break each month or, if this is going to prove difficult such as in nursing homes, simply break from cream every weekend where possible.
- Pregnancy - IF you commenced cream prior to becoming pregnant, DO NOT BREAK FROM CREAM. Any drop in progesterone levels may trigger a miscarriage. You can safely continue taking bioidentical progesterone cream throughout your pregnancy without fear of it interfering with your baby's development.

Allergic reaction to cream

Some women report a bad reaction to their cream however if it contains pure micronized progesterone, the body generally will not react adversely to a human-identical molecule but rather to some other ingredient in the formulation. That's why it is very important when you start cream that you test the base, and apply to skin areas that are not sun altered (eg face, neck) or normally sensitive to chemicals.

Also do not put it on areas that are open to wounds or are prone to rashes. Test your progesterone cream on areas that are unaffected. If you continue to develop a rash, stop the cream and question the ingredients.

If you know you have an allergy to nuts, check on the contents that the oil used is not that particular nut oil. If you suspect it does, test the cream on a small area of skin on the inside of your wrist.

Please, do not apply to your throat as an adverse reaction could potentially lead to constriction of the airway if you discover you are allergic to a particular ingredient in the cream base).

Don't give up on progesterone supplementation simply because you are experiencing a 'reaction' to your cream (itching). We recommended you swap brands, perhaps opting for a cream that is free from additional hormones, herbs and alcohols.

What is the difference between capsules and cream?

Approximately 90% of all hormone replacement therapy prescribed in the United States is an oral medication. There are, however, alternative routes available that bypass the stomach and possible related side effects.

Hormones taken orally in pill form enter the bloodstream from the small intestine, and go directly to the liver. Because the liver is not accustomed to receiving large amounts of hormones, it begins to break them down, leaving only a small percentage of the ingested hormone available to cells.

This is called first pass loss (or first-pass metabolism) through the liver.

By comparison, transdermally delivered hormones such as progesterone are up to 80% more bioavailable than equivalent doses administered orally. This has been proven by salivary hormone testing. In other words, oral delivery systems provide only a fraction of biological activity in comparison to the same dosage of steroid hormones administered from a transdermal delivery system (TDS).

In practical terms, an oral dose of 100 mg progesterone might be equivalent to 20 mg progesterone cream delivered transdermally.

Don't confuse oral (swallowing a pill) with lozenges (sometimes called by the French name of troches) dissolved between the teeth and the cheek that, like cream, will bypass the liver.

The effective transdermal application of steroidal hormones like progesterone, testosterone or estrogen is possible because these prerequisites are all met:

- These steroidal hormones are small, fat-soluble molecules that are easily absorbed across the skin where they can be stored in the fat tissues.

- The hormones can reach a saturation level that is sufficiently high so that the fatty tissue diffuses them into the capillaries for uptake by the general blood circulation and transports them to the target tissues.
- During the transdermal delivery process, the skin does not inactivate these steroid hormones, nor does it produce harmful metabolites from them.

From a purely economic viewpoint, you don't need to use as much progesterone when you use the transdermal form. It could be said, oral delivery is less cost effective.

Natural hormones in forms that are absorbed directly into the blood circulation before they get to the liver include hormone creams, lozenges and patches, however creams give more flexibility because they can be tailor-made to suit the individual, and can be compounded to include any variety of natural hormones such as the three different types of natural estrogen (estradiol, estrone and estriol), natural progesterone, testosterone and DHEA.

The hormonal lozenges are placed between the upper gum and the cheek, and left to slowly dissolve into the small blood vessels under the surface of the mucous membrane of the cheek. They must not be chewed, sucked or swallowed, otherwise they will end up in the intestines and pass straight through the liver. The doses used in the lozenges are generally higher than those used in the creams. And, like creams, lozenges can be tailor-made to suit the individual, using any possible combination, and amounts of natural hormones such as estradiol, progesterone, testosterone and DHEA.

Let's pause a moment to consider the liver. A variety of medications can cause organ damage, and anyone who has a history of liver disease should check carefully with their doctor before starting new medications. Steroid-based medications can result in hepatitis-like side effects, as can oral contraceptives, antibiotics, analgesics, and any medication designed to alter liver function.

Many women with a fatty / dysfunctional liver often cannot cope with potent doses of oral hormone replacement therapy as it overloads the workload of the liver. And this can actually aggravate weight problems and obesity. These ladies usually do quite well with natural progesterone transdermal cream.

We know that bioidentical hormones such as progesterone, estrogen and testosterone cannot be patented. However, pharmaceutical companies tip-toe around this barrier by patenting their unique delivery system. Many women are probably already familiar with estradiol patch therapy developed around transdermal delivery. Vivelle-Dot transdermal estradiol patch, for example, use the patented DOT Matrix™ technology. "DOT" stands for "Delivery Optimized Thermodynamics. We also have Ortho Evra, a combination birth control patch containing bioidentical estradiol & artificial progestin, also based on TDS and targeting the Contraception market.

The Trimegestone patch, still in research & development stage, contains a combination of estradiol and potent progestin which, according to the company, "promises a product with a safety margin exceeding currently available products." The 1995 PEPI trials clearly demonstrated that natural progesterone actually works better than synthetic progestin in terms of protecting the heart, and that natural progesterone can protect against uterine cancer as well as synthetic progestin. Yet drug companies continue to convince us otherwise!

Transdermal patches containing bioidentical progesterone cannot be used in the treatment of infertility as the volume of progesterone that needs to be delivered renders this method prohibitive. However, drug companies have developed a patented bioadhesive 4% and 8% vaginal gel containing micronized progesterone in an emulsion system, which is contained in single use, one piece polyethylene vaginal applicators.

There are many premium progesterone creams containing micronized progesterone USP on the market today priced at between US\$20-\$25 which can deliver up to approximately 10% (100mg) progesterone per application and last up to 3 months per jar.

Is it not interesting that the makers of Crinone® state in a Patient Leaflet that there have been no reports of overdosing? That's precisely what we've been singing from the roof tops for years ... bioidentical progesterone supplementation delivered transdermally has a significant safety margin and carries none of the side effects or health risks of synthetic progestins.

We'll leave the final word on this subject to Dr Martha Howard: "oral pharmaceuticals can be harmful to the liver and gall bladder. Oral administration is outmoded. Plant-derived creams fit better in the body's receptors. I prefer transdermal delivery systems - it's safer and more natural."

Different delivery systems

The various delivery systems of human-identical progesterone

Oral (Prometrium):

Research has shown that progesterone is most effectively absorbed and utilised by the human body when applied transdermally as a cream. It is not as effective when taken in capsule form because the liver breaks it down before it can exert an effect in the body.

For example, you would need to ingest 100mg of natural progesterone in capsule form (not available in Australia) to get the equivalent dosage of 10mg topically. The remaining 90% is rendered inactive by the liver and excreted in the bile.

Alternatively, direct transdermal application is taken up immediately by the body and used before being excreted through the liver.

Please note: If you live in Australia and are taking 'oral progesterone', it may be a synthetic progestogen (unless you have ordered it yourself from overseas and have a guarantee of your product).

Creams Used Topically:

Progesterone cream is applied directly onto the skin surface where it is absorbed and taken up by the blood vessels. This also bypasses the liver.

There is NO patch to date that contains natural progesterone, possibly due in part because research has shown that natural progesterone is most effectively absorbed and utilised by the human body when applied as a cream.

Creams Used Vaginally:

Not a standard procedure. We qualify certain guidelines here because the manufacturers of progesterone creams will tell you they have NO indication for usage in this manner.

There are few drug company endorsements of this unique approach to cream application as opposed to gel and suppositories. Most creams will have instructions for EXTERNAL USE ONLY. Dr Lee recommended topical application since evidence suggests it offers a more sustained delivery. However, if you choose to work with natural progesterone cream applied vaginally, this is strictly a personal choice and one you must be prepared to take full responsibility for, always erring on the side of absolute caution.

We are NOT making reference to the product 'Crinone Gel' which is specifically designed for vaginal use.

Let us point out once again, we are not medical professionals and this information came from various sources in our own research. It is for information purposes only and is not a prescription for your particular needs. Consult with your health care professional if in doubt or if you have questions. We do not diagnose or try to overrule the advice of your health care professional. We refer you to our 'Medical Reference' page.

Common guidelines we suggest women adhere to when applying cream vaginally:

- Ensure the cream is of the highest quality. Vaginal tissue is very delicate and sensitive, and can be thin, dry and atrophied, particularly for post-menopausal women. So check with your cream manufacturer or compounding pharmacist that there are no irritants or ingredients that contraindicate this form of usage. Be very gentle using an applicator as it may traumatise vaginal tissue because of the above reasons.

- Always insert with a clean, sterile applicator. Many market products come with reusable applicators such as the anti-fungal creams and estrogen vaginal creams. If you do not have an applicator, massaging cream up into the vagina with finger insertion will also have some good results and be more effective than topical application, but certainly will not have the impact of a deep vaginal deliverance. This is often a good way to start using progesterone (vaginally) to test sensitivity and skin irritation. Do not use before sexual activity. Best results are achieved at night-time because you are relaxed, lying still and the cream has time to be well absorbed.
- Insertion of cream vaginally may cause a slight burning sensation or internal throbbing. Discontinue if discomfort continues beyond a few minutes post application.
- Sensation of vaginal burning seems to correlate with the time of the month, and vaginal secretions and mucosal health, particularly pronounced in the latter stage of your cycle.
- Because of its effective route of absorption, vaginal application should be very gradual (small dosage to start with, and alternate your days). Suggested starting dosage should be no more than 10-15mg of progesterone vaginally and assess your body's reaction. If you're getting a favourable response, we suggest you apply cream once or twice a week, building up to alternate days and, if need be, progress to daily doses. We also note that women prefer to alternate between vaginal and transdermal delivery for optimal site receptivity.
- Some of the reported feedback from women using this delivery of progesterone include severe estrogen dominance wake up, even after being stabilised using topical delivery but not having optimal effects. Our observation is that we feel it delivers higher levels of progesterone and turns on more receptors thus stimulating estrogen dominance wake up.
- Note: This form of usage may result in a change of vaginal lubrication and discharge (usually within 24 hrs). You may notice vaginal secretions to be somewhat similar to that of ovulation - thick, sticky, odourless discharge, clear to slightly yellow in appearance. This discharge IS NOT always present after cream application. And make sure you DO NOT mistake this discharge for ovulation.
- When women reach a plateau and cream becomes ineffective, vaginal application has worked very well where topical delivery has rendered the progesterone therapy ineffective. These women have followed all the rules, taken their appropriate breaks from cream, but progesterone stopped delivering results. Because of the conditions they are trying to treat / control with progesterone, they require higher levels of progesterone dosage and maintenance. It is more economical to use less cream and derive the same dosage as that of a topical application.
- This unique approach to progesterone application seems to have a greater impact on the specific conditions such as endometriosis, fibroids, cervical hyperplasia, thickening of the uterus, and polycystic ovarian syndrome. This is because it appears to target tissue in these areas, as well as being systemically available via the blood. We know for a fact that when a woman suffering fibrocystic breasts rubs progesterone cream on her breast tissue, the body responds favourably and very quickly to this direct application approach. So we apply the same principle for vaginal application when attempting to address conditions relating to organs within the pelvic cavity.
- Other benefits reported by women using cream this way is halting migraines, improving bladder function such a stress incontinence, thrush, normalising vaginal pH levels, secretions and vaginal dryness. Some women still need to use progesterone in conjunction with estriol cream but they may find they need less over time to maintain healthy tissue.
- Vaginal application can bring on endometrial activity resulting in a period within 24 hrs; unusual discharge and colour (not offensive in smell), shedding of fibrous matter as reported by women with fibroids, headaches can result, tender breasts, severe PMS. If this is the case, stop. Resort back to phytoestrogens and topical application until it settles and then try again on a lesser dose.
- Please do not attempt this approach without full knowledge of your condition, particularly if it's of a bleeding nature. Or, if you have not undergone a recent medical checkup that included an internal examination or ultrasound.
- Indications when NOT to use cream vaginally: recent surgery, signs of infection, active thrush, cystitis, you suspect you are pregnant, history of STDs, or any condition that is being treated by a doctor.

In summary, advantages / disadvantages include:

- doubles the absorbability rate
- heightens progesterone cell receptivity
- may induce spiking of progesterone levels in the body that are not as sustained as transdermal delivery
- more cost effective because you use less
- ability to raise progesterone levels quickly, particularly in times of stress or an impending migraine, or where reserves are not there
- an alternative when topical absorption appears to be poor or women appear to not assimilate their cream effectively

Please note, this overview of vaginal usage of progesterone cream has uniquely evolved out of women's experimentation and providing feedback to the Natural-Progesterone-Advisory-Network.com website using one specific manufactured cream. Prior to pursuing this form of progesterone therapy we did contact the manufacturer asking if there was any ingredient that might be harmful if applied vaginally. His response was, "No, but it was not designed to be used that way". Being the women that we are, and having come across articles supporting vaginal delivery, we endeavoured to experiment with our bodies once again. Results to date have been very encouraging.

Please refer to our 'Medical References' section on Vaginal Progesterone Absorption. All these articles give evidence that vaginally administered progesterone is well absorbed, possibly better than transdermal. It also gives evidence that for those women who feel they must use an estrogen supplement, vaginal progesterone, in adequate doses will protect their endometrium from the estrogenic effects.

Lozenges / Troches:

Dissolved buccaly (between the teeth and the cheek), these are similar to the topical route in that it bypasses the liver, making it immediately available to the body. It will give you higher doses more quickly but might increase the side effects (break-through bleeding).

Troches administer a larger dose of progesterone relative to the cream because when the troche dissolves much of the saliva in which the contents of the troche are dispersed is swallowed. Progesterone taken orally is essentially inactivated by the liver before it can achieve any beneficial effects.

Pessaries / Vaginal Suppositories / Vaginal Gel:

The amount absorbed is double that of transdermal delivery. This also bypasses the liver, and results are rapid. Australian pessaries, used predominantly in higher dosage for fertility purposes, are wax-coated and may compromise the delivery as opposed to cream or gel. To date, Crinone gel is not accessible to our Network so we cannot comment on its usage and performance, but we are looking forward to the opportunity.

Anal Suppositories:

Another form of deliverance, one that very few women adopt.

Can cream 'go off'?

Yes, it can. Ingredients in any product can go off, and you wouldn't know until perhaps a month or two when your reserves drop and you begin noticing the effects of progesterone deficiency with perhaps the return of estrogen dominance symptoms. Oxygenation, for example, will break down the progesterone, as will extreme temperatures.

Progesterone creams dispensed in tubes do not, by design, expose the entire batch to oxygen, sunlight or bacteria, where jars of cream can be easily contaminated when you dip your fingers, and the entire

content is exposed to oxygen each time you unscrew the lid. This is not to imply jars are inferior to tubes of cream. It's a matter of ensuring your applicator is free of bacteria, you tightly replace the lid, you leave your progesterone cream in a dark, temperature-controlled environment, and during extreme temperatures you store your cream in the fridge.

A pure progesterone cream formulated well does not have an odour. Therefore, if your cream has a rancid smell, then you can be pretty sure it's off or formulated with the wrong base. Cream separating or feeling gritty may be another sign.

Suggested hints: It's sometimes advisable to split your cream into two jars and work on half a jar at a time. Store the other half to prolong its shelf life, limiting exposure to oxygen.

Check expiry date. Cream can last unopened for up to twelve months if stored correctly. This can be confirmed by your cream manufacturer.

Can progesterone cream cause insomnia?

One of the first benefits women report after commencing progesterone supplementation is an improved sleep pattern.

However, there are women who report bouts of wakefulness at night-time after applying progesterone cream. This isn't uncommon.

Clearly, for these women, applying cream first thing in the morning after showering will help them avoid bouts of insomnia at bedtime.

Very thin women who do not have a huge amount of body fat with which to build up a 'store' of progesterone may need to split their dose during the day to ensure adequate coverage.

Interestingly, one of the indicators that you might have applied too much progesterone is a sense of drowsiness during the day.

How to use progesterone to control headaches/migraines

Your approach to cyclic headaches and migraines is to tackle estrogen dominance head-on.

And the best way to avoid monthly migraines is to recognise when they start (in your cycle) and begin applying cream a couple of days prior. In this manner, you are treating the hormonal imbalance that trigger cyclic headache. Then, as your monthly cycle progresses, you can increase your dose accordingly.

Work in the vicinity of 20mg up to 100mg per day if you have to.

However, we've found that if women do hourly doses - dabbed onto their temples and behind the neck when they feel most susceptible and stressed - the higher levels may not be necessary, because you have managed to control and assess your symptoms on a 1-2 hourly regime.

It's amazing how, when you become calmer, the curtailing of stress may be all that's required to reduce the triggers of the onset of a migraine. Also bump up your intake of magnesium supplements which is a muscle relaxant, invaluable in the treatment of muscle spasms, cramps, nervous tension, and pain management.

Progesterone exerts a vasodilator (relaxing) effect on the blood vessels further assisting anti-spasmodic action that can set off headaches.

Drinking heaps of pure water also prevents toxic build up, flushes out body wastes and toxins, and maintains fluid balance preventing dehydration.

If you cannot recognise the onset of a headache/migraine or it strikes unannounced, try adopting an intra-vaginal dosage starting at 20mg (which would effectively double your dose to that equivalent of 40mg topically). Wait a couple of hours and reapply if symptoms are not abating (with caution dosage of another 10mg). Repeat until headache subsides. This can markedly reduce the impact of your headache, occasionally thwarting the onset of a migraine. Be aware that the vaginal route has a high impact (equal

to double the topical equivalent) on your body through direct absorption, so go easy on how much you apply.

We suggest women experiment with this unique approach before actually relying on it to treat the onset of a migraine. Note here, a full-on migraine is really beyond management with progesterone cream. You may need to resort to medical treatment or see your doctor. Progesterone will not help prevent nausea and vomiting if your migraine has progressed.

Intra-vaginal application method

Important: Make sure your cream is indicated for vaginal use.

Suggested guideline for introduction to vaginal dosage is 10mg (1%) once a week, to allow you body time to adjust to this method, and for you to assess your sensitivity and response to intra-vaginal progesterone application.

The first few applications can bring on estrogen dominance wakeup, and this is the last thing you need when you are battling a headache. In fact, it could possibly make the headache worse. So introduce very gradually and with caution. Women who have mastered this method find it a reliable emergency deliverance system with excellent outcome.

Drugs to avoid when supplementing progesterone

- The Contraceptive Pill
 - The Mini Pill
 - Levonorgestrol (Microlut / Microval)
 - Norethisterone (Micronor / Noriday)
 - The Morning After Pill
- Prednisolone / Prednisone
- Cortisone Acetate
- Combination HRT Patches combining estrogen and progestogens
- Depo-Provera
- Dydrogesterone (Duphaston)
- Medroxyprogesterone (Provera / Ralovera)
- Norethisterone (Primolut N)
- Cortisone based analgesics, injections
- Other unknown drugs

Synthetic progestins compete with human-identical progesterone for the same progesterone receptor site, negating progesterone benefits. This also includes estrogen/progestogen combinations. Estrogen patches on their own can be used with natural progesterone. Refer to our section on Estrogen.

Some of the women using Natural Progesterone cream have resorted to using the 'The Morning After Pill'. It has been observed that women experience a huge step backwards as a result of the high levels of artificial progestins introduced into the body, short term. The effects have varied with each woman.

We cannot say how long it takes for the artificial progestins to move off progesterone receptor sites to allow bioidentical progesterone access once again.

Women have asked us if they should stop progesterone when using 'The Morning After Pill', and we suggest they continue on with progesterone supplementation as usual, otherwise it could cause a greater disruption to their cycles.

Contra-indications

Progesterone should not be used by women with any of the following conditions:

- Severe active liver disease, i.e., cholestatic jaundice, hepatitis, Rotor syndrome or Dubin-Johnson syndrome
- Any unexplained or abnormal vaginal bleeding
- History of herpes gestationis, jaundice of pregnancy
- Known sensitivity to progesterone creams or any of their individual components

Caution / consideration

Some medications may interfere with the progesterone effect. Today, we don't have sufficient information to determine the level of interaction with these medications. Women frequently ask us if their medication can be taken in conjunction with progesterone. This is why it is imperative you refer back to your GP.

It's important that readers understand we are not medical professionals and this information came from various sources in our own observation. It is for information purposes only and is not a prescription for your particular needs. Consult with your health care professional if in doubt or if you have questions. We do not diagnose or try to overrule the advice of your health care professional.

Using progesterone in conjunction with other medical treatments

Will progesterone interfere with my blood pressure medication?

Progesterone can be used with your antihypertensive drugs but must be done with strict supervision of your doctor and regular check ups and regular blood pressure testing. Again, progesterone helps to eliminate the fluid retention aspect of the body because it is actually negating the estrogenic effects of sodium retention. Too much estrogen will cause fluid to be retained in the body. With the adjunct of progesterone, it reduces the amount of estrogen and the effects of retention, thereby often reducing the blood pressure in the body (progesterone also exerts an anti-spasmodic influence of blood vessels).

We emphasize that blood pressure changes may be due to physiological effects or other reasons and not to self medicate because they have a high blood pressure. Reports have indicated that the reduction of antihypertensive drugs have been necessary over a period of time under the doctor's supervision purely because their blood pressure has been restored to normal.

Addition to hypertension: There is a potential interaction with progesterone and the group of medications known as beta blockers. This interaction may cause an increase in the resistance to blood flow in the hands and feet. The result may be an increase in the side effects of the beta blocker, especially the cold hands and feet. We stress that there have NOT been reports of this effect as yet, but the potential is there. You are referred to Mercurio article in our 'References' page.

Can you take progesterone while on anti-depressant drugs?

Yes you can. We again emphasize that anyone on any form of medication and using progesterone should be under the supervision and the monitoring of their doctor. Many women have found after seven months on progesterone they feel the inclination to start weaning off their antidepressants over a period of a few months, under the supervision of their doctor, and have had excellent results in maintaining a state of anti-depression.

They also have found that once coming off their anti-depressant drugs, often their libido and sex drive have also improved because a lot of the antidepressants have also suppressed a lot of their libido and/or an ability to be sexually aroused. Not all anti-depressants have done this, but overall a lot have had this common denominator.

Some anti-depressants may impair the functioning of the limbic brain including the hypothalamus which may affect the menstrual cycle. One particular lady who'd been on progesterone for several months, having achieved wonderful results, began to experience anxiety of unknown origin. Her doctor put her on low doses of an anti-depressant drug which completely destroyed her libido and was unable to experience sexual stimulation and orgasm.

One and a half weeks into the medication, she experienced migraines for 3 days, constant nausea, her breasts became swollen, night sweats, break through bleeding, and she started neglecting herself. This lady has a history of severe liver damage from substance abuse. Hormone balance had been achieved through the use of natural progesterone, complimentary nutritional supplementation and diet. Clearly, her body could not cope with any form of medication that would put workload back on her liver, throwing out her finely tuned hormone balance. Within a week of stopping medication, her progesterone kicked back in and hormone balance was restored.

Can you take progesterone while on thyroid medication?

If you have been diagnosed with a thyroid problem, and you are on thyroid medication, and now want to incorporate natural progesterone into your regime, there's no reason why you can't providing you do so under the strict supervision of your treating physician.

Progesterone may cause a potentiation of thyroxine's effects leading to hyperthyroidism. Normal T3 and T4 levels with elevated TSH suggests impaired thyroid hormone activity rather than insufficiency. Periodical TSH testing should be adopted on initiation or progesterone treatment in these patients.

Please do not stop your thyroid medication because you have read that progesterone helps thyroid function. Your thyroid dosage, however, may require regular adjustment as progesterone exerts an influence upon the thyroid gland. Correcting estrogen dominance may not correct your thyroid function.

The thyroid gland function can be improved with trace minerals such as selenium, iodine, zinc and manganese.

If you are unsure whether your thyroid is functioning optimally that can be characterised by an inability to lose weight, puffy and swollen body appearance, lethargy, muscle weakness, dry skin, hair loss and constipation, we suggest BEFORE resorting to progesterone to fix these problems you might be well advised to ask your doctor to order the appropriate tests. This includes blood profile to measure the levels of both thyroid hormones T4 and T3, and also TSH (Thyroid Stimulating Hormone). A shortage of T4 would be administered in the form of thyroxine tablets. In the USA, thyroid replacement therapy is available in cream form by way of natural thyroid hormone replacement using bio-identical hormones.

Can you take bone building drugs such as Fosamax and Raloxifene with progesterone?

Yes, you can, however if you are using progesterone for bone building it will be severely compromised, if not rendered ineffective for this purpose. We suggest you consider why you are taking the bone building drugs in the first place and decide for yourself whether it is bone delay that you are seeking or bone building. Because the bone building drugs are not forming new bone, they are actually stopping and delaying the resorption of old bone. Blocking off the action of absorbing old, brittle bone, prevents progesterone moving in to build new bone in place of the old. On X-ray, bone building drugs look fantastic as the bone appears dense, but in actual fact may be quite weak and brittle because the X-ray is depicting 'old' bone that should have been removed and replaced with new. Slowing bone resorption doesn't necessarily make your bones stronger.

As explained above, there are two different actions involved - taking away old bone, rebuild new bone. We cannot make the decision for you but we strongly urge you to seek out options, information, and do drug research. Ask your doctor for full disclosure of side effects, benefits, and the test trials, then look at these seriously because at the end of the day, it is your health, your decision, and your body. You might like to read our section on 'Osteoporosis'.

Raloxifene blocks estrogen receptors. It is a selective estrogen receptor drug which has estrogenic effects on bones, and is known to cause hot flushes and blood clots. We don't know what other effects it has on progesterone or visa versa.

Can you take Tamoxifen and progesterone at the same time?

Tamoxifen is prescribed to women for the treatment of breast cancer.

Tamoxifen is sufficiently estrogenic to cause endometrial hyperplasia. As such, progesterone will block this effect. Women report some terrible side effects while taking Tamoxifen such as hot flushes, and get great results once they go on progesterone therapy, which takes about 4 months to take full effect.

Don't forget to make sure your doctor orders regular pelvic ultrasounds to check endometrial thickening. And make sure your doctor knows you are taking progesterone.

Can you take progesterone during chemotherapy treatment?

We don't know medically if there is a reason why you can't, except that the endocrinologists may be very adamant about no other form of treatment. Some even frown on taking vitamins. Yet some women have reported initiating progesterone replacement therapy because they've asked their doctor if they can take natural things throughout their treatment and the doctor has indicated that it's fine. Nonetheless, we remind our women that this is a hormone and not a vitamin.

Throughout surgery, many women have continued to take their progesterone prior to, and directly after surgery as it appears to assist their body with the stresses and the corticosteroid pathway. The body may be in shock and traumatised, so progesterone being the mother hormone, can actually help build other vital steroid hormones.

We know for a fact when the body is stressed, whether it be mental, emotional or chemical, it will actually take more progesterone in the form of cortisol. Often women will suffer the next month as a result with period problems or heavier bleeding, or headaches and signs of estrogen dominance. This is purely because progesterone levels that would normally sustain the body are just not enough under stress.

Surgery is therefore one of those qualifying periods where we say to women, if you can't take progesterone during surgery, certainly increase your dose prior to, and resume progesterone application directly afterwards where possible, particularly if used cyclic.

You need to try and follow those cycles as closely as you can, otherwise you may be throwing the rhythm of the body out.

Treating hormonal imbalance with nutrition and diet plan

We have always tried to present progesterone in a balance way and acknowledge that progesterone is not a silver bullet. It is not the answer to every health issue and problem (of metabolic imbalance) a woman might encounter.

Some women mistakenly think that using progesterone will resolve all their health issues.

We have always emphasized that progesterone in itself will not work effectively or to its maximum benefits without the support of some nutrition fundamentals and a good eating plan in place. However, if a woman is truly progesterone deficient she may still derive benefits from progesterone alone, given the numerous roles it plays throughout the body.

If a woman is estrogen dominant by virtue of the fact she is overweight and/or exposed to xenoestrogen in her environment progesterone will have some benefit, but she will not realise sustained improvement - largely because progesterone cannot negate obesity or constant exposure to foreign estrogens without attention to these existing problems.

If a woman is reluctant to use hormone supplementation and instead tackles hormone imbalance with phytoestrogens, a good diet and health plan, exercise regimes, a liver support & detox program, etc., she may possibly achieve hormonal harmony without progesterone. We often suggest that women who are considered low risk and possibly do not require hormone replacement therapy try this strategy first before introducing hormones into their body because there's a likelihood their hormonal function is perhaps toned down. Their adrenals might be exhausted, and with the right nutrition and eating plan the body can crank up itself and hormone balance be restored, along with improved overall metabolism.

We have, however, observed a common thread throughout all these different types of scenarios: That progesterone works brilliantly with a good eating plan and nutritional program, outweighing progesterone usage on its own. Conversely, it is not uncommon to speak with women who have incorporated nutrition, diet, stress relief, exercise and so forth searching for that elusive feeling of wellbeing, only to discover that, for these women, the missing link is actually progesterone. Is this perhaps because it's our 'essence' hormone?

For those of you who have been very frightened, put off, or in the past disgruntle about using nutritional products purely because you felt it was a marketing con, or it had not proved beneficial, or perhaps you hadn't seen the results, please don't give up or abandon the idea completely. Chances are you didn't have the missing piece to the jigsaw.

Yes, progesterone can work without nutritional support. However, if you want the best mileage out of your progesterone cream, incorporate nutritional supplements, exercise and a balanced diet. Just keep in mind that for some women a good diet, lifestyle modifications and nutritional supplement ARE enough to rebalance their body and keep them symptom free. Natural hormone replacement therapy may not be for everyone.

What's the different between a Wild Yam cream and progesterone?

To make a Wild Yam Extract cream, plant sterols (oils & fats) are extracted from the Mexican Wild Yam and Soy plants.

We know that Wild Yam creams have a 'estrogenic' effect on the body, but there is no scientific proof that when cream is applied to the skin (or ingested in tablet or powder form) the active ingredient (diosgenin) derived from Wild Yam creams can be converted by the body into progesterone.

Why is this so? Because the active ingredient - diosgenin - is not bioidentical to the progesterone molecule found in the body, hence Wild Yam Extract creams cannot do the work of progesterone.

Wild Yam Extract creams can exert *estrogenic* benefits on the body but it is not the same estrogen that our body makes. The active ingredient can latch onto estrogen receptor sites, hence the estrogen benefits, but cannot latch onto progesterone sites.

When women understand the differences between these two molecules, and that there are two individual hormones - estrogen and progesterone - performing separate roles in the body, they then appreciate that one active ingredient cannot be touted as performing two different hormonal roles.

The argument goes that using Wild Yam Extract creams are more 'natural' because the molecule is unaltered and, therefore, safer to use as a precursor to progesterone therapy (which we've just explained above is incorrect). However, let's point out here that a chemical process is still required to extract these saponins from the Wild Yam and Soy plants. Chemicals ARE involved in the extraction process of Wild Yam Extract. By definition, an EXTRACT means that a chemical process is involved.

We clarify this point now because many women have been encouraged to stop using natural progesterone by their natural therapists stating the natural progesterone creams have involved chemical processes that could be harmful. But they omit to mention that a chemical extraction process is involved even with the 'purist' of natural Wild Yam Extract creams. Discern for yourself, and check the motivation behind these statements.

The very fact that progesterone is derived from Mexican Wild Yam is coincidental. Since the 1940's scientists have been using soya beans, wild yams and other plants from the tuber family to make progesterone. To make natural progesterone, Wild Yam Extract must be taken into the laboratory and synthesised with the aid of an enzyme, rendering it a hormone. This laboratory conversion is necessary because, as we stated above, the body has no means by which to convert the raw plant sterols into progesterone.

You can, at this stage, safely introduce synthesised progesterone into the body because your body sees this 'real' progesterone as having the same molecular configuration. No further conversion is necessary by the body. It's a perfect match. The key fits the lock. Because it's such a perfect match, the body recognises it as natural, and you don't experience any nasty side-effects that occur with some synthetic

hormones. Further still, because it IS real progesterone, the body can use it to make other steroid hormones.

Women get very confused, largely because Dr John Lee's work on progesterone has been promoted alongside Wild Yam creams. If you do see Wild Yam creams being marketed as a precursor of progesterone, steer clear (if you are after an authentic progesterone cream) because it does not contain human-identical progesterone. It's just another way of confusing women into buying a product they didn't ask for in the first place.

Many a marketing sales pitch will tell you that diosgenin is a precursor to progesterone and the body is capable of converting. You'll remember in a previous chapter we outlined how diosgenin, derived from Wild Yam and/or Soy, is synthesised in the laboratory with the aid of an enzyme to render it a molecule your body can interrupt. How then can the body convert this raw substance into a human hormone once it enters the body? The fact is it cannot. There is no enzyme in the body to do this.

One popular brand of Wild Yam Extract cream making these claims here in Australia was put to the test by a reputed research institute and found that there was no evidence that the body could convert diosgenin into natural progesterone.

Yet a significant number of herbalists or naturopaths believe in the body's ability to do the conversion, resulting in a flood of questions from women claiming that their homoeopathic and herbalist remedies will increase or supplement the body's progesterone levels 'naturally'. Again, a play on words. Yes, Wild Yam Extract is a building block in the manufacture of progesterone, but NOT in the body - in the laboratory. Wild Yam constituents cannot be converted into progesterone by the human body. It does not happen.

This confusion arises out of the fact that all our steroid hormones are made in our body from cholesterol. And the oils and fats extracted from the Wild Yam and Soy plants are very similar to our body's cholesterol molecule. That's where the similarity ends and the arguments stop. Based on this hypothesis, Wild Yam extract creams would be a precursor to ALL steroid hormones, not just progesterone.

Clearly, it's more complex than that. However, if you introduce natural progesterone into the body, your body WILL 'naturally' manufacture other steroid hormones as required.

Feel free to use a wild yam cream if you wish. Be aware, however, you are NOT going to get any progesterone benefits. It's more likely Wild Yam extract cream will have a *estrogenic* effect on your body - of some benefit, certainly, but not in the same league as natural progesterone.

Confusion reigns

You know, just about every woman looking to source a premium progesterone cream has, at one time or another, been falsely sold on the notion that wild yam extract creams and progesterone creams are one and the same. The fact is, they are not. Each represents the same compound - diosgenin - at two very different stages of conversion.

And this confusion is not limited to lay women. Members of the medical fraternity, when arguing vehemently against the efficacy of natural progesterone, constantly make reference to homeopathic wild yam extract creams containing only diosgenin.

Here's a little overview which I hope will help you get your head around what can be a rather perplexing subject matter.

There exists at least two mainstream references to the word 'natural':

- natural in that a substance is found in the body, and
- natural in that it is found in nature.

Progesterone creams are referred to as 'Natural Progesterone' because the hormone is found in the body. And the body sees as 'natural' that which has the same molecular configuration.

The progesterone that goes into a tube or jar of cream has undergone a process in a laboratory whereby it is converted from one substance - diosgenin - into United States Pharmacopeia (USP) grade progesterone.

It is referred to as 'natural' because the end result represents the same human-identical molecule chemically identical to progesterone made by our ovaries. It can, therefore, be introduced into the body with a relative margin of safety as progesterone replacement therapy with minimal side effects because the body recognises it.

Of equal importance is the fact bio-identical progesterone, once introduced into the body, can also be utilised by the body as a precursor to manufacture other steroid hormones. This is NOT the case with synthetic hormone replacement therapy (HRT).

Since the 1940's scientists have been using wild yams, soya beans and other plants from the tuber family to extract plant sterols (oils & fats) that make USP progesterone in the laboratory.

We know that wild yam creams containing diosgenin appear to have a 'estrogenic' effect on the body, but there is no scientific proof that these creams when applied to the skin (or ingested in tablet or powder form) can be converted by the body into the hormone progesterone.

Why is this so? Well, because the active ingredient [diosgenin] is not human-identical to the progesterone molecule found in the body, hence these wild yam extract creams cannot do the work of progesterone.

As stated above, human-identical, natural-to-the-body progesterone is manufactured from diosgenin in a laboratory with the aid of an enzyme.

USP grade progesterone is used by major pharmaceutical companies as the base from which they synthesise their estrogen, testosterone, cortisone, and synthetic progestin products.

In Australia, progesterone is classified an S4 drug, available only on prescription. In other words, we need our doctor's cooperation to get a prescription to purchase cream from a compounding pharmacist or pharmaceutical company. But here's the rub! The Australian RX Drug Guide written by Dr. Jonathon Upfal does not even have a listing for micronized progesterone - only artificial progestin analogues. The irony here is, even though presently classified as a "drug", the large majority of doctors are unlikely (or are unwilling) to prescribe human-identical progesterone because they know little or nothing of its application.

Interestingly, you'll find a majority of these wild yam extract creams in countries where, by law, progesterone is available only on prescription. Where manufacturers are unable to get access to USP grade progesterone (S4 drug), they cunningly push onto unsuspecting women the notion that the active ingredient in their wild yam cream - diosgenin - will converted into progesterone in the body. Such claims fly in the face of the facts - that this is physically impossible because there is no enzyme in the body to take up diosgenin.

These wild yam extract creams that contain absolutely no USP grade progesterone are sold through health food outlets and by some naturopaths as complying with the late Dr John Lee's protocol and research on progesterone. This simply isn't true.

One popular brand of wild yam extract cream manufacturer making these claims here in Australia some years back was put to the test by a reputed research institute. They concluded that there was no evidence that the body could convert diosgenin into progesterone.

Some women have been encouraged by their natural therapists to stop using natural progesterone on the basis that natural progesterone creams have involved chemical processes that could be harmful. But they omit to mention that a chemical extraction process is involved even with the 'purist' of natural wild yam extract creams containing diosgenin. They argue that wild yam extract creams are more 'natural' because the molecule is unaltered and, therefore, safer to use as the body's precursor to progesterone. This argument doesn't logically make sense given that, by definition, an 'extract' means that a chemical extraction process is required to remove these saponins from the wild yam and soy plants.

Is wild yam something to be avoided? Not necessarily. I believe the fundamental point here is that IT IS NOT the fact that cream contains wild yam extract; it is what the manufacturer is claiming the extract will do.

So don't be surprised to discover that some premium progesterone creams INCLUDE wild yam. At the end of the day, you need to make up your own mind as to which cream what works best for you, ideally in consultation with your cream manufacturer

The bottom line today is simply this: If you cannot see the words 'Progesterone USP' or 'Progesterone BP' on your cream's list of ingredients, it may not contain any progesterone.

And progesterone creams that contain less than 800 milligrams per 2 oz jar will not be effective if you are truly progesterone deficient.

Why is wild yam extract included as an ingredient in some progesterone creams promoted by Dr John Lee?

While Dr. Lee is clear in both his desire to differentiate progesterone and wild yam and his statement that he does not know the specific effects of wild yam on the body, there is some confusion about the benefits that are known. Unfortunately, many women assume that the inclusion of wild yam, for any reason, is something to be avoided.

Master herbalists tell us that wild yam is known as an adaptogen herb. It would be like using fertilizer on a garden. If the plants need it they use it.

Wild yam has been used in female-related herbal formulations for years. A recent search of several herbal books on women's health revealed wild yam used in many formulas for pregnancy, nursing, menopause, and other female-specific issues.

The point here is that it is not the fact that a progesterone cream contains wild yam extract; it is what the manufacturer is claiming the extract will do.

We do not believe the manufacturers of these natural progesterone creams claim that the wild yam extract in their cream will **TURN INTO ANY HORMONE IN YOUR BODY.**

As stated above, there is no scientific evidence to the contrary. We believe it's included in creams because there is evidence of a synergistic benefit by the yam extract being in the cream.

Self-care and self-medication

Self-medication is the use of any drug, whether conscious or otherwise, to make oneself feel better; this would include alcohol, nicotine and caffeine.

The use of medicines available without prescription is nowadays generally accepted as an important part of healthcare. It is in line with the growing desire of everybody to take more responsibility for their own health. When practised correctly, self-medication can also save expenses for the national healthcare systems.

Women are taking more responsibility for their own health.

Women are becoming increasingly interested in playing a more active role in managing their own health. Indeed, consumer research has demonstrated that people consider health as their most precious possession requiring constant effort and attention.

Information about the wide variety of health problems that can be treated without the intervention of a medical doctor is forever more widely available. At the same time, women are - thanks to the Internet and other media - better informed about the increasing range of treatments which their national health authorities are making available for these problems.

Given that women are more knowledgeable than before on health matters and want to take more responsibility for their own health, the logical course of action is to shift the responsibility for a woman's health from the health-care system to the patient/consumer.

Self-care and self-medication will continue to play a key role in this process as statistics show that women are indeed capable and willing to treat certain health problems themselves.

Governments, industry and health professionals such as doctors and pharmacists have to ensure that they move in line with consumer expectations. This requires a high degree of cooperation between them. In the USA, perceived breakdowns in the trust of employers, government and health institutions have increased American's desire to take health care into their own hands, according to a recent study by the

Consumer Healthcare Products Association (CHPA), which represents OTC drug and dietary supplement makers, and Roper Starch Worldwide.

Women are demanding greater independence and responsibility in their healthcare. They are more assertive, more questioning and more concerned about their options. They want to exercise greater judgement in informed and responsible self-medication.

Overdosing - does it pose a health risk?

Feedback provided to this Network suggests overdosing can occur when women apply cream a little too liberally without monitoring progesterone uptake, and fail to reduce their dose to the least amount of progesterone they can manage while achieving sustained symptom relief.

When a woman's progesterone levels exceed the corresponding reference range captured on their saliva assay, they simply need to go off cream until readings suggest they are in need of supplementation (estrogen dominance).

Rudel and Kincl (International Encyclopaedia of Pharmacology and Therapeutics: The toxicity of progesterone, 405-409), in their review of the international literature, noted that "Nowhere ... is the oral toxicity of progesterone reported." They therefore undertook a study with rats, administering various doses of progesterone both orally (via gavage) and by subcutaneous injection for 26 weeks. Their only finding was an increase in the body and liver weight of female rats receiving parenteral progesterone.

Dr Jane Murray writes, "Not infrequently, women complain of drowsiness, headache, dizziness, or nausea just after ingesting an oral dose of micronized progesterone or transmucosal lozenges. Intravenous administration induces sleep at doses of 250 to 500mg. Synthetic progestins, on the other hand, often cause androgenic side effects (acne, body and facial hair), depression, and weight gain."

Progesterone creams contain the hormone identical to that produced by the human ovary. And because you're not going against Mother Nature, women report minimal, apparently benign side-effects. If experienced these may include breast tenderness and swelling, fluid retention or slight vaginal bleeding. Dizziness, nausea, fatigue, headaches and light headedness have been reported occasionally and usually disappear with adjustment of dose.

Empirical evidence suggests the self-medication of micronized progesterone creams only poses a concern when women:

- are not made aware of how much progesterone is contained in their jar (or tube) of cream
- use cream that is supplied without the manufacturer's application instructions
- require a more individualised approach to hormone balancing
- have a medical condition that is contraindicative of progesterone use
- are using prescription medication and opt not to inform their doctor that progesterone supplementation is now part of the equation
- are unable to determine cream quality, safety and efficacy.

To be perfectly candid here, the Natural-Progesterone-Advisory-Network.com website seems to be the place women flock when trying to make sense of natural progesterone's action in the body, suggesting women aren't always capable or want the responsibility of balancing their hormones without help and guidance of a healthcare professional, which is where we recommend they turn if in the slightest doubt they DO NOT have a handle on progesterone supplementation.

A 'one size fits all' approach to natural progesterone is just not always realistic. One needs to individualise dosage and application methods according to her medical and family history, lifestyle considerations, diet, metabolism, etc. This fact is sometimes over-shadowed by cream availability and apparent simplicity of cream application.

Women ought to be given the choice on this one. Many women use progesterone cream effectively and responsibly, and although the jury is still out, the growing body of evidence suggests we run a very small risk of actually endangering ourselves self-medicating with progesterone. We stay healthy. We visit our GP once or twice a year for the odd check-up. Basically we go to great lengths to make sure we are NOT a burden to our country's often time floundering healthcare system.

For those women who struggle to come to terms with the whole concept of hormone balancing using bio-identical hormones, they need their GP on side.

When asked, "Can a woman ever have too much progesterone?" [Dr Katarina Dalton](#) responded, "No, I don't think she can. A normal menstruating woman can't have too much because she can't get up to that "normal" level that she has in pregnancy. There's no harm in overdosing. You can't reach it. Very definitely overdose."

Research has shown natural progesterone is safer than all over-the-counter pain medications currently available, and there has never been a single case of anyone being admitted to hospital due to a poisoning from this product.

Doctors have no idea about NHRT, and those that do are hard to find

It is common knowledge that pharmaceutical companies aggressively market HRT to doctors, often overexpounding its virtues by stretching the truth a little here and there, which effectively distorts the facts. In our opinion, 'playing down' the known risks to women's health should be viewed as criminal negligence, yet our health authorities do nothing to stop this nonsense, and won't give us access to safe hormones!

Who is calling all the shots, when drug companies are allowed to continue peddling their neatly packaged (potential killer) products to your busy doctor, but you are not permitted to purchase a cream, which will keep you well?

It's quite obvious some doctors really struggle to come to grips with what exactly bio-identical HRT is, and why hormone profiles using salivary assays gives more accurate results than blood tests.

A flow on from this is that women often cop a 'dressing down' when they approach their GP for a prescription for progesterone and baseline hormone profile.

Some of us may actually manage to convince our GP to write a script, and go so far as to order a saliva hormone profile kit, but then our doctor leaves the interpretation of symptom relief, saliva assays reports, dosage adjustment, etc., up to us - the patient!

If a woman happens to overdose on progesterone cream, detoxing is subsequently required to bring levels back within normal limits. This is achieved with follow-up salivary hormone profiles, and a thorough investigation to learn why her body might not be metabolising progesterone (thyroid and/or liver function, diet, etc). The fix may be a simple adjustment of dosage.

Technically we're not self-medicating. We've elicited the cooperation of our GP required to legally obtain progesterone thereby meeting the guidelines set down by the TGA. But why aren't these same doctors monitoring our progress? Are they capable of monitoring our progress? Most doctors want nothing whatsoever to do with 'bio-identical' hormones, preferring instead to stick to tried and tested drugs they're more familiar with. So ... who steps in and resolves this 'stand-off' between women and their family doctors?

The dilemma facing women EVERYWHERE!

" ... I went through 4 doctors before I found the one I have now. One was downright angry at me for even attempting to "self-medicate" myself and one laughed in my face when I told him I was using natural progesterone cream and said that if it had a placebo effect, then more power to me....then went on to say that if I used it for more than 5 days before my period, that I would mess up my cycle!!! Guess the placebo effect he mentioned was pretty powerful!! I finally found an OBGYN/FACOG that understands the use of natural progesterone and while I don't think she has studied in great depth, will discuss it with me as well as be okay with me using it. Now if I just had a dr. that knew more than I did and could answer my questions, I would be in heaven!!!" ~ June, USA ~

" ... Hi, I am a 56 yr old woman who had a complete hysterectomy at age 42. I was then put on Premarin alone since my ovaries were removed. I stayed on Premarin for 13 years and stopped it 5 months ago when I decided that it was not good for me. Breast cancer runs in my family. I called my doctor to request "bio-identical hormones" and she said, "what are they"...she would not help me. I asked for

natural hormones and she would not prescribe anything and to stay on Premarin. I tried over the counter Estroven with several other vitamins...hot flashes are slowly ruining my life. I do not sleep, and daily have hot flashes. This has been going on for 5 months. Still I refuse to go back on Premarin. No one will help me. I just want to cry all day long ... it seems like no one will help me get my body back on track other than taking Premarin. I felt great on it, never having a hot flash but I know it is bad for me. I ordered Progesterone cream and vitamins from the alternative medicine network and hope that they will work. I cannot afford to order the salivary test or hormone test. Is there anything you can advise me to do? I read the testimonials and nothing relates to me...Please reply to this, I am desperate for help...thanks for taking the time to read this."

A follow up email: "... I got my blood tests back and they indicated that everything was very low, (estrogen - progesterone - testosterone). My doctor said to stay on the Climara patch. Would you be able to tell me if the patch is a bioidentical hormone? From what I have read it is. All of the symptoms you listed are EXACTLY what I have!

Then later on that week: "... I called my doctor this morning and requested the "lowest" amount possible of estrogen for the patches, come to find out, she gave me the highest amount they make for them...I don't understand her at all, she knows how I feel yet she continues to want to keep me on a high dosage of estrogen... They gave me 0.1mg per day and the pharmacist said I should be on 0.5, the lowest is 0.25 but she said I would still have hot flashes with it. I wish I know what I was doing with all this stuff!"
~ Sara, USA ~

"... Thought I'd share my experience with you re progesterone cream. Saw my GP today re my hormone levels. She advised that she had only tested my estrogen levels and did not routinely check progesterone. When I mentioned that I had been reading about Progesterone she chastised me for 'reading too much and asking too many questions' and informed me quite bluntly and aggressively that she does not write prescriptions for progesterone cream! I was stunned by this hysterical response from a female GP. I'm now looking for a new GP - did you have any difficulty getting a prescription?"

I was totally shocked by my GP's manner today. It appals me that GP's have become so formulaic and orthodox in their practice of medicine. Despite the mantra of medicine as a partnership with the patient taking responsibility for their own health and being informed, in reality, the conventional and deferential model still seems to operate." ~ Despina, Australia ~

Is it too much to hope that our doctors will ONE DAY SOON embrace a more INTEGRATIVE approach to medicine!

Washing progesterone from your body

The more we come to understand progesterone supplementation, the more we appreciate it's a constant balancing act of observation and dosage adjustment.

Monitoring how your body metabolises progesterone cream is extremely important. And this can be achieved quite simply through regular salivary hormone profiles.

If you discover via test results that your progesterone levels exceed the upper reference limit, then it is recommended that you STOP using cream and begin monthly monitoring of your progesterone levels.

Typically, one would expect to stay within a minimum estrogen [E2] to progesterone [P4] ratio of 1:200-300 ... upper ratio being no greater than 1:1,000.

Washing excess progesterone from your body may take anywhere from weeks to months, depending on the individual.

Do not resume progesterone supplementation unless medically indicated, i.e., your progesterone levels drop below the respective reference range on your salivary hormone profile.

Next step, investigate what's interfering with the metabolism of progesterone. And on this subject I would strongly recommend you read '[Your Guide to Metabolic Health](#), A How-To Guide to Getting Well' by Dr. Honeyman-Lowe & Dr. Lowe.

A doctor competent at diagnosis can help you determine the cause - specifically you'd be looking at hypothyroidism or thyroid hormone resistance.

Thyroid function affects liver clearance of progesterone.

A [Function Liver Detoxification Profile](#) (FLDP) would also be of tremendous value here. A liver function test (LFT) is a blood test that helps a doctor determine whether the liver is functioning properly. The test measures the levels of liver enzymes in the blood as a way of helping diagnose liver problems.

We strongly recommend you visit [The Liver Doctor](#) website to learn all there is to know about liver dysfunction and cleansing.



Journaling your progress

Taking control

It's gratifying to watch a woman take control of her situation, adopting a more positive approach to hormone imbalance. In so doing, she discovers that cyclic hormone headaches are not normal. That she no longer has to feel anxious and apprehensive, and plan her month around the two days she is going to be bed-ridden, throwing up, incapacitated with pain or bleeding heavily. All the things she'd been told, taught or come to accept as normal are, in fact, abnormal. She experiences a sense of wellbeing she has not known for a very long time.

There is this renewed level of joy and enthusiasm in her life. More involvement and an ability to commit to activities she may have avoided at that particular time of the month. Ultimately, she rediscovers her freedom.

Break the cycle of pain and incapacitation with progesterone therapy and you see women who have failed in previous attempts to help themselves begin delving into their 'too hard basket', gravitating towards lifestyles changes that positively effects their health and their family.

Charting helps women become aware of things and situations that have, in the past, upset them and triggered an immediate need for 'comfort' food, a hit of caffeine and/or nicotine, drug dependencies such as analgesics.

We suggest women use their charts to reformulate their own life to make it work for them.

It's our belief that if you give a woman back her missing hormones, some genuine understanding, empowering knowledge, and a formula for self-help, she will go on and do the rest.

Once there's a 'shift' - a conscious state that is arrived at through charting - women suddenly realise that they have considerable control over their health (by establish, proven strategies). They then choose to move away from lifestyle habits and triggers that can contribute to their health problems, no longer seeing the giving up of these things as a state of deprivation.

We just want to remind yourself that you ARE already magnificent.

Keep this in mind as you review your charts and progress. Be patient and gentle with yourself. And remain committed. For we do not doubt your ability, no matter how difficult you may believe it to be, to accomplish the kind of results that you feel good about.

A time for reflection

Most women, when asked to refer back over their lists of twelve months ago, are quite shocked to see how many symptoms were on their original list. So, for this reason, we ask you to continue your journey. Be patient and persistent. What you put in you'll get back in improved health.

In other words, discover what works for you, get good at it. Allow it to become a habit and way of life that, in time, sustains good health.

Our website offers you some charting guidelines. Pick the one that suits you. Or using our guidelines, create your own. You are free to make up what works for you. And at the end of each month, we encourage you to not only tick off what symptoms still exist and how many negatives or unusual symptoms you have reported for the month, but to list all the things that have improved.

The score sheet is ideal for putting together a quick summary that indicates the effectiveness of progesterone for that month.

The main thing to remember here is that these are your charts, more or less a diary of your journey and validation of who you are.

For very busy women, fasten the Quick Tick Chart to your refrigerator and you can be sure if you forget to fill it in your husband and kids certainly won't.

Our website often hears women report that their charts have been completed by their kids and husband for the month!!

Clearly, in some case, the family are more tuned in than women realise. And these charts have served as a positive support infrastructure because the family starts to see patterns emerge from a different level of comprehension. Certainly women report they get more hugs.

Your monthly journal and list of all the positives are so important because so many women have been conditioned to expect a negative cyclic experience. Two examples would be migraine sufferers and women with endometriosis who suffer pain that incapacitates each month, sometimes for days. These women tend to be focused and fear-driven by ingrained negative belief systems based on past experiences.

Charting can help break such cycles and re-program their belief system, thus inducing the healing process. When documented proof of improved health is evident in their charts, it can dramatically alter their perception. This is especially important since we tend to focus on what's not right with our body forgetting to acknowledge and give thanks for that which has improved our quality of life.

For to get well and be healthy you need to focus on the best possible outcome, not the worst. Good health is, after all, a synergy of mind, body and soul. Our positive attitude, commitment, and love of ourselves fuels the body's power to heal.

Noticing subtle changes

To become aware of changes over a period of months, you need to ask yourself the questions below, or at least those that apply to your condition. Month to month, you probably won't realise the subtle changes.

It's only when you reflect over a period of 12 months that you realise you have found alleviation from so many minor symptoms - symptoms that add up to a significant health problem when left untreated.

Catherine, along with hundreds of other women, learned to identify with the use of charts when her hormones are imbalanced. Hormone imbalance for Catherine triggers uncharacteristic behaviour leading to aggression. She often suffers gastric pain and cramps in the stomach, coupled with painful breasts. An early warning to hormone imbalance for Catherine is the onset of anxiety attacks and loss of concentration. Basically, Catherine tracks her symptoms with the use of a chart to help her immediately identify and address estrogen dominance before it gets out of hand.

A case comes to mind of another women who told us how she's learnt to recognise when she's heading towards estrogen dominance. Acne, fluid retention, nasal congestion, sinusitis, and headaches tend to be her first indicators.

Mary was diagnosed with an enlarged thyroid and yet tests proved normal. Following 18 months of progesterone supplementation, her thyroid is back to normal. But, interestingly, her neck size changes, indicating thyroid interference when she has allowed estrogen dominance symptoms to go unaddressed.

It just goes to show you how important charting is in the bigger picture. Mary wouldn't have recognised these subtle changes as being associated with estrogen dominance had she not tracked her progress.

Julie, however, has very few indications of estrogen dominance other than a sense of apprehension. An inability to cope and interact harmoniously with her surroundings and her loved ones that, if left unchecked, can manifest as panic attacks, withdrawal into herself, dark feelings of doom and gloom, and apathy.

Therefore, not surprisingly, our website strongly urges woman to keep charts.

Learn how to monitor your health to better identify key elements to your predominant symptoms, and learn to monitor the signals of the start of estrogen dominance. Use your charts to identify your own personal formula for quick correction.

Rita tackles her imbalance by increasing her progesterone creams vaginally, paying particular attention to stress management, nutritional and diet plan, particularly phytoestrogens, and incorporating liver cleansing principles. Mary, like Rita, ups her progesterone dosage that month, looks at reducing her

refined sugars and stress levels, increases her phytoestrogens to tone down her estrogen receptors, and revisits her charts to determine patterns and triggers.

Our point here is, simply, imbalances can occur at any time in any disguise, but once you setup a hormone 'template' by charting for the initial 7 months, you have the blueprint that you can always refer back to.

Many women are actually staggered at the value of charting when they may need to revisit them 2-3 years down the track. And it may only take a small adjustment to get themselves back in balance ... because they already have the road map!

Many of the symptoms may never reoccur because progesterone has actually corrected the problem. There will always be a persistent 'weakness' that you will, in time, come to see as idiosyncratic to you. That can be an indicator you need to start listening to your body, and implementing whatever strategies required to maintain continued health.

Through these charts you will learn that symptoms can be quite insidious. They creep up undetected and are easily overlooked, particularly if a woman is out of balance or pre-occupied. If you understand these patterns and realise the connection, you can quickly get on top of it. Take action to correct the problems before they compound.

This is particularly true for women who suffer joint pain, arthritis, fibromyalgia, hypothyroidism (low thyroid function), high blood pressure or bladder problems, sinusitis, and headaches. They tend to be unaware their symptoms all fit together like a jigsaw puzzle.

To appreciate the benefits of progesterone and to fully recognise the positive effects, you have to stay on the cream and monitor your progress, long term. If you do this, then results can be truly astounding. What you end up with is a charted record of your body's rhythms; in itself a template for future references.

Is it important to keep a chart?

This is entirely up to you. We suggest that you do keep your own chart to better understand how your body functions and to tune into its needs. Charts help you become aware of the day to day changes in your body. They help you interpret symptoms that may be relevant to your hormonal balance and general wellbeing.

Symptom relief is an important barometer in your hormonal well-being, and acts as a guide to using the least amount of progesterone required to maintain balance.

When you first begin natural progesterone therapy, it's always advisable to go through the list of estrogen dominant symptoms and mark off what applies to you and date it. Add to this list anything that is unusual or is idiosyncratic to your hormonal profile.

Don't, whatever you do, judge what you put down believing it to be totally irrelevant. Write it down anyway because it's guaranteed somewhere along the track your 'peculiar' symptom may actually correlate with other women's stories of hormonal imbalance.

Women become so conditioned to discounting themselves and undermining their problems, especially if they have been long-standing.

Make no mistake you are not alone in this struggle with this new emerging condition - estrogen dominance. Women who approach our Network seeking help are invariably surprised to learn that their collection of symptoms has absolute relevance within the context of determining and balancing estrogen dominance.

Comments like "I can relate to that" or "the same thing happens to me" tells us women out there continue to suffer in silence, year in, year out, unable to compare and validate their experiences with other women.

The Natural-Progesterone-Advisory-Network.com website is essentially about empowering women so each can, in time, resurrect herself from the 'hormonal' abyss she finds herself. And in order to do this, she needs to get in tune with her own hormonal persona so to speak.

For your convenience we have listed all these aspects of your overall health in sections. Be aware of them. You may find your own amongst these to include in your charts. These questions below make you aware of your own body, particularly before using progesterone, and how you are responding once you've started using progesterone.

This is an on-going journey, and things will change in your body, over months and over years.

Which Chart Suits You?

#1 - Monthly Score Sheet

Charting should be conducted monthly to assess reduction / flare-up of symptoms. Your monthly score should be reducing each month. We commonly use a 7 month time frame as a fair gauge to work in, although we see most symptoms disappear around 4 months if it's a progesterone deficiency / estrogen dominance problem. If some symptoms persist you would need to look at possible physiological cause other than hormonal, i.e., depression that is not alleviated by progesterone.

If your score is not reducing over 4-7 months, it indicates that your progesterone cream is not being assimilated by the body effectively. This can be for various reasons (see also 'Cream Usage & Guidelines').

Most women who are estrogen dominant present with a score between 26-36 (out of a possible 42). And within 4 months we have observed most women's total score drops to under <10, after following our suggested guidelines. Nonetheless, it's important you maintain yours charts for a minimum of 7 months, at which time stability would have been established.

Suggested Score Guideline for Monthly Score Sheet:

- High Score: (dosage initially >10% or 100mg)
- Moderate - High Score: (dosage between 4%-6% or 40-60mg)
- Moderate Score: (dosage between 3%-4% or 30-40mg)
- Low Score: (dosage between 1%-2% or 16-20mg)

[Click here to download](#)

#2 - Health Observation Calendar

This chart suits the methodical person who likes to record keep in symbols, and who is very involved in her health agenda. It probably wouldn't suit the lady with a busy lifestyle who's on the go.

[Click her to download](#)

#3 - Calendar style notation of symptoms

If you are a woman looking to record 'unusual' symptoms and may not be recording in-depth details, this chart gives you a guideline of where / what may be happening at certain times of the month. The charts can then be used as a comparison, month to month. Patterns can be determined using this method. It's always important to note dosage of cream on all charts, to correlate dosage versus symptom relief.

[Click here to download](#)

#4 - Quick tick chart

This is a very popular chart because it's so user-friendly. All you need to do is tick the appropriate columns each day as they apply. It doesn't require lengthy reporting, just helps you acknowledge how you're feeling, and what's going on. Perfect to stick on your refrigerator.

[Click here to download](#)

How to approach your Charting

We've already provided you with a sample of charts and pointed out the benefits of each style. Now, for your convenience, we pull together all the aspects of your overall health in sections so that you can be aware of them. We present you with the questions you may wish to ask yourself, month to month, to and gauge how progesterone is influencing your particular problem. Choose the sections and questions that apply to you.

Gynaecological Symptoms

- Is there incidence of, or changes in thrush, vaginal irritation, itchiness?
- Has vaginal lubrication improved?
- Is there evidence of a discharge? Note type, colour, odour.
- Is sex less painful?
- Is vaginal tissue strengthening, not feeling as gritty and fragile with penetration?
- Is pelvic comfort improved overall, i.e., no dragging or bearing down feeling or back ache, less restricted?
- With hyperplasia, has the next Pap smear result become normal (are the cells showing positive normalisation after a few months on progesterone)?
- Has vulva acne disappeared (do not confuse with herpes)?
- Is sexual libido fluctuating or stabilising?

Menstrual Cycles

- Have your periods improved?
- Are your cycles regular? Or are they wandering?
- How long do your cycles go for? What is normal for you?
- What sort of menstrual cycles do you experience (heavy, light)?
- Is there a pattern of bleeding, i.e., spotting, heavy, light, stop/start?
- Are there clots? How often, small or large? With every period?
- Is there pain, cramping, nausea or bowel irritability with your period, prior to, or both? What sort of pain is it (duration/location)?
- With fibroids, have they shrunk (by scan results), is there less haemorrhaging or less bleeding?

Skin & Hair

- Have you observed changes in your skin, i.e., texture, blemishes, unusual growth/lesions, pimples, dryness or scarring, is there evidence of psoriasis or less psoriasis? Are these problems lessening?
- Does your skin feel creepy, crawly, itchy, the feeling of mites or bugs running all over? If so, is this diminishing?
- Is your complexion clear or muddy?
- Are there black rings under your eyes?
- Is there a tiredness about your skin and/or dehydrated?
- Is skin elasticity and vitality improving?
- Does your moisturiser sit on the surface and not soak in readily?
- Does your skin appear full of fluid, dimply?
- Is there acne? Is it cyclic? All over or specifically facial 'T' zone?
- Is your head dry, scaly, do you suffer from dandruff? Do you have dry limp hair, greasy hair, tight feeling in skull?
- Has your hair stopped falling out or are you losing more?
- Is your skin overall more subtle and hydrated, less scaly?
- Is your skin less prone to bruising or tearing?
- Do you have any body rashes?
- Are your ears less itchy? Sensations of ringing, etc.?
- Have you noticed an increase in body and facial hair?

Breasts

- Are the breasts less lumpy?
- Have lumps gone altogether? Are fibrocysts diminishing in size & discomfort?
- Is the breast tissue softening and more subtle?

- Are the nipples more sensitive and not so itchy, less tenderness, less swelling, less fullness, less pain, and not burning as much?
- Is there less breast engorgement overall?
- Monitor the presence of hairs around the areola.

On-going Chronic Conditions (including Auto Immune)

- Any sign of congestion, phlegmy or dry throat? Is it cyclic?
- Is there any associated teeth or facial pain? Is it cyclic?
- Are you experiencing flu-like symptoms, blocked ears & nose, cranial pressure, aching eyes? Are symptoms frequent, and do they follow a pattern? Any improvement noted?
- Sinus conditions improved? Is there less congestion and pain? Is it pronounced prior to period?
- Have your allergy symptoms improved or gotten worse?
- Any inflammation present such as arthritis, joint & muscle pain or burning? Is there an obvious change to the patterns, duration, intensity?
- Have you recently been diagnosed with an auto immune disorder? Lupus, for example. Is it in remission or has it accelerated?
- Have you had less need of Ventolin and asthma drugs? Is your asthma problem improving? Is it more predominant just prior to periods?

Pain Disorders

Reproductive

- Is there pain on ovulation?
- Is there pain in the region of your ovaries, i.e., spasmodic, constant, cyclic? Type and intensity? Any phantom pain after ovaries that have been removed?
- Any pain in the back area?
- Any pain present prior, during, or after your period?
- Less bearing down feeling? Less muscle spasms?
- Any pain associated with sexual intercourse? Improvement with different positions?

Muscular-Skeletal

- If you have arthritis has the pain improved?
- Are you suffering a chronic pain condition such as Fibromyalgia that has improved?
- Increased joint pain or less?
- Increased muscle pain or less? Is it worse morning or night, or following activity?
- Has your sciatica or hip pain improved?
- Has back pain improved?
- Are your legs and feet less achy, particularly your feet in the morning?
- Are your heels less tender or less burning sensation?
- Are your knees less painful?
- Restless leg syndrome improving?

Other Pain

- Are aches and pains more obvious at certain times of the month or are they all the time?
- Have your migraines / headaches improved? Less intense or a change in character?
- Chronic depression can masquerade as a pain disorder.

Pain Considerations

- Is your pain threshold improving, meaning are you able to tolerate pain at higher levels?
- Is the nature of your pain changing in character / location / intensity?
- Are you finding you're able to cope and are less stressed, your body more relaxed?
- Is your mental attitude towards your pain strengthening?

Bladder

- Are you going to the toilet more or less frequently?
- Is there better bladder tone and are you able to empty your bladder more completely?
- Is there more bladder control and less incontinence?
- Is the bladder able to hold more fluid?

- Is there less occurrence of bladder infections or burning sensations? Is your bladder feel less sensitive?
- Is the urine colour changing, less concentrated? Has the odour changed?

Gastrointestinal

- Have your gastrointestinal tract symptoms improved (digestion & elimination)?
- Are there less stomach digestion problems ,less wind, less burping, less heartburn, indigestion, less sugar cravings?
- Have your bowel movements become regular, less constipation, less diarrhoea? Are these patterns cyclic?
- Is your elimination process moving through the bowel much quicker and have your bowel patterns changed for the better?
- Is there less bloating and stomach distension, less discomfort on eating?
- Are you naturally choosing to eat more whole and healthy foods?
- Are you experiencing any nausea or has it lessened?
- Is there an improvement if you are suffering from colitis, irritable bowel syndrome, Chrones disease, or other related conditions?

Sleep Patterns

- Do you have a better quality of sleep (deeper, more revitalising)?
- Do you have better sleep overall (more relaxing)?
- Are you waking less or more?
- Do you feel rested on waking or do you feel worse?
- Are you less tired?
- Are you having better dreams?
- Are you getting up to go to the toilet less frequently during the night?
- Are your patterns of wakefulness settling?
- If you wake up, are you less anxious or preoccupied with worry? Are you experiencing less obsessional thought patterns?
- Do you have the need to nap in the day?
- Are your night sweats less severe, and reducing in time, duration, and occurrence?
- Are you less over-heated at night time?

Sex

- Do you find yourself anticipating sexual intimacy? Is your libido improving?
- Are you finding yourself preoccupied with thoughts of sex?
- Is sexual intercourse less painful and more enjoyable?
- Are your orgasms improving in intensity?
- Is your sexual satisfaction greater?
- Is your emotional intimacy improving?
- Do you have less vaginal dryness, better lubrication?
- Are your sexual needs changing?
- Are you experiencing erotic / colourful dreams?

Metabolic

- Any weight loss or weight gain?
- Are you less cold this month, particularly hands and feet?
- Is your body over-heating? Or is your body temperature more regulated?
- Are you aware that your metabolism has increased (energy)?
- Have you got the ability to burn energy better (possible weight loss)?
- Has your blood picture, your electrolyte profile improved, (eg. increased B12, stabilised blood sugar, improved iron readings)?
- Have you more even levels of energy, rather than busts of energy followed by exhaustion?
- Are you looking for less sugar fixes, not relying on sugar for quick energy?
- Do you have less need of stimulants for energy, such as coffee, fast-foods, refined sugars, fizzy drinks?
- Are there signs that your liver and adrenal function are improving with evidence of more efficient elimination of body waste and toxins through bowel, bladder and skin?

Cardio Vascular

- Are your varicose veins throbbing as much?
- Has your blood pressure improved or normalised?
- Have you had any incidents of vertigo, fainting spells, or dizziness?
- Are you less fluid retentive, particularly in the hands, legs, ankles, are your rings fitting better?
- Are your extremities warmer (feet & hands) indicating better circulation?
- Have you had less headaches?
- Less palpitations?
- Less hot flushes/night sweats?

Fertility

- Are you aware that you have ovulated this month?
- Are the follicle stimulating hormone (FSH) and luteinising hormone (LH) readings within normal range?
- Do you have fertile mucus (is there a presence of a clear, egg-white like, stretchy vaginal discharge, appearing around the middle of your cycle)?
- Is there a return of regular cycles? Is there a pattern emerging?
- Have you conceived? If there's a possibility, please do NOT suddenly come off your cream. Get a test to confirm your condition.

Muscular, Skeletal & Nerves

- Are your overall general aches and pains improving?
- Is your head and neck less tense?
- Are muscle spasms, cramps, 'busy legs' particularly at night time lessening?
- Are your joints more mobile, flexible?
- Has nerve pain improved (eg. facial neuralgia, sciatica)?
- Are you noticing an improvement to your discomfort and generalised pain?
- Are your joints more flexible, and is there's less stiffness particularly of the spine and lower pelvic region?
- Is there evidence of improvement of symptoms such as eye lids twitching?
- Has your hearing slightly improved, such as less tinnitus (ringing or roaring sound in the ears)? Less muffled or swishing sound? Less internal fuzziness?

Vision

- Are your eyes less tired?
- Has your vision improved or is it blurred? Has visual adjustment improved?
- Do your eyes feel dry and gritty?
- Are the eyes more moist?
- Are your eyes sensitive to light?
- Do you feel pain or pressure at the back of your eye sockets?
- Are your eyes more lubricated? If your eyes have been watery, are they improving?

Concentration Memory Performance

- Has your concentration span improved?
- Are you able to easily make decisions without procrastinating?
- Are you more confident in your own judgement?
- Are you more systematic in your approach to tasks?
- Are you able to take on multiple tasks once again?
- Are you less forgetful?
- Are you less dependent on your diary to retain, recall, and organise?
- Are you able to put things away and not lose them?
- Are you able to remember your children's names, and not confuse their names with that of the your dog!
- Is your head less foggy?
- Is your thinking faculties and general awareness improving? Is there more clarity of thought, better recall?

Headaches

- Are your migraines diminishing?
- Are normal headaches less frequent or have been eliminated entirely?
- Are you taking less medication for headaches?

- Are you more relaxed, less stressed?
- Do you have less neck tension contributing to headaches?
- Are you able to control your headaches before they become migraines (recognising triggers).
- Has that tight head-band/tight scalp pain behind the eyes and temples disappeared or improved?

Emotional Wellbeing

- Are you still fluctuating between high and low moods, or are you stabilising?
- Do you feel good about yourself?
- Are you more confident?
- Can you interact better in a social situation, do you feel less vulnerable and fragile?
- Are you more assertive, particularly where your own needs are concerned?
- Has your moodiness improved?
- Do you still feel old, redundant and full of self loathing?
- Do you continue to sabotage, discount, or dismiss yourself?
- Do you feel more energised?
- Are you willing to take risks?
- Are you willing to tackle new projects?
- Do you feel less sluggish?
- Are you coping much better with general exercise, do you feel inclined to be more active?
- Are you able to maintain and use energy better?
- Are you still experiencing panic or anxiety attacks? Are they less frequent, less intense, more controllable?
- Are you coping better, not freaking out or over-reacting?
- Do you behave less erratically, less inclined to flee from situations, or behave inappropriately?
- Do you feel less disorientated, or did you lose your way, perhaps got lost on the most common route to work that you have travelled for the last 20 years?
- Do you find yourself incapable of making 'small talk', feeling inadequate in social situations?
- Have you lost the art of entertaining, and find yourself floundering without reason?
- Did you forget someone's name that you should have remembered?
- Are you feeling less agitated?
- Did you yell at the kids less this month?
- Are you more easygoing, more patient, loving, tolerate?
- Are you more settled in your relationship, not so obsessed with faults?
- Has your self worth improved?
- Are you happy and comfortable with yourself, and experiencing a sense of completeness?
- Are you having more positive inner dialogue or are you still hard on yourself?
- Are you negative about yourself, feeling alienated against the world?
- Are you still wearing the 'should do' label that is causing you to feel guilty?
- Are you easily brought to tears?
- Are you feeling depressed or weepy for no reason, or dipping in and out of depression?
- Are you more loving and lovable, more dependable?
- Are you less co-dependent, looking for other's acceptance and approval?
- Do you experience a feeling of wellbeing and renewed independence?
- Do you feel strong and resilient emotionally?
- Does the world look brighter to you now?

All the above symptoms can be monitored on a monthly basis, and give a general indication of your progression and response to progesterone.

Become your own detective!

It truly is a rewarding experience to put the effort into your charts. Often women will stick their chart on the fridge at home and tick off daily. Other women chose to reflect of an evening in the privacy of their bedroom. The main point here is that your charting is convenient and designed to suit you. It is like a road map back to you, and the way to discovering rewarding results

Share your charts with your doctor

Your doctor will appreciate your efforts to capture your hormonal profile because he can use the data you have meticulously collected to better assess which way he would like to go with treatment and monitoring.

Similarly, your charts will help him better understand progesterone, how it is all interrelated, and that all these years you weren't imagining things. Your symptoms were very real.

By charting and gaining a confidence about your own body, the vibration level at which you deliver your information to your doctor is such that it comes across with conviction.

Even if he says it is a placebo (an imagined response) you can retort, "Well it's a damn good placebo!" Hopefully, by this stage of your journey into improved health, you won't feel the need to storm out of his surgery, to justify, or discount your needs. If, however, your GP fails in his duty to appreciate and respect your physical and psychological wellbeing, then perhaps it's time to seek out a more understanding doctor.

By taking these charts to your doctor, he will be able to assess - hopefully with your active involvement - which way he'd like to go with on-going treatment and monitoring, particularly when it comes to other medications that you may be taking which could require adjustments due to positive responses of progesterone. An example of this would be women on blood pressure tablets. Often women find they require less simply because their blood pressure has reduced after using progesterone.

This will also help him to understand progesterone, how it's all interrelated, that progesterone is multifactorial, and that all these things you have been complaining about over the years were not imagined, nor were you the hypochondriac that you may have been led to believe.



Salivary hormone profile

Remarkable insights into health and disease

Dr. Joe (N) Mania PhD and
Dr. Sidney Golinsky R.Ph. MD. PhD, FACA.

Experts agree that diagnosis and prevention of disease using saliva assays is about to enter a period of explosive growth as more and more laboratories and medical practitioners gear up for this new technology.



Unlike blood testing, saliva analysis is looking at the cellular level (the biologically active compounds) and saliva is therefore truly representative of what is clinically relevant. Blood analysis, on the other hand, is looking at compounds as they travel through the blood serum, most of which are protein bound.

Physicians experienced in saliva analysis are able to predict, diagnose or prevent many health problems and diseases.

Small molecules freely travel through the cells and into saliva ducts and it is these small molecules that can be assayed in saliva. Hormones (estrogen, progesterone, testosterone, cortisol, DHT, DHEA, androstenedione etc) are all very small molecules and all can be tested in saliva. It is hormones that largely determine your health and how you feel. A saliva assay can make information available that may be obscured when looking for information in the blood.

Unlike blood analysis, saliva assays will always report a substantial increase in hormone levels when hormone creams are applied to the skin. This phenomenon opens up some serious medical issues and a dilemma for many doctors.

There is a common controversy within the medical fraternity when a doctor conducts blood tests both before and after the application of hormone creams to the skin and finds no difference in hormone levels. The obvious but very wrong conclusion is that hormone creams do not work. There are a number of studies that explain this discrepancy.

One of the most compelling is a published, double blind, randomized study where 40 women scheduled for breast surgery for the removal of a lump were divided into 4 groups of ten to study the effects of topical hormones when applied to the breast. For 10-13 days prior to surgery, one group received a placebo; one group received only natural progesterone. (Ref: Chang and Fournier et al. Fertility and Sterility April 1995-785-91).

At the time of surgery, a blood sample was taken and a sample of breast tissue was also taken from the breast approximately 1 cm from the lump. In each case the blood analysis reported hormone levels that were statistically unchanged, but amazingly, when the tissue was analysed, there was up to 100 times more hormones in the tissue of those that used a topical hormone than those that used the placebo.

The tissue analysis is telling us that the hormones reached the cells where they are needed whereas the blood analysis offers no evidence of this fact. What this study tells us (as does a saliva assay) is that when a physician claims there is no evidence that the creams are working; they are looking for the evidence in the wrong place - in the blood serum. Serum is polar while most hormones are non polar. It is no wonder that blood testing shows little or no change in hormone levels when hormone creams are used.

A factor of significance when assaying saliva is that hormones at the cellular level are found at very low levels; hence results are reported in Pico grams. Only a small number of medical testing labs have so far developed the technology to assay hormones at these low levels. Usually, the labs who have succeeded tend to keep their technology a closely guarded secret. The technology however is improving all the time. The new technology test equipment is extremely sensitive and easily measures the low levels of hormones found in saliva.

If you do not feel right, then something is wrong. If your hormones are low or out of balance, then you will not feel good. Hormones are needed to keep you happy. Saliva testing will identify hormonal status and hormonal imbalance. Intervention with natural hormones can change a persons feeling of well being for the better and can substantially reduce the risk of almost all of the diseases of western society. The risk of prostate cancer, breast cancer, heart disease, diabetes, osteoporosis, weight problems and a host

of other less serious health conditions can be determined and often prevented when acting on information provided from a saliva assay.

Breast cancer, for example, is extremely rare amongst women who have good levels of progesterone.

A physician, when trying to track down the cause of excess weight, or extreme tiredness, may treat the patient for hypothyroidism. Whereas, if the physician was to look deeper and look at a saliva assay, he may find that the adrenal glands are not producing enough cortisol. Cortisol is a permissive hormone, it gets everything ready for the thyroid hormone at the tissue level so that the thyroid can come in and activate metabolism. The problem that is causing the symptoms of hyperthyroidism may not be thyroid, but cortisol at the tissue level.

Just a few of the many health issues and diseases that can be diagnosed through saliva and helped resolved or prevented through hormone supplementation include but not limited to are: acne, cholesterol, male pattern baldness, cancer, fibroids, stress, weight problems, sexual dysfunction, headaches, heart problems, heart palpitations, allergies, cold body temperature, sleep problems, inability to absorb calcium, difficulties in conceiving. In fact it is hormone supplementation that has become the centrepiece of those growing number of doctors who have joined the emerging science of anti-aging medicine.

Starting about 6 years ago, the revolution of natural progesterone began to gain momentum and women around the world are now experiencing remarkable changes in their lives when they use natural progesterone cream to balance their hormones to offset the problems of estrogen dominance.

Harvard trained Dr. John R. Lee, through his books, his lectures and his unselfish dedication started this revolution and now women and their doctors are realizing the benefits of natural hormones, especially progesterone and the use of saliva assays to get to the truth of what is going on in a person's body.

The levels of some hormones, especially those that effect energy and sleep, vary throughout the day (a consequence of the circadian rhythm) and important information about what is going on in the human body can only be determined by checking such hormones levels at certain times of the day.

Melatonin, for example should be checked at about 3 am in the morning, cortisol should be checked at about 7 am and possibly at other times throughout the day as well. In the case of pre menopausal women, Progesterone should be checked on about the 21st day of their cycle. It would not be an easy task to find a doctor who can make himself available to draw blood at these odd times and hours so as to create a valid health profile to act upon. A saliva assay not only solves this problem but also in many cases provides much more accurate and meaningful information than blood tests.

Individuals will often order a saliva assay to establish a baseline before embarking on hormone supplements. More frequently, however, a saliva assay is ordered to pinpoint the cause of a problem. While saliva kits can be ordered direct, we encourage individuals to work with their doctors. A growing number of doctors are gaining experience with analysis of saliva results, but to many, it is still a new science.

It is very helpful to both the laboratory and the doctor if, with the saliva sample, the patient provides details of their problems - a statement of what is bothering them. This information can be reviewed by the laboratory against actual results. It is often very clear from saliva results why the patient is experiencing the problems they are reporting. Saliva analysis is a diagnostic tool that will often enable the doctor to identify the actual cause of many health problems and diseases.

While most doctors are more likely to treat (and suppress) symptoms with drugs and not investigate the actual cause, saliva analysis helps the doctor to recommend a course of action to correct the root cause of a problem. Resolving the root cause will usually involve a natural solution. It is those doctors who either have an open mind or who have converted to alternative medicine who are usually best able to work with their patient to address the cause and not just the symptoms.

The cost of testing saliva is typically less than a blood analysis - about \$30 per hormone. Saliva testing offers convenience and is non invasive. There is no pain, and an individual can draw the sample at the correct time, in the privacy of his or her own home.

The saliva test kit comprises a collection tube, instructions, a requisition form and a prepaid FedEx LabPak when the kit is sent to physicians. The steps required include rinsing the mouth with water and collecting the sample before the mouth is contaminated with toothpaste and food. It is simply a case of removing the cap from the tube and providing spit.

Once the sample is collected and the paperwork is filled out, it can be dropped into the mail and the results will be available within 3 weeks. Actual laboratory turnaround time is 72 hours or less. If the saliva sample is not immediately sent to the labs, keep it refrigerated. Saliva, nevertheless, is very stable at room temperature and will last for many weeks.

The theory and science behind saliva hormone testing

For detailed information on the science behind saliva hormone testing, Drs. Gillson and Zava have written a paper on [Salivary Hormone Analysis](#). This fully referenced paper details the theory and science behind saliva hormone testing.

Measuring progesterone with saliva assays versus blood serum

The John R. Lee, M.D. Medical Letter - Saliva Vs Serum or Plasma test for Progesterone

(This information on Saliva has been graciously made available by Dr John Lee to help educate women and their treating doctors - July 1999 Issue.)

Confusion exists among medical professionals and the general public about the question of progesterone absorption. This confusion often hinges on a misunderstanding of the test used to measure progesterone levels in the body. Let us try to clarify the issue.

What a blood test measures

"Blood" tests for progesterone refer to the serum or plasma concentration of progesterone. Plasma is the watery, non-cellular portion of the blood from which cellular components such as red blood cells and white blood cells, are excluded. Serum is essentially the same as plasma except that fibrinogen has been removed. Serum and plasma, being watery, contain water-soluble (hydrophilic) substances such as water-soluble vitamins, carbohydrates, and proteins. Serum and plasma do not contain fat-soluble (lipophilic) substances. For the purposes of this discussion, serum and plasma are interchangeable and I will refer to them as serum.

Sex hormones such as progesterone, estrogen and testosterone are fat-soluble steroids similar to cholesterol. When you have a serum cholesterol measurement, you are measuring cholesterol bound to protein which makes it water-soluble. (Recall that serum cholesterol is described as HDL or LDL cholesterol, referring to the proteins to which it is bound.)

How progesterone travels in blood

The ovary-produced progesterone found in serum is also largely protein-bound. Protein-bound progesterone is not readily bio available to receptors in target tissues throughout the body. It is on its way to the liver to be excreted in bile. Only 2 to 5 percent of serum progesterone is "free" or non-protein-bound. This is the progesterone available to target tissues and to saliva. Thus, progesterone measured by serum levels is mostly a measure of progesterone that is not going to be used by the body. A serum test can be used to compare one woman's progesterone production to that of another woman, or to test how much progesterone is being made by a woman's ovaries.

When progesterone is given intravenously, 80 percent of it is taken up by red blood cell membranes that are fatty in nature and therefore available to fat-soluble progesterone molecules. Less than 20 percent will be found in serum. It is obvious that serum levels would not detect the great majority of the progesterone added to whole blood.

Absorption of transdermal progesterone

Progesterone is a highly lipophilic (fat loving) molecule that is well absorbed through skin into the underlying fat layer. In fact, it is among the most lipophilic of the steroid hormones. From the fat layer, the progesterone is taken up gradually by red blood cell membranes in capillaries passing through the fat. The progesterone transported by red blood cell membranes is readily available to all target tissues and to saliva. This progesterone is completely bio available and readily measured by saliva testing. Only a small

fraction of it is carried by the watery serum. Obviously, serum testing is not a good way to measure transdermal progesterone absorption.

Yet, many doctors continue to question the skin absorption of progesterone. A recent example is a report in the April 0.5, 1998 issue of the Lancet that serum levels did not reflect a substantial rise of progesterone after topical application in post menopausal women. This report is being used to argue that progesterone is not well absorbed. This implication is erroneous. Rather, it means that the authors did not understand the significant difference between serum and saliva progesterone levels. Some even imply that saliva testing is relatively unknown and its reliability is unproven. This is an odd admission since researchers have been using saliva testing for years and a number of laboratories offer routine saliva hormone testing. A sampling of references supporting all points of importance in this matter can be found at the end of this report.

How to use Saliva Hormone Assay to determine progesterone dosage

Achieving Balance is the Key

The goal of progesterone supplementation is to restore normal physiologic levels of post menopausal progesterone. Progesterone/estrogen balance is the key. When sufficient numbers of normal ovulating women are tested by saliva hormone assay, the typical range of progesterone is found to be 0.3 to 0.6 ng/ml. Under usual circumstances, there should be no reason to exceed that range.

In my experience, the topical dose required to achieve a saliva level of 0.5 ng/ml is commonly only 18 to 15 mg per day. For creams containing 900 to 1000 mg per 2-oz container, 12-16 mg a day for 84 days would use up only about one-third of a 2-oz container. Larger doses are often used initially to "catch up" on the existing progesterone deficiency state, but the maintenance dose will usually be around 15 mg per day. Since considerable variation in progesterone is well tolerated, a modest elevation of saliva levels to 0.8 to 1.5 ng/ml is acceptable.

Progesterone levels and PMS

Saliva progesterone levels several times higher than 0.6 ng/ml are justified in certain situations. In PMS, for example, stress is often a factor. Stress increases cortisol production. Cortisol blockades some progesterone receptors and thereby prevents progesterone function. To compete with this cortisol blockade, topical progesterone in the range of 30 to 40 mg/day is sometimes initially required to achieve a beneficial effect.

Progesterone and Endometriosis

Likewise, in women with endometriosis, the goal is to increase progesterone levels to that found in women two months pregnant. This level may require that supplemental topical progesterone be in a range of 30 to 50 mg/day from day 8 to day 86 of the menstrual cycle. (See the July '98 issue of the John Lee Medical Letter, for a more detailed article on the causes and treatment of endometriosis.)

Progesterone dosage is determined largely by response: the right dose is the amount that results in progressive decrease of endometriosis pain. When pain is largely gone, levels can be decreased gradually over time to doses necessary to maintain the progesterone benefit.

Progesterone and Estrogen Receptors

In women whose doctors are giving them excessive supplemental estrogen, a different problem must be faced. Excessive estrogen in circumstances of deficient progesterone induces a decrease in receptor sensitivity. One of progesterone's functions is to restore the normal sensitivity of estrogen receptors. When progesterone is restored, estrogen receptor sensitivity is restored, also. It is not surprising that, in these cases, some women develop symptoms of estrogen dominance (water retention, headaches, weight gain, swollen breasts) when progesterone is first supplemented. Obviously, the estrogen dose must be lowered. If this is done too rapidly, however, hot flashes can occur. The key is to reduce estrogen gradually while progesterone is being restored.

In my experience, estrogen dosage can be reduced 50 percent as soon as progesterone is added. Then, every 2 to 3 months, the estrogen dose can be further decreased gradually. Many women eventually discover they do not need any supplemental estrogen at all: the estrogen normally produced by body fat in postmenopausal women is often sufficient; for its needs once the progesterone is restored.

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Saliva Hormone Testing as used by Researchers

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Good Evidence Concerning the Absorption of Steroids Through Human Skin

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The Evidence of Red Blood Cell Transport of Progesterone

Devenuto F, et al. Human erythrocyte membrane: Uptake of progesterone and chemical alterations. *Biochim Biophys Acta*, 1969;193:36-

Koefoed P, Brahm J. Permeability of human red cell membrane to steroid sex hormones. *Biochim. Biophys Acta* 1994; 1195: 55-62.

Direct Comparison of Plasma and Saliva Levels After Topical Progesterone Application

Dollbaum CM, Duwe GF. Absorption of progesterone after topical application: plasma and saliva levels. Presented at the 7th Annual Meeting of the American Menopause Society, 1997.

The last reference is particularly revealing. Creams with varying concentrations of progesterone were applied to menopausal women after which both plasma and saliva levels were measured.

As can be seen, in these menopausal women given the placebo topical cream, the plasma level was more than 10 times greater than saliva level. This indicates how little of their blood progesterone was of the non-protein-bound, bioavailable kind.

When only 0.34 mg of progesterone was applied topically, the plasma level rose 59 percent, whereas saliva level rose 5-fold. This indicates that only a small portion of the added progesterone entered the plasma, whereas the saliva clearly showed a hefty increase of bioavailable progesterone.

When an 88-fold larger dose was applied topically, the plasma level rose only 5.6-fold while the simultaneous saliva level rose 57 fold. This indicates that only the saliva reflected the great increase in absorbed bioavailable progesterone. The progesterone found in the saliva obviously was blood-borne, but it should be clear that the portion of the blood carrying the progesterone was not the plasma (serum) but, rather, was via red blood cells.

In all situations, however, it should be clear that plasma progesterone levels are not indicative of the true level of bioavailable progesterone such as is obtained from topical application. Saliva levels are far more appropriate for this purpose.

(This concludes Dr John Lee's information sheet on Saliva.)

Why not do a blood test to check progesterone?

In the revised and updated version of his book *'What Your Doctor May Not Tell You About Menopause'* published in 2004, Dr Lee maintains that as much as 90 percent of an oral dose is destroyed in the gastrointestinal tract within 15 minutes or so of taking it. The progesterone that is destroyed becomes by-products or metabolites that enter the liver where they and the real progesterone are transported into the bloodstream. Several research groups, including one in France (Nahoul) and another in the United States (Levin), using highly sophisticated methods of analysis, came to the conclusion that about 80 percent of what is measured as progesterone by conventional blood tests is really inactive metabolites of progesterone.

Therefore, if you are taking 100 mg of oral progesterone and your blood test comes back as 10 ng/ml, the real progesterone level is more likely only to be about 2 ng/ml and the rest of it inactive metabolites, or metabolites that are causing side effects rather than benefits. These metabolites are not as likely to get into saliva, and therefore a measurement of bioavailable progesterone (through a saliva test) will give far more accurate levels than serum (or plasma) levels.

Doctors find progesterone dosage confusing

Troches and creams are completely different dose forms and utilise different pathways to achieve systemic absorption.

In simple terms progesterone in a cream is absorbed through the skin, travels through the network of microcirculation, working its way into the larger blood vessels and reaches the liver where it is broken down into inactive metabolites and excreted.

Troches are taken under the tongue via what is called the buccal route. Buccal absorption works on the fact that under the tongue there is a very high concentration of large blood vessels very close to the surface and drugs can pass across the membranes into the general circulation. Glyceryl trinitrate in angina tablets have worked using this method for decades. The steroids in the troches pass into the circulation in a similar manner.

The reason for the dose differences between the two preparations is the time and route the progesterone takes to get to the liver. Transdermal creams allow for greater amounts of body tissue to be exposed to the effects of progesterone than does the troche route because a large percentage of the troche gets to the liver quickly and is metabolised.

Another reason for troches having a larger dose of progesterone relative to the cream is because when the troche dissolves much of the saliva in which the contents of the troche are dispersed is swallowed. Once swallowed the hepatic first-pass effect (liver) inactivates the progesterone. As you are aware progesterone taken orally is essentially inactivated by the liver before it can achieve any beneficial effects.

When Dr David Zava was in Melbourne 18 months or so ago he was asked a question from the floor about the percentage of progesterone absorbed from troches. He had no idea, but one of the compounding pharmacists made a guesstimate of about 50%. Until someone does a proper study on the pharmacokinetics of the troche we won't know.

What the only formal study with a progesterone troche has shown is that three hours after taking a troche dose levels have peaked and are back to baseline, hence troche dosing is often 3-4 times daily to achieve a sustained exposure to progesterone.

Creams on the other hand utilise fatty and cellular tissue as 'reservoirs' for storing progesterone which is why creams achieve a more sustained level of progesterone exposure. This 'storage' was validated by Chang et al in their 1995 study utilising transdermal progesterone on women with breast cancer.

In short troches use more progesterone because a large amount is deactivated by the liver in a short period of time relative to creams. Creams use smaller amounts because it takes longer for these amounts to get to the liver and tissues are exposed to the progesterone for longer and hence have a greater capacity to take up and utilise the hormone.

Dr John Lee always based his dosing around the ovary's ability to produce between 15-20mg of progesterone daily in a normal healthy woman. These women are exposed on a monthly basis to normal progesterone production and their body tissues are progesterone replete.

A progesterone deficient woman's tissues are crying out for progesterone and I have found a Pro-Feme dose of around 32mg daily (2cm of 3.2% or 4cm of 1.6% Pro-Feme) will achieve a better and quicker clinical outcome in these women than drip feeding 5-10mg daily.

Where to get Saliva Hormone Testing kits

- ZRT Laboratory (David Zava, Ph.D), 12505 NW Cornell Rd., Portland, OR, USA, 97229, phone (503) 469-0741, fax (503) 469-1305, www.salivatest.com, e-mail info@zrtlab.com.

Hormone Hotline (www.salivatest.com/hotline.html) is a 24 hour taped audio-library with a growing list of topics on every aspect of hormone balance and testing. The Hotline number is 503-466-9166.

Great Smokies Diagnostic Laboratory, 63 Zillicoa St., Asheville, NC, USA, 28801-1074, (800) 522-4762 (for doctors), (888) 891-3061 (for consumers), www.salivatest.com/hotline.html.

- Aeron Lifecycles, 1933 Davis Street, Suite 310, San Leandro, CA, USA, 94577, (800) 631-7900, www.salivatest.com/hotline.html.
- Diagnos-Techs, Inc., Clinical & Research Laboratory, 6620 South 192nd Pl., J-104, Kent, WA, USA, 98032, (800) 878-3787.
- National Biotech Laboratory, 13758 Lake City Way, N.E. Seattle, WA, USA, 98125, (800) 846-6285.
- Rocky Mountain Analytical, Unit A , 253147 Bearspaw Road, NW Calgary, Alberta, Canada T3L 2P5, Phone: (403) 241-4513, Fax: (403) 241-4516 .
- Analytical Reference Laboratories (ARL), 5 Leveson Street, North Melbourne, Victoria, Australia, 3051, (61-3) 9328-3586, fax (61-3) 9326-5004, www.arlaus.com.au, e-mail info@arlaus.com.au.

NOTE: New York State Residents

New York State health law prohibits the testing of specimens collected in or mailed from New York, and prohibits the transmission of data from any laboratory to NY physicians or residents. Therefore, direct receipt of lab results for NY residents is not possible.

New York State Public Health Law Title 1 Article 5 states that laboratories need to be approved, licensed and examined by the State.

Unfortunately, unless the sample is collected out of state and mailed, testing facilities are unable to run the test. Dr David Zava and team of ZRT Laboratory are looking into the licensing requirements for New York but it may be some time before they are able to do business in New York.

NOTE: California State Residents

California State health law requires that the testing of any specimen collected or mailed from California be accompanied by a written order from a health care professional licensed in California to order laboratory tests. This includes the following disciplines: M.D.; D.C.; LAc; R.D.; D.O.; N.P.; and Pharmacists (R.PH).

As of September 2002 (Senate Bill 577), such lab tests may be ordered by complementary/alternative health care practitioners "not providing services that require medical training." California consumers not working with a licensed health care professional should contact a compounding pharmacist in their area or contact our Network for further information and, if need be, investigation.

What Tests Are Available in Australia

- A number of the services provided by **Analytical Reference Laboratories Pty Ltd (ARL)** require a test collection kit eg. , Salivary Hormone Profile and Complete Digestive Stool Analysis (CDSA). Test kits are sent directly to the patient/client once a request form has been issued by the practitioner.

[Click here](#) to view ARL's sample reports.

Practitioners are requested to give their patient /clients a request form and have the patient/client contact ARL on 1300 55 44 80 to order a test kit. The FREE test kit will be sent directly to the patient/client. Having completed the specimen collection the test kit will be returned, via courier, to the ARL laboratory for processing. Test kits are couriered to ARL from anywhere within Australia.

www.arlaus.com.au

- **BioNatural Self Health and Sustainable Living** supply [self-test kits](#) to all clients regardless of needing a doctor's prescription. This maintains a freedom of choice for the purchaser to have their body results analysed and accessible to them.

The process is as follows, i.e. , you buy the test, make the saliva sample and send it to Nutritional Laboratory Services in a self-addressed stamped envelope. There is no added fee for the test to be analysed as it is built into the purchaser cost. The only difference is with the Allergy Self Test kit where the body sample taken is from 'blood' and therefore a pathology lab needs to analyse this.

There is an extra cost of \$200 made payable to the correct lab for results and all the instructions are included.

www.bionatural.com.au

Selected Bibliography on the Efficacy of Salivary Testing

www.salivatest.com/store/bhrt_index.html

www.salivatest.com/store/saliva_ref.html

www.biodia.com

www.arlaus.com.au/reference.html

www.ibl-hamburg.com

Hormone imbalance checklist

Female

The following symptom score sheet [for women](#) will help you to determine whether hormone testing is necessary. Each hormone category is divided into hormone deficiency and hormone excess, as each takes in a different set of symptoms. Check only those symptoms which are troublesome and persist over time. Go through each category, checking off deficiency and/or excess symptoms that apply to you. Three or more persistent symptoms in any given category is a strong indication of hormonal imbalance.

If the Symptom Checklist below shows that you have a hormone imbalance, our 'Where to get Saliva Hormone Testing kits' section [above] will show you where to go from here.

Estrogen Deficiency

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Foggy Thinking
- Memory Lapses
- Incontinence
- Tearfulness
- Depression
- Sleep Disturbances
- Heart Palpitations
- Bone Loss

Androgen Deficiency

- Low Libido
- Vaginal Dryness
- Foggy Thinking
- Fatigue
- Aches and Pains
- Memory Lapses
- Incontinence
- Depression
- Sleep Disturbances
- Bone Loss
- Decreased Muscle Mass
- Thinning Skin

Cortisol Deficiency

- Fatigue
- Sugar Cravings
- Allergies
- Chemical Sensitivity
- Stress
- Cold Body Temperature
- Heart Palpitations
- Aches or Pains
- Arthritis

Estrogen Excess

- Mood Swings
- Tender Breasts
- Water Retention
- Foggy Thinking
- Nervousness
- Irritability
- Anxiety
- Fibrocystic Breasts
- Weight Gain (Hips)
- Bleeding Changes
- Headaches

Androgen Excess

- Excessive Facial / Body Hair
- Loss of Scalp Hair
- Increased Acne
- Oily Skin

Cortisol Excess

- Sleep Disturbances
- Depression
- Bone Loss
- Fatigue
- Weight Gain in Waist
- Loss of Muscle Mass
- Thinning Skin
- Decreased Libido

Progesterone Deficiency

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Foggy Thinking
- Memory Lapses
- Incontinence
- Tearfulness
- Depression
- Sleep Disturbances
- Heart Palpitations
- Bone Loss

Progesterone Excess

- Sleepiness
- Breast Swelling
- Breast Tenderness
- Decreased Libido
- Mild Depression
- Yeast Infections

Male

The following symptom score sheet [for men](#) will help you to determine whether hormone testing is necessary. Each hormone category is divided into hormone deficiency and hormone excess, as each takes in a different set of symptoms. Check only those symptoms which are troublesome and persist over time. Go through each category, checking off deficiency and/or excess symptoms that apply to you. Three or more persistent symptoms in any given category is a strong indication of hormonal imbalance.

Men with heart disease, diabetes, a prostate condition, or who are overweight are advised to have their cortisol, estradiol and testosterone levels checked.

Estrogen Deficiency

- Hot Flashes
- Night Sweats
- Bone Loss

If you check two or more in this category this is a strong indication you may have an estrogen deficiency.

Estrogen Excess

- Weight Gain in Breasts
- Weight Gain in Hips
- Decreased Libido
- Cold Body Temperature
- Decreased Urinary Flow
- Increased Urinary Urge
- Prostate Problems

Androgen Deficiency

- Low Libido
- Burned Out Feeling
- Decreased Stamina
- Apathy
- Fatigue
- Aches or Pains
- Depression

Androgen Excess

- Aggression
- Irritability
- Increased Acne
- Oily Skin

- Bone Loss
- Decreased Muscle Mass
- Thinning Skin
- Decreased Mental Sharpness
- Decreased Erections

Cortisol Deficiency

- Fatigue
- Sugar Cravings
- Allergies
- Chemical Sensitivity
- Stress
- Cold Body Temperature
- Heart Palpitations
- Aches or Pains
- Arthritis
- Decreased Concentration

Cortisol Excess

- Sleep Disturbances
- Depression
- Bone Loss
- 'Tired but wired' Feeling
- Weight Gain in Waist
- Loss of Muscle Mass
- Thinning Skin
- Decreased Libido
- Increased Forgetfulness



Revolutionary new test for cancer

Use the AMAS Test to detect and defeat cancer

It's new and it's called the AMAS test. Nothing else comes close to this patented test which has already been tested on 8,000 patients. It was developed by a doctor at Boston University.

The test couldn't be easier. The doctor takes a blood sample and screens it for a substance called Anti-Malignant Antibody in Serum (AMAS).

The antibody is manufactured by your own immune system in response to any common kind of cancer cell. This is a factor in the blood that goes up regardless of the type of cancer or malignancy. The false positives and negativities in this test are less than 1%.

With the AMAS test, you can reliably surmise when cancer is lurking somewhere in your body and take action at once.

Breast cancer, prostate cancer, lung cancer, colon cancer, you name it... your chances for beating any cancer will skyrocket with this early detection.

The AMAS test is normal (negative) in non-cancerous bodies; terminal cases; and in recovered cases. It is positive in early cancer and detects early cancer 18 months ahead of other cancer tests. The AMAS test will monitor progress in response to treatment. This is valuable!

Exciting! You bet. If there's any cancer in your family, AMAS should absolutely be part of your regular check-up.

Your doctor probably hasn't heard of the AMAS test. It's marketed under the name "Target Reagent."

An innovative aid in early cancer diagnosis and follow-up

- Detects all types of active, non-terminal cancer, regardless of site or tissue type affected;
- Is 95% to 99% accurate;
- Detects tumours as small as a pencil dot;
- Distinguishes between benign and malignant tumours;
- Can reduce the need for traditional testing methods such as PAP smears, mammograms, PSAs and biopsies;
- Is paid for by Medicare and other insurance companies, CPT (billing) code 86-317.

The AMAS test is one of the best diagnostic aids available today for the early detection and monitoring of cancer. It is superior to conventional blood tests such as the PSA (Prostate Specific Antigen), CEA and CA125, which measure antigen, a cancer indicator that is not detectable until late in the disease. Thus, these tests are especially poorly suited for early detection and are not suitable as early biomarkers in chemoprevention.

The AMAS test works by indicating the presence of a cancer-specific antibody, anti-malign. A function of the immune system, anti-malign antibody is released at the onset of cancer. More than 3,314 double-blind studies have proven a direct correlation between the presence of anti-malignant antibody and all types of active, none-terminal cancer.

The specificity and 95% to 99% accuracy of the AMAS test permits confirmation of a diagnosis of cancer while reducing or eliminating the need for other traditional detection tests. These include mammograms, biopsies, x-rays, CT scans, MRIs, and other expensive, uncomfortable procedures. It is easy to see that the medical people might want this to be kept secret.

High risk individuals are recommended to begin using the AMAS test as early as age 30.

High risk individuals

- Anyone who has been diagnosed or treated for cancer and is concerned about monitoring for recurrences;
- Anyone coming from a family with a history of cancer;

- Anyone who smokes or smoked cigarettes;
- Research has determined that obesity is a higher risk factor than a history of cancer in the family.

How does the AMAS test work?

Malignan is a peptide found in people with a wide range of cancers. If the anti-malignan antibody is detected in the blood, it means that the body detected the presence of this peptide, and launched an immune response against it.

Clinical studies have shown that the AMAS test is up to 95 percent accurate on the first reading, and up to 99 percent accurate after two readings.

In one study at Beth Israel Hospital in New York, the AMAS test demonstrated amazing accuracy. Within the study group of 125 people, the test was positive for 21 people who were later confirmed to have cancer, while it was negative for 97 people who showed no signs of cancer. The remaining seven people produced positive readings on the AMAS test but showed no signs of cancer; yet the study notes that all were symptomatic, had a family history of cancer, or both - indicating that the AMAS test may have detected a problem that conventional screening methods could not find.

There have been more than 4,000 double-blind studies of AMAS Test accuracy in the past ten years. The 99 percent sensitivity of the test has convinced Great Britain's National Health Service to start buying it as part of the current national effort to eliminate breast cancer early.

Oncology Times reports that "The National Health Service sent an invitation to every woman in the UK between the ages of 50 and 64 urging them to get a free mammogram. Should all six million accept, as many as 500,000 would be expected to have abnormal mammograms. Only 50,000 of this group of women would be expected to have cancer. Rather than do 500,000 biopsies, the Health Service is buying a preliminary number of AMAS tests (as a backup tool) for cancer screening as abnormal mammograms appear.

Ordering your AMAS kit

The AMAS kit itself is FREE. The current cost of processing an AMAS test is \$135.00 USD.

Please note, the costs of drawing the blood, separating the serum and shipping the serum in dry ice by overnight FEDEX morning delivery are not paid by Oncolab.

An AMAS test and shipping kit is needed for the test. It includes specially-designed collecting tubes, technician instructions, medical authorization forms and clinical documentation. The kit is also a shipping box, complete with packaging materials needed to ship the blood sample to Oncolab, the only source for an AMAS test.

- To obtain your AMAS test and shipping kit from Oncolab, phone before 6 pm Eastern Standard Time on (800) 9CA-TEST or (617) 536-0850.
- Alternatively, you can download the 'AMAS Test Brochure' or 'Requisition Form' in PDF format from www.AmasCancerTest.com.

Definitely visit www.AmasCancerTest.com to learn more about this innovative aid in early cancer diagnosis and follow-up.

Is the AMAS test available in other countries?

Yes. Serum specimens are sent in dry ice from all over the world to the one lab (Oncolab, Inc.) in Boston, USA. So, no matter where you are in the world, you can order your free kit and follow the instructions contained therein.

For patients outside the USA, this test may be claimable through your private health insurance, but since this can change from country to country, and depend on your health care provider, we would recommend you do your own research. And make sure you have the support of your treating physician. Patient costs may also vary.

After receiving your AMAS test kit

- Get a doctor's signature to approve your blood test.
- Schedule your local blood draw between Monday and Thursday. SmithKline and Lab Corp are familiar with specifications of drawing a blood sample for Oncolab's AMAS test.
- Ask the lab if it will supply three pounds of dry ice, needed for shipping your blood sample to Oncolab. If not, ice cream parlours are a good source for dry ice. Pick it up on the day of the blood draw.
- Fill out all insurance and authorization forms. Bring them to your blood lab, they are sent to Oncolab with your blood sample.
- If your doctor includes a fax number on the authorization form, you can receive results in three to seven days.

See your doctor for AMAS test results and any follow-up recommendations as detailed in the clinical documentation accompanying your test kit.

AMAS can detect nearly any type of cancer

The AMAS test can be used to detect all types of cancer. A positive reading indicates that there are cancerous cells in your body, but it cannot specify the type or the location. But as with the infrared imaging procedure I wrote about yesterday, it offers a good alternative for routine screening. With such high accuracy rates, a negative AMAS reading means that a mammogram or other screening procedure is not necessary. And a positive reading would be followed by additional tests anyway - so its lack of specificity doesn't pose any real obstacles.

All known cancer cells contain malignant. The body zeroes in on this with an antibody called anti-malignant. This blood test measures the amount of anti-malignant activity going on in the body. It is 95% accurate according to journal reports of double-blind, multi-centre testing. Studies show accuracy rises to an amazing 99% with repeat testing. This makes it much more accurate than many biopsies. It is often accompanied with a CBC (complete blood count) to measure general immune status, since it would not be valid to use this test with a non-functioning immune system. It is FDA approved, and the lab accepts Medicare as full payment.

Talk to your doctor

AMAS was first discovered in the mid-1980s, and the AMAS test has been available for over a decade - but still, most doctors are unaware of it.

If you are interested in taking the AMAS test, talk to your doctor. Ask him to check out the information on AmasCancerTest.com, and to call 1-800-922-8378 to request a packet of scientific peer-reviewed literature demonstrating AMAS' benefits.

The AMAS test kit is FREE ... and includes journal studies, an insulated box and a request form to be signed by a doctor.

For best results, use a lab with a refrigerated centrifuge to draw the blood. The blood must be shipped in dry ice, and marked "overnight for morning delivery" at patient's expense.

Follow the links below for discussion papers (pros & cons) on the AMAS Test and why your GP may not have heard of it.

www.amascancertest.com
www.obgyn.net/industry/articles/000525-AMAS.htm
www.pathguy.com/malignin.htm
www.bcaction.org/Pages/SearchablePages/1996Newsletters
www.annieappleseedproject.org/conwdrsambog.html
www.annieappleseedproject.org/amastest.html



Progesterone cream guidelines

10 Things You MUST Know About Natural Progesterone

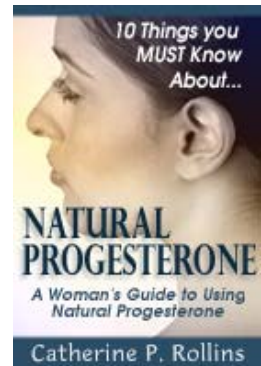
This publication was written to help women get the best results from their cream use by answering their questions and helping them overcome the natural stumbling blocks that occur when they introduce progesterone back in their body.

It is available now exclusively from the Natural-Progesterone-Advisory-Network.com website.

[Click here](#) to DOWNLOAD your FREE copy today.

Or copy & paste the link below into your browser:

<http://www.natural-progesterone-advisory-network.com/ebook/10-things-MakingPlans.pdf>



"Look over the guidelines in Catherine's excellent new ebook '10 Things You MUST Know About Natural Progesterone'. It really should be titled, 'Progesterone Therapy from A-Z'. A superb resource!"
~ Dr Robert W Patterson, MD, Sanford, NC ~

Here's a sneak preview

Chapter 1 - Know your progesterone cream

- Depending on which country you purchased your cream from, check that the list of ingredients includes pure, micronized progesterone to BP (British Pharmacopoeia) or USP (United States Pharmacopoeia) standard.

The United States Pharmacopeia (USP) is a nongovernmental, standards-setting organization that advances public health by ensuring the quality and consistency of medicines, promoting the safe and proper use of medications, and verifying ingredients in dietary supplements.

USP or BP grade progesterone is therefore preferred.

- Make sure you know how much natural progesterone is contained in your jar or tube of cream. And how much is delivered per application. Are you getting the correct dosage into your body? Make sure your container of cream contains at least 450 mg of progesterone per 28 grams (1 ounce).
- Natural progesterone creams containing plant derived estrogens are not recommended in those women with a history of breast or uterine cancer, obesity, diabetes, or a history of clotting or vascular disorders. Certain herbs stimulate estrogen receptor positive breast cancer cells to grow, and/or compete against any natural progesterone taken and should therefore be avoided.

(continued)

Other chapters include:

- Chapter 2 - Putting progesterone back into your body
- Chapter 3 - Correct application of cream
- Chapter 4 - Cyclic use
- Chapter 5 - Discovering your optimal level
- Chapter 6 - Capturing your data
- Chapter 7 - Self-medicating
- Chapter 8 - Getting a prescription from your doctor
- Chapter 9 - Be active in your choices
- Chapter 10 - Our formula for hormone harmony



Can natural progesterone help you?

Abdominal pain - Menstrual cramps - Dysmenorrhea

Menstrual cramps, otherwise called Dysmenorrhea a Greek word for painful menstruation, is classified as primary (from the beginning and usually lifelong) or secondary (due to some physical cause and usually of later onset).

Menstrual cycles last about 28 days (cycles of 23 to 35 days are usually considered normal as well). During this cycle, the hormones estrogen and progesterone send messages to the lining of the uterus. About day 5 of the cycle, the estrogen causes the lining of the uterus to grow and thicken. Around day 14, an egg is released from the ovary. After this, progesterone causes the glands to release nutrients and blood vessels swell to prepare for the possibility of pregnancy. If the egg is not fertilized, it moves to the uterus and is absorbed or disintegrates. Estrogen and progesterone levels decrease, and the lining of the uterus breaks up and is shed as menstrual fluid.

The uterus, like other muscles, contracts and relaxes. Most of these contractions are not even noticed, but strong ones can be painful. During menstruation, the uterus contracts more strongly than at other times and produces the uncomfortable feeling we know as menstrual cramps.

There are two different types of menstrual cramps.

Primary Dysmenorrhea

Prostaglandins, natural substances made by cells in the uterine wall, make the muscles of the uterus contract. Strong contractions cut off blood and oxygen supply temporarily and cause extreme pain. This pain is known as primary dysmenorrhea.

Primary dysmenorrhea is not a sign that something is wrong. It frequently begins during adolescence, but could begin later in life. Frequently, it disappears after a full-term pregnancy.

Secondary Dysmenorrhea

This differs from primary dysmenorrhea in that the pain lasts longer than the usual 2-3 days during the monthly flow. It may also occur during other times of the month. This is typically an indication of an underlying cause of the pain, such as endometriosis or pelvic inflammatory disease

The most common causes of infections are endometriosis (tissue from the lining of the uterus implants outside the uterus) and adenomyosis (benign growths in the uterine walls), and adhesions (scarring or adherence of two surfaces).

What is the treatment of secondary dysmenorrhea?

The treatment of secondary dysmenorrhea depends on its cause. There are a number of underlying conditions which can contribute to the pain including:

- Endometriosis (cells from the uterine lining that have escaped to other areas of the body)
- Uterine Fibroids (non-cancerous uterine growths that respond to estrogen levels)
- Adenomyosis (a benign condition in which the cells of the inner uterine lining invade its muscular wall, the myometrium)
- Pelvic inflammatory disease (PID)
- Adhesions (abnormal fibrous attachments between organs) or
- Use of an intrauterine device (IUD) for contraception

All of these conditions should be first diagnosed by a physician who will then recommend the appropriate treatment.

Premenstrual syndrome (PMS), irregular menstruation, menstrual cramps and a tendency toward miscarriage may be at least partially caused by an imbalance of these two hormones—too much estrogen and too little progesterone.

If a woman begins to experience changes in her menstrual cramps, such as severity, timing, or location, she should consult her physician, especially if the changes are of sudden onset.

Acne - Alopecia - Androgen excess syndrome

Androgen-excess syndrome has several major features:

- seborrhea (a form of skin inflammation which has no known cause)
- acne
- hirsutism
- obesity
- hair loss (alopecia)
- velvety, light-brown-to-black, markings usually on the neck, under the arms or in the groin, associated with high insulin levels (acanthosis nigricans).

Circulating androgens arrive at the receptors, enter the cell, and are metabolised to the final, most potent androgens - testosterone which, in turn, is converted by an enzyme called 5 alpha reductase into another form of testosterone called dihydrotestosterone or DHT - the androgen hormone that triggers hair loss in androgenetic alopecia.

This altered androgen metabolism (conversion from weak to potent androgens) is the most common cause of hirsutism and it appears to be the result of an increased conversion in the skin of testosterone to DHT.

Whether a woman is hirsute often is difficult to judge because hair growth varies among individual women and across ethnic groups. What is considered hirsutism in one culture may be considered typical in another. For example, women from the Mediterranean and the Indian subcontinent have more facial and body hair than do women from East Asia, sub-Saharan Africa, and northern Europe.

Dark-haired darkly pigmented whites of either sex tend to be more hirsute than blond or fair-skinned people.

Consideration needs to be given to the increased risks conveyed by long-term androgen excess which include:

- infertility
- cardiovascular disease
- hypertension
- osteoporosis
- uterine cancer
- pituitary adenoma

To some degree, estrogen reduces the effect of androgens in women. Estrogens increase liver manufacture of sex hormone binding globulin (SHBG). Androgens decrease it. Thus lack of estrogens can effectively increase available blood androgens. We see this at menopause when a woman's estrogen levels decline, coinciding with excessive hair sprouting up on her face ... and perhaps less and less of it growing on her head! You can help your body oppose androgen dominance in a number of ways.

Progesterone is the one hormone in a woman's body that modulates other hormones helping to restore balance. It's certainly proving to be a major player in the successful treatment of PCOS. Progesterone supplementation might, therefore, be a good starting point.

Progesterone supplementation can have a positive effect on acne that tends to be a by-product of increased androgen production (PCOS). Seborrhea (flaky, itchy skin) clears rapidly with topical progesterone cream, while keratoses (keratinized epithelial cells) are reported to soften and disappear when cream is applied directly to them.

We would certainly suggest women pay particular attention to diet and nutrition, avoid all refined carbohydrates and sugars, introduce a premium phytoestrogen-vitamin-mineral formulation, incorporate an essential fatty acid supplement, get plenty of exercise, drink lots of filtered water, reduce weight (if need be), learn to manage your stress levels, and rest up.

Adenomyosis - Endometriosis

Adenomyosis, also called endometriosis interna, uterine endometriosis, internal endometriosis, is the presence of endometrial glands and supporting tissues in the muscle of the uterus where it would not occur normally. When the gland tissue grows during the menstrual cycle and then at menses tries to slough, the old tissue and blood cannot escape the uterine muscle and flow out of the cervix as part of normal menses.

This trapping of the blood and tissue causes uterine pain in the form of monthly menstrual cramps. It also produces abnormal uterine bleeding when some of the blood finally escapes the muscle resulting in prolonged spotting. It more often occurs in the posterior wall of the uterus.

Adenomyosis may be present and cause no symptoms.

Adenomyosis occurs more often as we reach our 40's.

In hysterectomy specimens, adenomyosis can be found from 15% to 25% of the time. The glandular change of the endometrial cells in adenomyosis are often incomplete in the second half of the menstrual cycle (luteal phase) and as a result, adenomyosis may not be very responsive to suppression by progesterone.

About 50% of adenomyosis is asymptomatic although as it goes deeper into the uterine muscle it tends to be more likely to produce symptoms. It is also often associated with fibroids, and often associated with other conditions such as ovarian cysts, prolapse and even gynaecological cancers that can cause pelvic pain.

Most commonly, adenomyosis is mistaken for another common condition, uterine fibroids. There is however a fundamental difference between a fibroid (a distinct tumour) and adenomyoma. Each fibroid originates from one abnormal cell. Under the effect of estrogen this cell multiplies. The growing tumour may displace and compress tissues but it does not invade the surrounding uterine muscle because of this growth pattern of fibroids, it is possible to remove all of the tumour without removing any normal uterine tissue during myomectomy (surgical removal of fibroids). In contrast, adenomyoma is not a discrete tumour but rather a local swelling of the uterine wall as a result of the penetration of endometrial tissue. Therefore it is not possible to remove tissue affected by adenomyosis without actually removing the involved uterine muscle.

Chemicals that mimic estrogen (xenoestrogens) appear to be implicated in adenomyosis. There are 85,000 chemicals in use in the USA, and some of these chemicals have hormonal effects that provoke adenomyosis.

While the cause of endometriosis is unknown we do know that it is an estrogen driven disease. And the body's natural anti-estrogen is progesterone.

Controlling the symptoms of endometriosis with progesterone

We know that when a woman falls pregnant, often endometriosis will disappear, only to return again after pregnancy. There is some very strong correlation between the two. This suggests that the sex hormones are involved and that high progesterone levels produced in pregnancy play an important part in controlling this disease.

That's why progesterone is recommended from days 8 to 26 (just before menstruation) or whenever your normal menstrual cycle ends, breaking from cream briefly to refresh receptor sites. This mimics a pseudo-pregnancy state, and facilitates healing.

Higher than normal doses are required which appear to be well tolerated. Levels around about 60-80mg/day are usually required for pain management. You know you are taking too high a dose if you begin to feel sleepy after applying cream.

Most women will find that they can reduce their dosage of progesterone after 7-12 months, however, attempts to go below 40mg/day progesterone often allows symptoms to creep back in.

Keep in mind that a delayed diagnosis of endometriosis after numerous years of medication and synthetic hormone cocktails often leads to liver dysfunction, adrenal exhaustion, and chronic pain / fatigue which can compromise the uptake of progesterone.

No one is suggesting progesterone cures endometriosis but we certainly know, based on empirical evidence, that it appears to play a major role in controlling its distressing symptoms. We know that women who stopped progesterone felt great for a few months and then suddenly, after progesterone stores had washed from the body, the disease would flare back up.

Most women with endometriosis remain on progesterone cream for maintenance and pain control, and adjust their dose when necessary, increasing when indicated such as in times of stress.

Adrenal fatigue

Adrenal fatigue is produced when our adrenal glands cannot adequately meet the demands of stress. The adrenal glands mobilize our body's response to every kind of stress (whether it's physical, emotional or psychological) through hormones that regulate energy production and storage, heart rate, muscle tone, and other processes that enable us to cope with the stress.

Whether we have an emotional crisis such as the death of a loved one, a physical crisis such as major surgery, or any type of severe repeated or constant stress in our life, our adrenals have to respond. If they don't, or if their response is inadequate, we will experience some degree of adrenal fatigue.

In adrenal fatigue our adrenal glands function, but not enough to maintain our normal, healthy homeostasis. Their output of regulatory hormones has been diminished by over-stimulation. This over-stimulation can be caused either by a very intense single stress or by chronic or repeated stresses that have a cumulative effect.

Anyone can suffer from adrenal fatigue at some time in his or her life. An illness, a life crisis, or a continuing difficult situation can drain the adrenal resources of even the healthiest person. However there are factors that can make us more prone to adrenal fatigue. These include certain lifestyles (poor diet, substance abuse, too little sleep and rest, or too many pressures), a chronic illness or repeated infections such as bronchitis or pneumonia, or a mother who suffered from adrenal fatigue around the time of our birth.

The processes that take place in any chronic disease from arthritis to cancer place demands on our adrenals. Therefore, take it as a general rule that if we are suffering from a chronic disease, and morning fatigue is one of the symptoms, our adrenals are likely fatigued to some degree.

Also anytime a medical treatment includes the use of corticosteroids, diminished adrenal function is most likely present.

All corticosteroids are designed to imitate the actions of cortisol, a hormone secreted by the adrenals, and so the need for them arises primarily when the adrenals are not providing the required amounts of cortisol.

- Alcoholism and Addiction
- Allergies
- Autoimmune Disease
- Syndrome X and Burnout
- Chronic or Recurrent Infections
- Dental Problems
- Diabetes (Adult Onset)
- Fibromyalgia
- Herpes
- HIV and Hepatitis C
- Hypoglycaemia
- Mild Depression
- PMS and Difficult Menopause
- Rheumatoid Arthritis
- Sleep Disorders

Dr Lee, in his publication '[What Your Doctor May Not Tell You About Menopause](#)' maintained that women, by the time they reached their mid- to late 30s or early 40s had so stressed their adrenal glands that they had nothing left to give.

He argued that when Western women stop making progesterone in their ovaries and their adrenal cortex and brain need to pick up 100 percent of that function to produce corticosteroids, there isn't much progesterone left over for other functions, such as balancing estrogen levels.

The adrenals of many women in Western cultures are so depleted they can't even make enough progesterone to make the corticosteroids. This may be an important factor in chronic fatigue syndrome, which is so common in women in their mid-30s and early 40s.

Amenorrhea - Missed menstrual periods

Amenorrhea means not having menstrual periods.

Amenorrhea is either primary or secondary. Primary amenorrhea is not having menstrual periods by the age of 16. Secondary amenorrhea is the absence of three or more periods in a row in a woman who has had regular menstrual periods.

The most common cause of secondary amenorrhea is pregnancy. Sometimes a breast-feeding mother may not have menstrual periods. Periods may also take 3 months or longer to resume after a woman stops taking birth control pills or stops nursing.

Secondary amenorrhea may also result from:

- emotional stress
- brain injury
- tumour in the brain (pituitary gland), ovary, or adrenal gland, or a cyst in the ovary
- pseudocyesis (when a woman is convinced she is pregnant, but is not)
- depression
- thyroid problems, such as on under-active or overactive thyroid gland
- malnutrition
- vigorous exercise, such as daily or long-distance running
- increased production of the hormone prolactin by the pituitary gland
- drugs, such as tranquilizers and antidepressants
- rapid weight gain or loss
- chemotherapy
- chronic illness (for example, kidney failure, cystic fibrosis, and colitis)
- radiation therapy (especially in the pelvic area)
- Asherman's syndrome, which is scarring of the lining resulting from an infection or surgery such as a D&C (dilation and curettage)
- in some cases, heavy smoking

Smoking may contribute to amenorrhea. A survey study found that young women smoking one pack or more per day were more likely to be amenorrhea than other women.

Long lapses between periods, lasting 6 months or longer, are common with ongoing physical stress. This is particularly the case if you have lost a lot of weight, as with anorexia. It may also happen if you have little or no body fat, as is true for some women athletes.

Permanent secondary amenorrhea occurs after menopause. Menopause may occur prematurely before age 40. Periods also stop after a hysterectomy (surgical removal of the uterus).

Not having menstrual periods is a symptom, not a disease. Other symptoms depend on what is causing the amenorrhea. For example, if you have a hormone imbalance, you may have a lot of body and facial hair, acne, breast milk secretions, a change in voice or sex drive, weight gain, or weight loss.

Frequently, amenorrhea with normal puberty is associated with Polycystic Ovarian Syndrome (PCOS), typically characterized by irregular or absent periods, anovulation, hirsutism, acne, weight gain, insulin resistance, and male-pattern balding that tend to suggest androgen dominance.

Often the cause of amenorrhea is that the ovaries do not release eggs (ovulate). Your ovaries may be releasing the hormone estrogen but not producing progesterone, a hormone necessary for periods to occur. In this case, the usual treatment is physiologic doses of progesterone cream of between 20-30 mgs progesterone per day from day 12 to day 26 to mimic what the body would produce naturally.

Continued exposure to estrogen without the presence of progesterone the last two weeks of our menstrual cycle to 'trigger' a shedding of the uterine lining, places us at risk.

In more advanced cases [of PCOS], high doses of progesterone may be required. Your GP may prescribe a high dose progesterone cream (10% ~ 100mg per 1 gram application) to 'kick start' your period. Your physician, in raising your progesterone levels as quickly as possible with a relatively high dose, is in fact using progesterone's natural anti-estrogen properties to protect you.

To prevent amenorrhea from recurring, examine your lifestyle. Make changes in your diet or activities to maintain your ideal weight, consider herbal support like Vitex (chaste tree), Dong Quai, Maca and/or Tribulus; incorporate vitamin & mineral supplements; avoid cigarette smoking, excessive use of alcohol and mood-altering stimulants or sedative drugs; try to resolve areas of emotional stress and conflict in your life; be moderate in all your activities; try to balance your work, recreation, and rest; and above all maintain a positive outlook.

Given that amenorrhea may also result from potentially serious disorders of the ovaries, the hypothalamus, or the pituitary gland, we strongly suggest you seek out a competent healthcare professional to evaluate your menstrual cycles in relation to your hormone levels, and guide you back to optimal health.

Andropause (male menopause) – Prostate health

Our website has certainly received its share of calls from men interested to learn how progesterone can be incorporated in the treatment of male-related illnesses that are linked to hormone imbalance and male menopause, i.e., benign prostatic hypertrophy (enlarged cells in the prostate gland) or hyperplasia (enlarged by an increase in the number of cells in the gland), commonly referred to as BPH.

Progesterone in men is vital to good health. It is the primary precursor of their adrenal cortical hormones and testosterone. Men synthesise progesterone in smaller amounts than women do but it is still important.

The metabolic actions of the prostate gland are determined in large part by hormones, especially estradiol, progesterone, and testosterone, which are made by the testes. These, in turn, are mediated by pituitary hormones, especially FSH and LH, just as ovarian function is women is.

Both the prostate gland and the uterus develop from the same embryonic cells, and both respond to the same hormones - estradiol, progesterone, and testosterone.

In the same manner, both the ovaries and the testes develop from the same embryonic cells. A fertilised ovum with XX chromosomes develops ovaries and a uterus, while the fertilised ovum with XY chromosomes develops testes and a prostate gland.

Dr John Lee wrote, in his publication *'What Your Doctor May Not Tell You About Prostate Health & Natural Hormone Supplementation'* that in the prostate (and in the hair follicles) is an enzyme (5-alpha-reductase) that converts testosterone into dihydrotestosterone (DHT). Higher DHT levels in hair follicles is a primary cause of male pattern baldness.

He argues that DHT stimulates proliferation of prostate cells, more so than testosterone does, enlarging the prostate gland and narrowing the urethral channel, leading to urination problems, and speculation that elevated DHT is the cause of prostate cancer.

Inhibiting this conversion of testosterone to DHT is often a treatment goal for men with BPH.

Since progesterone is a potent inhibitor of 5-alpha-reductase, the decline of progesterone in aging males plays a role in increasing the conversion rate of testosterone to DHT.

Adding progesterone back into the body helps restore normal inhibition of 5-alpha-reductase, thus preventing testosterone from changing into dihydrotestosterone (DHT), which stimulates proliferation of prostate cells.

Basically, Dr. Lee suggests men undergo progesterone replacement therapy using a maintenance dose of 8-10mg a day and 1-2mg per day of testosterone to protect against prostate cancer.

Men do NOT need to cycle like premenopausal women and can safely take the progesterone daily.

Prostate cancer on the increase

Prostate problems are the fastest-growing health concern among men in Western countries, and the rate of prostate cancer is increasing steadily.

The initiation of normal cells turning into cancer cells is the same for both the breast or uterus and the prostate gland. In these organs, cancer initiation is due primarily to estrogen dominance combined with lifestyle factors and/or toxic insults that predispose estrogen to become oxidised.

The incidence of prostate cancer increases with age. The majority of men in the US will acquire prostate cancer if they live beyond 65. It is a slow-growing cancer (more rapidly growing in younger men, however). For men over 65, the doubling time of a prostate cancer nodule is usually about 5 years. Compare this with the doubling time of a breast cancer nodule, which is about 3 to 4 months. If left untreated, prostate cancer tends to eventually metastasize to bones.

A case of estrogen dominance

Men are often wary of taking progesterone supplementation for fear it will induce female characteristics. This couldn't be further from the truth. It is the hormone estrogen that is responsible for the characteristics of the female body.

In men, estrogen gradually rises with age, while saliva levels of progesterone and testosterone gradually fall with age. Thus, with aging, estrogen dominance occurs.

A clear sign of estrogen dominance in aging men is their tendency to develop breasts. This indicates these men are low in progesterone and testosterone.

We know that the prostate gland responds to the hormones estradiol, progesterone, and testosterone, and that a man's progesterone and testosterone levels fall as he ages. If, however, his estradiol levels continue to remain high he should consider himself in a state of 'estrogen dominance'. And research right now is pointing an accusing finger at estradiol as an initiator and promoter of cancer.

Excess testosterone can spill over and become estrogen, causing water retention, prostate enlargement, atrophy of the genitals, decrease in libido, and cancer.

Being overweight is another factor to consider since fat cells convert into estrogens which then stimulates prostate growth.

As we know from breast cancer research, insulin resistance leads to estrogen dominance and an increased risk of breast cancer. It seems to be that the same pattern occurs in prostate cancer.

Regular exposure to xenoestrogens such as pesticides like home and garden sprays only add to the problem.

Middle aged men are not immune to estrogen dominance that can lead to symptoms such as weight gain, large-than-normal breasts, gallbladder problems, anxiety and insomnia, and prostate enlargement that leads to urinary problems.

Will progesterone help men with osteoporosis? Yes, it will. Progesterone will help build new bone for men in much the same way it does for women.

According to Dr Lee, two studies published in the American Journal of Pathology in 1999 show that estrogen increases prostate cancer, and that progesterone receptors in the prostate are more abundant in cases of more aggressive prostate cancer. Misinterpretation of this type of result is common.

Conventional interpretation suggests that this might indicate that progesterone causes the more aggressive breast and prostate cancers. The truth is that progesterone receptors are made by estrogen. The higher the estradiol/progesterone ratio, the greater are the number of progesterone receptors that will emerge.

This is the tissue's effort to restore proper progesterone function in situations where estrogen dominance is present. Thus, increase of progesterone receptors is evidence of estrogen dominance, and not evidence that progesterone increases the risk of cancer.

Arthritis - Osteoarthritis - Rheumatoid arthritis

Arthritis is a generic Greek word that usually means only that one's joints, or the tissue around one's joints, hurt or are inflamed. It does not refer to any specific cause or any specific mechanism of action. It's more a Greek translation for a symptom than a diagnosis. It is characterized by pain, swelling, stiffness, deformity, and/or a diminished range of motion.

Osteoarthritis involves deterioration of the cartilage that covers the ends of the bones. A degenerative joint disease, osteoarthritis sometimes is caused by injury or a defect in the protein that makes up cartilage. More commonly, it is related to the wear and tear of aging.

Rheumatoid arthritis and juvenile rheumatoid arthritis are types of inflammatory arthritis. Rheumatoid arthritis is an autoimmune disorder - a "self-attacking-self" disease in which the body's immune system improperly identifies the synovial membranes that secrete the lubricating fluid in the joints as foreign. Inflammation results, and the cartilage and tissues in and around the joints are damaged or destroyed.

If your joints ache, or the connective tissue around your joints aches, your doctor is inclined to call it arthritis and prescribe non-steroidal anti-inflammatory drugs (NSAIDs) such as aspirin, ibuprofen, or any of a dozen similar medications. You must realize that your joint aching is not due to a NSAID deficiency, and your doctor's prescription is merely treating symptoms, not causes.

Connective tissue aches and pains have a variety of causes. Some of them include:

- nutritional deficiencies
- repeated trauma of cartilage and the connective tissue that holds joints together
- repeated strain causing microscopic tears in connective tissue around joints and tendon sheaths (like carpal tunnel syndrome)
- inflammatory reactions to these connective tissue strains due to prostaglandin imbalance secondary to dietary choices (like too much milk and meat and not enough foods with omega-3 and omega-6 fatty acids); and
- lack of physiological cortisone responses to check the inflammatory reactions

Painkillers and the so-called NSAIDs are effective in reducing symptoms quickly but often cause serious side effects such as ulcers and gastrointestinal bleeding, and they do not stop the progression of the disease. In the long run they have actually proven to worsen the condition by accelerating joint destruction.

Natural progesterone has anti-inflammatory properties that the synthetic analogues do not have. You can rub progesterone cream or oil directly on the joint or tissue that hurts.

Many women with arthritic or inflammatory problems find, after about 2 years on progesterone, they are reporting significant joint and muscular mobility. And their pain has dramatically reduced, allowing them to resume physical activities that were once restrictive or beyond them.

Many have reported remission of their arthritis with no further progression 3 years on.

Autoimmune disorders

Multiple Sclerosis, Lupus, Hashimoto's Thyroiditis & Graves Disease

Can progesterone help alleviate autoimmune disorders like Hashimoto's disease, Grave's disease, Multiple Sclerosis or Lupus? Autoimmune disorders are those disease states in which your own antibodies attack some gland or tissue in your body. The development of an autoimmune disease may be influenced by the genes a person inherits together with the way the person's immune system responds to certain triggers or environmental influences.

- Multiple sclerosis is a disease in which the immune system targets nerve tissues of the central nervous system. Most commonly, damage to the central nervous system occurs intermittently,

allowing a person to lead a fairly normal life. At the other extreme, the symptoms may become constant, resulting in a progressive disease with possible blindness, paralysis, and premature death.

- Patients with systemic lupus erythematosus most commonly experience profound fatigue, rashes, and joint pains. In severe cases, the immune system may attack and damage several organs such as the kidney, brain, or lung.
- Hashimoto's thyroiditis and Grave's disease result from immune system destruction or stimulation of thyroid tissue. Symptoms of low (hypo-) or overactive (hyper-) thyroid function are non-specific and can develop slowly or suddenly; these include fatigue, nervousness, cold or heat intolerance, weakness, changes in hair texture or amount, and weight gain or loss.

Estriol

The onset of autoimmune disorders occurs most often in middle-aged women - the time of life when estrogen dominance becomes common. Recent studies have shown that women who use HRT containing estrogen (estradiol) are more likely to get lupus. Birth control pills also cause autoimmune diseases by causing the body to form antibodies to its own hormones.

According to Dr Wright, estriol can reduce the risk of and help alleviate auto-immune diseases. UCLA researchers demonstrated that women with MS responded dramatically to large doses of estriol because it stimulated an estrogen receptor known as "estrogen receptor alpha". Estriol stimulates "estrogen receptor alpha" in just the way needed to decrease the symptoms of multiple sclerosis. It's well known that autoimmune diseases like rheumatoid arthritis and multiple sclerosis (MS) often go into remission during pregnancy (when our body manufactures high levels of progesterone and estriol), only to return in force after child-birth.

Correcting estrogen dominance by blocking estradiol estrogen action using estriol in conjunction with progesterone can lead to a gradual improvement.

Cortisol ~ Thyroid

Cortisol, secreted by the cortex of the adrenal glands, suppresses autoimmune reactions. But when the adrenal glands release too little cortisol, the virulence of antigen / antibody reactions is enhanced. Autoimmune attacks on normal body proteins will then proceed swiftly. Adrenal cortical suppression is especially common in patients with hypothyroidism and thyroid hormone resistance. Adrenal function returns to normal in the hypothyroid or thyroid hormone resistance patient after she begins taking enough of the proper form of thyroid hormone. Her increased cortisol level may then slow down or halt autoimmune destruction of her thyroid gland.

DHEA

DHEA is a mild androgen (or male hormone) produced by the adrenal glands, and used by the body to make other powerful hormones including the sex hormones testosterone and estrogen. Researchers have been investigating DHEA's effect on lupus since the 1980s. Studies in humans, so far, have focused on women, who make up 90 percent of those with lupus. Researchers aren't sure of the mechanism by which DHEA affects lupus. But they do have clues. They know that DHEA levels are low in women with lupus, and that DHEA increases testosterone and estrogen levels, along with other hormones. Because DHEA has been shown to increase estrogen and testosterone levels, there's concern it could contribute to existing hormonally influenced cancers, such as breast, ovarian and uterine cancers in women and prostate cancer in men.

Progesterone

It has long been known that progesterone is produced in the central nervous system and that it plays a role in helping nerves communicate with each other. This is why progesterone, like other hormones such as estrogen and testosterone, is related to neurotransmitters, that is, substances that carry messages from nerve to nerve and help run the vast communication network within the body. Researchers found that progesterone is produced in yet another site in the nervous system, in special cells called Schwann cells. These are found in the peripheral nervous system, the collection of nerves that branch off from the central nervous system. In the peripheral nervous system, progesterone may play a previously undetected

role in the maintenance of nerves. Progesterone promotes the formation of the myelin sheath, the fatty substance that surrounds and protects nerve fibres. The myelin sheath is to nerves what plastic insulation is to electrical wires. In multiple sclerosis, a disease of the central nervous system, the loss of myelin results in a breakdown of the nerve signalling system throughout the body. Progesterone is the main precursor to corticosteroids and in progesterone-deficient women, restoration of normal progesterone levels may enhance corticosteroid production, thus suppressing the autoimmune attack.

Bottom Line: If you're suffering from an autoimmune disease, you don't have to wait for all the academic research answers to come in. Bioidentical hormone replacement therapy (BHRT) at physiological doses is, according to research, relatively safe, and, if nothing else has worked for you, it's an option you and your physician should consider exploring.

Premenstrual Syndrome/Tension (PMS/PMT)

Backaches ~ Bloating

PMS is a term which means Pre Menstrual Syndrome (PMS), sometimes referred to as Pre Menstrual Tension (PMT). It refers to a constellation of symptoms that, when combined, form the basis of this diagnostic term. It's a medical term used to describe associated mental and physical problems that occur usually during the second half of the menstrual cycle, although PMS has been observed in many women throughout their cycle.

The main clue in diagnosing PMS is not so much the nature, but the cyclic timing of these symptoms. Symptoms appear around Day 12-14 right through to your period. Some women can display PMS symptoms unabated, even after their period has passed, though a majority will find relief after menstruation commences.

Typical PMS symptoms can include some or all of the following (there are many others, see Estrogen Dominance Symptoms List often associated with menopausal symptoms):

- irritability
- migraine / headaches
- loss of libido
- fatigue
- mood swings
- bloating / fluid retention
- depression
- backache
- lumpy and/or sore breasts
- weight gain

Many women displaying symptoms of PMS are displaying symptoms of estrogen dominance brought about by a lack of progesterone production. Emotional mood swings and irregular bleeding are commonly associated with anovulatory cycles (where no ovulation takes place). If no ovulation occurs during that month, PMS symptoms are usually more severe as there is no progesterone to oppose the estrogen build up (see diagram below).

PMS controversy

There appears to be a general misinterpretation of what these symptoms represent. Doctors believe PMS is caused by estrogen deficiency basing it on the fact estrogen levels drop slightly after ovulation, as it should to make way for progesterone (pro-gestation). For this reason PMS is often treated with estrogen replacement therapy and/or the oral Contraceptive Pill, and viewed as an estrogen deficient condition.

Doctors are assuming that your progesterone levels will surge during the last two weeks of a your cycle. But if you fail to ovulate that month, or produce sufficient levels of progesterone to balance the estrogen, then you will, in fact, be progesterone deficient (thus the term estrogen dominant). That's where PMS kicks in. And you may fail to ovulate ... even at a very tender age. You'd be surprised how many women of all ages fail to ovulate every month.

This might explain why many women respond beautifully to progesterone supplementation. Certainly, it reinforces the theory that maybe, just maybe PMS is an estrogen dominance disease consequent to inadequate progesterone levels. Women report an easing of symptoms with the flow of their period,

when estrogen and progesterone levels are close to zero. PMS subsides only to gradually build again next month.

The treatment approach to PMS is to address estrogen dominance before it sets in. Estrogen dominance occurs mostly in industrialized countries and commonly occurs in the following situations:

- When women are on estrogen replacement therapy.
- Pre-menopause when early follicle depletion results in the lack of ovulation and thus a lack of progesterone well before the onset of menopause.
- Exposure to xenoestrogens which is the cause of early follicle depletion. Xenoestrogens are foreign substances found outside the body in the air and food that have an estrogen effect on the body.
- Birth control pills with an excessive estrogen component.
- Women who have had a hysterectomy (or tubal ligation) leading to dysfunction of the ovaries.
- Post menopause, especially in women who are overweight or suffering insulin resistance.

Unopposed estrogen in our bodies results in all sorts of hormone-related health problems such as PMS, endometriosis, uterine fibroids, infertility, weight gain, increased blood clotting, thyroid dysfunction, even cancer, in both men and women.

In theory and in practice, the best way to treat PMS with progesterone is to work from day 12 if your have a 28 day cycle, or day 14 if your have a 30/32 day cycle. If you build up your progesterone levels from day 12, increasing gradually prior to your period, you will take control of your PMS very, very quickly.

Some women find it necessary to commence progesterone earlier than day 12 purely to overcome the build-up of tension and associated symptoms.

Women usually find that within 3 months of progesterone supplementation their life is back on track.

Bladder function - Urinary tract infection (UTI) – Incontinence

As estrogen levels decrease, vaginal tissues become thinner, drier, and more fragile. This can cause itching and burning, as well as painful sex. In addition, the vagina becomes more alkaline and less acidic, making it more susceptible to overgrowth of bacteria or yeast.

Estrogen loss also causes a thinning of the tissues at the base of the bladder and lining the urethra, as well as a loss of tone in the muscles that control the bladder. The result can be urine leakage and recurrent urinary tract infections (UTIs).

There can be many sources of urinary tract problems. Some women with urinary urgency or incontinence have stretched-out pelvic ligaments and muscles. The most frequent cause of the stretched or weakened tissues are difficult births or multiple births of large babies, followed by hormone imbalance, particularly low testosterone.

Some women with urinary urgency and incontinence have chronic, low-grade inflammation or infection of the urethra. This is particularly true in postmenopausal women, many of whom have chronic recurring urinary tract infections.

Some women develop urinary urgency and incontinence from food sensitivities. In particular, coffee and other high-caffeine products can become irritants to the bladder.

Low dose estriol cream (applied as a vaginal cream) is remarkably effective in preventing urinary tract infections in postmenopausal women. Estriol treatment may result in the re-emergence of friendly Lactobacilli bacteria, and the near elimination of colon bacteria, as well as restoration of normal vaginal mucosa and normal low pH, which inhibits the growth of many germs.

Progesterone also plays several roles in preventing vaginal and urinary tract infections. The presence of progesterone primes estrogen receptors, opposing signs of estrogen deficiency such as vaginal dryness and hot flashes, as well as estrogen dominance symptoms.

When progesterone is restored to normal physiological levels, estrogen receptors become more sensitive and signs of estrogen deficiency disappear.

An average adult urinates about five or six times a day, and a typical urination is about 300 ml, so almost two one-litre bottles daily is the normal output. By middle age it is not uncommon for both men and women to get up once at night to urinate. If you are urinating more often than this, (a condition called "frequency"), it is usually due to either increased urine flow out (which means the body is making more urine than normal) or a decreased bladder capacity (which means the bladder holds less urine than normal).

Several things can prompt the body to make more urine than normal -- especially drinking alcohol and caffeine or taking diuretic drugs. Urinating frequently can also be a sign of diabetes. Decreased bladder capacity is almost always due to an irritation. The biggest offender here is caffeinated beverages, especially coffee, which is a notorious bladder irritant, particularly in women. Switching to decaf is not a solution, because it still contains other irritating components of the coffee bean.

Drinking more rather than less water is generally a good idea here, as it will help dilute irritating factors in the urine. Anxiety can also cause urinary frequency by affecting the nerves that control the bladder.

Blood clots - Cardiovascular disease

Some GPs give their patients the "ok" to use bioidentical estrogen but tell women not to take bioidentical progesterone because it supposedly causes blood clots and heart attacks. When we hear our GP making these claims, we need to be aware that he or she has gotten human-identical progesterone confused with artificial, unnatural-to-the-body progestins.

Artificial progestins are synthetic chemical analogues of progesterone, meaning they simulate some progesterone-like effects, however, make no mistake, they are NOT equal to progesterone.

Artificial progestins have become widely used in birth control pills and in hormone replacement therapy (HRT). Natural progesterone manufactured in the laboratory to match that made by our ovaries has a completely different molecular structure than that of medroxyprogesterone acetate (Provera), or 19-nortestosterone (a common progestin synthesized from testosterone) used in birth control pills.

Here is a list of some of the side effects of artificial progestins:

- Increased sodium and water in body cells
- Causes loss of mineral electrolytes from cells
- Causes intracellular oedema
- Causes depression
- Increases birth defect risks
- Causes facial hirsutism, loss of scalp hair
- Causes thrombophlebitis, embolism risk
- Decreased glucose tolerance
- Causes allergic reactions
- Increases risk for cholestatic jaundice
- Causes acne, skin rashes
- Increases risk of coronary vasospasm
- Is estrogen replacement therapy safe?

Natural progesterone does NOT cause these side effects and, by all accounts, confers protection against estrogen-induced strokes and cardiovascular disease.

So what about estrogen replacement therapy? Is it safe?

Yes and no. Of the three estrogens our body makes (estrone, estradiol, estriol), estradiol and estrone can increase the risk of death due to deep vein thromboembolism - the formation of life-threatening blood clots in the veins. Estriol, on the other hand, has apparently very little effect on the blood-clotting factors. So be careful what form of natural estrogen your doctor prescribes if blood clots and heart attacks are a health concern for you.

A research paper '[Topical Progesterone Cream Does Not Increase Thrombotic and Inflammatory Factors in Postmenopausal Women](#)' concluded that topical progesterone cream administered in a daily dose of 20 mg. significantly relieved menopausal symptoms in postmenopausal women without altering pro-thrombotic potential.

Blood pressure - Hypertension

Progesterone can be used in conjunction with your anti-hypertensive drugs providing you do so under strict supervision of your doctor. Too much estrogen in our body will cause the retention of fluid made up of sodium and water, and the subsequent loss of potassium and magnesium. Hypertension or high blood pressure is the end product.

Progesterone supplementation can help eliminate this sodium and water influx into cells (intracellular oedema or water retention). In other words, when progesterone is introduced into the body, weight goes down (excess water is excreted), and blood pressure returns to normal.

Progesterone also exerts an anti-spasmodic influence of blood vessels. In fact, progesterone appears to have a protective effect against hypertension. Reports have indicated that a reduction in the dose of anti-hypertensive drugs has been necessary over a period of time, and in some cases, medication was halted altogether because blood pressure had been restored to normal.

This may not be the case if you are taking the Contraceptive Pill. The Contraceptive Pill contains artificial progestins that can also cause water retention, often accompanied by hypertension. Natural progesterone cream will be rendered ineffective because synthetic progestins compete for, and bind to progesterone receptors thus inhibiting the action of natural progesterone.

Please note, there is a potential interaction with progesterone and the group of medications known as beta blockers. This interaction may cause an increase in the resistance to blood flow in the hands and feet. The result may be an increase in the side effects of the beta blocker, especially the cold hands and feet.

We stress that this website has NOT received reports of this effect as yet, but the potential is there.

Keep in mind also that blood pressure changes may be due to physiological effects or other reasons unknown so keep your doctor informed at all times. You might be interested to learn that studies have shown that people living near the equator are less likely to have hypertension. It's a fact, blood pressure tend to be higher in winter, when we get less sunlight, which our body uses to synthesise vitamin D. By all accounts and observations, vitamin D may be nature's leading blood pressure regulator.

Bone Density - Osteoporosis

Osteoporosis presents itself very subtly in the body and its changes can be marked by dry skin, brittle finger nails, sometimes receding gums and lower back pain. Of course there can be other things like spontaneous fractures or easily occurring fractures, shrinkage in height and, for older women, the appearance of a "dowager's hump".

A bone mineral density (BMD) test measures the mineral density in the bone by bouncing a dual photon beam of light off the bone, measuring the difference in the density between bone and soft tissue. This shows how porous the bones have become and at what risk you are of having a fracture or degree of osteoporosis.

Many woman have started to lose bone after age 30 so it's a good idea to have a bone density test quite young, maybe 35, to have a base level to compare with later on.

Evidence suggests women take three (3) consecutive bone mineral density tests with the same machine for three (3) years and then make a decision based on those results, incorporating other precautionary factors such as good diet, progesterone supplementation, and avoid the risk factors that contribute to osteoporosis.

Why suggest 3 bone mineral density on the same machine? Because there can be slight errors on the machine and if there is a plus or a minus either side, the third one usually shows an average result of the bone mineral density outcome. It can also take more than three years to rebuild bone.

Some Risk Factors of Osteoporosis Include:

- Hormone imbalance
- Smoking / substance abuse
- Body type / build
- Antacids

- Tea & coffee consumption
- Family history, diet and lifestyle
- Cortisone
- Stress
- Vitamin D deficiency - lack of sunlight

Our bodies go through a continuous bone-building cycle, in which old bone is broken down and new bone is formed. This balanced process keeps our skeleton healthy and strong.

Osteoporosis is caused by an imbalance in this cycle, in which too much bone is broken down and not completely built.

The late Dr Lee gave us a perfect analogy of the two phases involved in keeping our bones strong. He suggests we think of the two players in bone integrity as 'pacmen'.

One class of 'pacmen' are the osteoclasts that move to various parts of your bone to find old bone and dissolve it away (bone resorption). Once this is completed, the other 'pacmen' called osteoblasts move on it to start building new bone (new bone formation).

Then your body goes into a resting phase where your bones remain good for a certain length of time before it gets old and crystallises and our pacmen get back to work.

We know that the onset of osteoporosis correlates with hormone imbalance in both women and men. Osteoporosis is often referred to as a disease of estrogen deficiency, and is usually medicalised as a disease occurring at menopause.

The fact that a female's bone loss starts in her mid thirties when estrogen levels are high indicates that estrogen does not totally prevent bone loss. Estrogen will slow the rate of bone loss by slightly poisoning the 'osteoclasts' thereby slowing down resorption, but it DOES NOT reverse it.

What does appear to correlate here is progesterone levels. When a woman reaches her mid thirties, she may fail to ovulate every period (anovulatory cycle), leading to a decline in progesterone production.

It's interesting that osteoporosis begins to set in 10 to 15 years before menopause around the time a woman begins to experience a deficiency in progesterone. The most important factor in osteoporosis is the lack of progesterone, which causes a decrease in new bone formation.

Evidence suggests that progesterone receptors are present in osteoblasts and that adding progesterone will actively increase bone mass and density and can reverse osteoporosis. Some doctors prescribe conventional HRT in the form of combination estrogen and artificial progestins, or even estrogen alone (if you no longer have an intact uterus).

We know that estrogen can retard bone resorption, however, the accumulated old bone is not good bone and results in an increase in hip fracture. A marked decline in estrogen levels at menopause can accelerate bone loss initially then, after a few years, this will plateau out again.

Given that many women are making adequate estrogen via their fat cells, muscle cells, and skin, progesterone alone may be sufficient to prevent and/or reverse osteoporosis.

Artificial progestins used in conventional HRT are not identical to the progesterone made by a woman's ovary, and therefore do not do the same work in bone building. In fact, artificial progestins may prevent any real progesterone that may be circulating in the body from occupying bone-building receptors, negating any bone-building benefits as both compete for the same receptor site.

Chronic stress may cause high cortisol levels in the body that also interfere with bone building. Steroids, like prednisone, are often prescribed to reduce inflammation from a variety of medical problems. These medicines may be essential for a person's medical treatment, but they have potential side effects, including decreased calcium absorption.

Progesterone at doses of 15-25mg per day (that is can be safely continued through to old age) has been shown to stimulate new bone formation, and is a vital link in a chain of multiple factors which together are necessary for good bone building.

Breakthrough bleeding - Change in menstrual cycles

It is quite common when a woman first starts progesterone to have a breakthrough bleed and the appearance of another period. This is often the result of cell receptor 'wake up' and influence on the uterine lining and receptor cells. Such activity can bring on a bleed.

Women need not be concerned about this unless it is heavy (haemorrhaging), constant, and/or causing pain that leaves you feeling concerned.

Many, many women report 'wake up' bleeding as being one of the first things that may happen when they start progesterone. It represents positive activity in the body.

The Natural-Progesterone-Advisory-Network.com website refers to this 'first' bleed as the 'pretend' period, indicating the positive impact and presence of natural progesterone.

However, we do hear from women who report too many irregular breakthrough bleeds. They cannot establish a regular cycle and are still feeling quite estrogen dominant with associated symptoms.

Our experience has led us to believe that often unsuitable creams can do this. We suggest that if there is more than one breakthrough bleed and your period becomes erratic rather than stabilising within a four month period, then you seriously need to reassess your cream base.

Progesterone balances the effects of estrogen on the uterus and it is necessary to produce regular periods, so if these periods are not being regulated, we suspect there is something wrong with your progesterone cream. If in doubt, stop the cream for a month before you try another brand (if all your prior tests are negative, showing no signs of fibroids, etc).

Incorporate phytoestrogens into your diet, and ALWAYS make sure your GP investigates thoroughly to rule out anything sinister.

Menstrual cycles have been known to lengthen or shorten while on progesterone treatment. We generalise with women and state that as long as there is a regular cycle occurring with a rhythmic break from cream, then your periods will come and go according to your unique profile, varying slightly by a day or two, here and there.

Stopping progesterone cream is not necessarily going to bring on a period if it's not ready to come. However, if your body is primed for a period, it will arrive within 24-36 hrs. Breaks are important - it keeps your cycle mimicking nature, and allows the receptors to up-regulate (refresh).

For women who no longer ovulate or perhaps their periods are winding down, or they are battling severe diseases like painful endometriosis, severe migraines and/or PMS, polycystic ovary syndrome, or fibroids, need to use higher doses or stay on cream longer.

These high doses will not down regulate providing you break from cream each month to stimulate cell receptors and your body is, in fact, utilising these levels. If you do not take even short breaks (3 days minimum) it will render progesterone's work in the body ineffective.

Breast Cancer - Ductal Carcinoma in Situ (DCIS)

Breast cancer is a major health issue. It is the most common cancer-related cause of death in women in Australia. One in twelve Australian women will develop the disease and each year many women die from it.

World-wide about 1,670,000 women have breast cancer. And in North America, a woman dies of breast cancer every 12 minutes!

Your risk of surviving malignant breast cancer is just about the same as it was 50 years ago, when the only treatment was mastectomy; about one in three. In other words, despite billions of dollars in research and hugely expensive and risky treatments, the conventional medical approach to breast cancer isn't working, and talk of prevention is virtually nonexistent.

The incidence of breast cancer is steadily rising and the numbers are appalling. Between 1973-1998 the incidence of breast cancer rose by over 40%.

Yet despite being the leading cause of death among middle-aged women in the USA, only 5% of the National Cancer Institute's budget is allocated to research and cancer prevention.

Women who are in their mid-thirties to mid-forties (premenopausal) have the highest escalating risk of breast cancer. In other words, your risk of having breast cancer increases the most steeply in these years. After menopause, however, your estrogen levels drop significantly and so, too, does your risk of breast cancer.

The fat in your breast tissue can also be more dangerous at age 60 than at age 20 because you've had more time to accumulate and retain toxins within the fat tissues of the breast.

However, in some countries the risk of breast cancer after menopause is very low, possibly attributed to less exposure to environmental estrogens and HRT, or diet, or a more active life.

Premenopausal women start to have cycles in which they don't ovulate, or in which they ovulate but don't produce adequate amounts of the hormone progesterone. They still make the hormone estrogen and bleed each month, but because their body does not manufacture enough progesterone, estrogen goes 'unopposed'.

Progesterone deficiency has been linked to an increased risk of cancer, while normal levels of progesterone in the body actually help protect you against some forms of cancer.

Dr. David Zava, Ph.D., Hormone expert and Co-Author, '[What Your Doctor May Not Tell You About Breast Cancer](#)' writes: "Most oncologists and general practitioners that work with natural progesterone find that primary breast cancer, and breast cancer recurrences are less frequent in women using topical progesterone, but it does happen. My experience, in reviewing pathology reports from women who have developed breast cancer while using topical progesterone, is that they usually have tumours that do not contain progesterone receptors, or the receptors are very low."

Of course, women with breast cancer need to be supported in demanding their right to be fully informed about the treatments they receive, and to be able to refuse treatment if they - through education or intuition - feel it's wrong for them, without being "disowned" by the medical system.

Ductal carcinoma in situ

The name - ductal carcinoma in situ, meaning "a cancer within the duct" - is, according to Dr John Lee and Dr David Zava, ambiguous. The in situ means the pathologists saw abnormal cells scattered here and there throughout a field of normal cells. Literally the phrase means "in place," indicating no penetration of the deeper layers of cells. But invasive or infiltrating carcinoma, by its very definition, invade the deeper tissue, while DCIS is contained within the duct. If DCIS becomes even the tiniest bit invasive, then it's automatically no longer considered DCIS.

DCIS is generally detected by a mammogram. Cancer cells inside the ducts appear on the mammogram, and may appear along with tiny specks or calcifications - the build-up of material left from dead cancer cells.

There are many grades of DCIS, most of which are virtually benign, but a few of which have a slightly higher risk than normal of leading to invasive breast cancer.

The calcium deposits and scatterings of abnormal cells found in most DCIS are probably the result of some underlying metabolic dysfunction - the debris of a battle and not a real cancer. If they occur in one breast, they're likely to show up in both breasts. This is another sign that the problem is a systemic metabolic dysfunction and not a random local incident.

In their groundbreaking publication '[What Your Doctor May Not Tell You About Breast Cancer](#)' Drs John Lee and David Zava write, "It makes sense that if DCIS is the result of an underlying metabolic imbalance, and the imbalance isn't corrected, it will come back. Recurrence isn't a real issue with most cases of DCIS - which is essentially a benign condition - and therefore to risk permanently damaging the body with radiation may be a grievous over-treatment. A recent meta-analysis of studies of radiation for breast cancer clearly demonstrated increased risks of dying from the radiation compared to the breast cancer itself - in good part due to the negative effects of radiation on the blood vessels and heart."

DCIS that is low grade, small celled, and without necrosis (dead and dying tissue) is less likely to become invasive, especially if you correct the underlying imbalance that caused the problem in the first place.

On the other hand, the more aggressive types of DCIS, which are high nuclear grade, large celled, and with comedo-type necrosis, have more potential to become invasive, and you should have them removed. These types of analyses can only be done in partnership with a trusted physician or oncologist, and preferably with a second opinion.

Most oncologists and general practitioners that work with natural progesterone find that primary breast cancer, and breast cancer recurrences are less frequent in women using topical progesterone.

Breast soreness / pain - Fibrocystic breasts

The term Fibrocystic Breast Disease refers to a benign (non-cancerous) condition of the breasts of many women.

Women with fibrocystic breasts usually have soft, moveable lumps in their breasts which may become very tender around the time of their period. After a woman has her period, the symptoms go away until just before the next menstrual period.

Because this is a rather common condition for about 1 in 5 women, and because it is benign, the term "disease" is not really appropriate.

Many medical professionals use different names to refer to this same condition. Other terms which you may hear include: fibrocystic breasts, fibrous breast tissue, cystic breasts, or dense breast tissue.

Progesterone balances the effect of estrogen upon the breasts (and uterus) and, therefore, has an influencing role in reducing breast pain and lumpiness. Improvement is usually within a 2-3 months once you commence progesterone replacement therapy.

Our breasts are extremely responsive to hormone fluctuations, some more than others. If you're one of these women, allow your breast messages to help you fine-tune your hormones. Learn to listen to your body. Let your breasts be your barometer to guide you with your hormonal balancing. In fact, many women use their breasts to assess and individualise their progesterone dosage.

We note here that progesterone will not resolve calcified breast lumps (benign) as some women have discovered. But overall their breast tissue has softened.

Progesterone deficiency has been linked to an increased risk of breast cancer, while normal levels of progesterone in the body actually help protect you against some forms of cancer. Whilst not a cure for cancer, progesterone can dramatically decrease cell multiplication rates, providing women with a degree of protection against estrogen-driven cancers like breast cancer.

Swollen, lumpy, tender breasts generally correlated with estrogen dominance (high estrogen, low progesterone).

This generally occurs during the last 7 to 8 days of the menstrual, just before menstruation, and is primarily due to estrogen dominance over a prolonged period of time. This is a sign that your ovaries are not producing enough progesterone.

Breast fibrocysts respond remarkably well to topical progesterone, a fact which the French first recognised some 30 years ago.

Women can expect a pronounced change in your breasts within a few weeks of introducing progesterone cream, particularly if you've suffered severe PMS for many years.

Some women are actually 'frightened' by this experience when introducing natural progesterone for the first time. But to have such a painful and unsettling experience two weeks into progesterone supplementation is not as rare as one might think. There are stages of natural progesterone's action in the body that women need to be aware of.

For example, we call the first 10-12 days of progesterone supplementation Estrogen Dominance Wake-up Crisis. As a consequence of reintroducing progesterone back into the body and thereby sensitising and stimulating the estrogen receptor sites, some women can actually go through a roller coaster of symptoms that may be quite frightening and debilitating unless they understand the reasons why.

Some of the more common symptoms reported can be increased PMS, breakthrough bleeding (spotting) or the onset of a very heavy non-cyclic period, increased tenderness of the breast, headaches ranging from unrelenting dull headaches to severe migraines, uncontrollable hot flushes, fluid retention, anxiety, teariness, aggravation, irritability and aggression, panic attacks, increased joint and muscle pain, exacerbation of thrush, impetigo, acne, weight gain, lethargy, palpitations, heartburn, and so on.

These symptoms are intrinsically connected to the 'waking up' of high levels of estrogen in the body that have, up until now, down-regulated due to the absence of progesterone.

Estrogen and progesterone are a pigeon-pair, each requiring the other to stimulate or 'prime' its activity in the body. That's why it's so important to maintain the correct balance between all our endocrine hormones.

As a result of this severe wake-up where the symptoms of estrogen dominance are exaggerated, women may want to double their recommended dose for the first 6-8 weeks in conjunction with a supporting herbal formulation to over-ride this phase.

Women may need to supplement evening primrose oil or borage oil during these early stages of progesterone therapy. These oils act as a natural anti-inflammatory to help ease the more severe symptoms that tend to persist until progesterone has time to oppose estrogen in the body, usually over three menstrual cycles.

You may also try swapping brands, perhaps opting for a cream that is free from additional hormones, herbs and alcohols.

Always seek medical advice to investigate suspicious lumps around the breast area or under the arms.

A baseline investigation would have been beneficial to determine hormone levels, and periodic salivary profiles taken thereafter to monitor and adjust hormone replacement therapy.

It is our aim is to most decidedly paint a realistic expectation of natural progesterone's action in the body.

Some women, using their own unpleasant experiences, conclude that progesterone "is not that safe at all." That progesterone "even in small doses, is not the solution." Actually, the reverse appears to be true. It's imperative we keep in mind that our 'risk' of some cancers such as breast cancer is determined by our overall exposure to estrogen during our lifetime. In fact, almost all the important human cancers that we get in Western civilization, have the same origin, which is estrogen. While we remain in a state of estrogen dominance, we are at risk. Maintaining a healthy progesterone-to-estrogen (estradiol) ratio may offer us a degree of protection.

Professor Zava would have us appreciate that, "Some women need to work on further lowering the estrogen burden, prior to progesterone supplementation, with exercise, stress reduction, better diet (higher fiber, lower red meat), herbs, and extracts of cruciferous vegetables (these allow for metabolism and clearance of estrogens down safer pathways that will help prevent symptoms and potential damage to DNA of breast cells)."

Our reader Dianna writes, "One day, I called in sick because my breasts had ballooned so large that it too painful to sit up and I had nothing to wear! It was during this time that I found a breast lump that we eventually decided to remove, only to find that it was not malignant, after all. I have since changed my diet to enhance the benefits of the progesterone and I almost never need pills for headaches, I never have pain with my monthly cycles, my moods don't swing so drastically, and the lump in my breast has disappeared! I can't believe it! It's wonderful, and my new husband is very happy with my high energy and always positive attitude."

Cold hands & feet - Thyroid function (hypothyroidism)

The thyroid gland, largest of the endocrine glands, is the body's metabolic thermostat. It regulates body temperature and the rate of energy production, which greatly influences the rate at which all body organs function.

This butterfly-shaped gland, located close to the windpipe, secretes two hormones: thyroxine (T4) and tri-iodothyronine (T3).

Approximately 93% of the thyroid gland production is T4 with 7% T3.

Secretion of thyroid hormones is regulated by thyroid-stimulating hormone, secreted by the pituitary gland in the brain. The thyroid gland also secretes a hormone called calcitonin, involved in calcium metabolism.

Although all the body's hormones interact, there is a closer than usual relationship of thyroid to ovarian hormones. Most commonly, as a woman approaches menopause, estrogen excess or progesterone deficiency tends to cause a hypothyroid state.

Progesterone deficiency, for example, can cause fatigue, weight gain, irritability, depression, memory and concentration problems, headaches, irregular and painful menstrual cycles, fluid retention, loss of sex drive, and cold hands and feet. These same symptoms are also characteristic of hypothyroidism and thyroid hormone resistance.

Emerging evidence suggests the symptoms of hypothyroidism occurring in patients with progesterone deficiency become less so when progesterone is added and hormone balance is achieved. In other words, progesterone supplementation can play a major role in balancing our hormones which can very likely include improved thyroid hormone function.

Many women suffering estrogen dominance are taking thyroid supplements that, when progesterone is introduced and estrogen dominance is corrected, can often reduce or eliminate thyroid medication altogether. Therefore, if you have been diagnosed with a thyroid problem, are on thyroid medication and now want to incorporate natural progesterone into your regime, there's no reason why you can't providing you do so under the strict supervision of your treating physician.

Your thyroid medication, however, may require regular adjustment as progesterone exerts an influence upon the thyroid gland (progesterone may cause a potentiation of thyroxine's effects leading to hyperthyroidism).

"I am 41 and the idea of someone my age taking hormones had never occurred to me before. I had a number of estrogen dominant symptoms, as well as low thyroid issues. I began using natural progesterone cream in November of 2003. It is now August of 2004 and I can honestly say I have never had more energy in my adult life than I have had in the past 9 months." ~ Jennifer ~

"I'm aged 46, have been on hypothyroid medication since I was 21, (low thyroid levels). It's been two years now, and I think the fertility endocrinologist is as impressed as I am with the result of the progesterone cream!" ~ Carolyn ~

Contraception

Theoretically, a surge of progesterone in the body, prior to ovulation, would 'trick' the biofeedback mechanism between the hypothalamus, the pituitary gland, and the ovaries that ovulation has already occurred, thus inhibiting ovulation. And without an egg being released from either ovary, conception cannot take place.

But this is in theory only. We don't know what safe level of topically applied progesterone would be required to inhibit ovulation for the purpose of contraception. Dr Dalton maintains 100mg (10%) progesterone applied from Day 8 until menstruation should be adequate for contraception, increasing dosage if you have a history of PMS.

Just be mindful of the fact that progesterone primarily enhances a woman's fertility. When applied at high doses PRIOR TO ovulation, you can potentially create a pseudo-pregnancy state that would suppress ovulation. But until more conclusive evidence is available, we advise women NOT to rely on progesterone supplementation as a form of contraception.

We believe, sometime in the future, natural progesterone will be developed as a natural form of contraception just as it is now being administered in fertility clinics to help sustain pregnancy.

Please note you cannot use the Contraceptive Pill and natural progesterone concurrently and get good benefits, since both will compete for the same receptor sites. And progestins used for fertility control (OCC) are NOT natural-to-the-body progesterone. They have two very different molecular configurations. Progestins (in The Pill) are designed to stop fertility whereas natural progesterone made

by the body enhances and maintains conception. Having made the distinction, you can see why the two are not compatible when used together.

Some of the women on natural progesterone cream have resorted to using *The Morning After Pill* for the purpose of abortion.

It has been observed that women experience a huge step backwards as a result of the high levels of progestins introduced into the body, short term. The effects have varied with each woman. It's difficult to determine how long it takes for the progestins to move off the receptor sites to allow progesterone access once again.

Women have asked us if they should stop progesterone when using *The Morning After Pill*, and we suggest they continue on with progesterone supplementation as usual, otherwise it could cause a greater disruption to their cycles.

Contraceptive Update: Does progesterone increase HIV?

Hormonal contraceptives provide effective protection against pregnancy, but offer virtually no protection against STDs (sexually transmitted diseases), including HIV.

A recent animal study has raised questions about the connection between hormonal contraceptives and the risk of HIV infection.

The finding raises the possibility that contraceptives containing progestins, which are synthetic versions of the natural hormone progesterone, may increase the risk of acquiring HIV infection among humans. Oral contraceptives, injectables, Norplant and the LNG-IUD contain progestins.

Artificial progestins, which are synthetic versions of the natural hormone progesterone, are used in all hormonal methods. While several studies have attempted to explore the relationship between HIV infection and progestin-containing contraceptives, the relationship remains unclear.

Some researchers suggest the possibility that certain physiological changes that may be caused by progestin use may increase susceptibility to HIV. These include, for example, the thinning of the vaginal lining.

Predicting ovulation for contraceptive purposes

During a woman's menstrual cycle, there are only about 3 days (72 hours) when her egg is available for fertilisation. Sperm can survive up to 72 hours (3 days) in the vagina and uterus, so if sexual intercourse occurs up to 3 days before a woman is fertile, she can still potentially become pregnant. Thus, there are about 6 days per month (3 days prior to fertility, and 3 days of fertility) that a woman can conceive.

There are devices on the market now that [detect fertility](#) through saliva method. This fertility detector device is a hand-held mini-microscope about the size and shape of a lipstick holder.

It is scientifically well established that hormones filter into saliva and that during fertility a 'ferning' pattern can be seen in saliva under a microscope. Just prior to or during fertile days the sample will typically resemble "ferns" while during non-fertile days, only random and shapeless 'dots' will be visible.

Cycle awareness can be especially helpful for women who tend to have anovulatory cycles (no ovulation occurs, infertility results, no progesterone is made by the ovary). If you know that you haven't ovulated in any given cycle, and thus your ovary won't be producing progesterone, you can then supplement with progesterone that month and avoid estrogen dominance symptoms such as PMS.

These kits come with a life-time guarantee, and can be used over and over again unlike the conventional urine tests to determine fertility that tend to be expensive, messy, and can only be used once.

Advantage of [Fertility Detector Devices](#):

- Lets you know 1 -3 days before you ovulate
- Reusable for 1 year
- 98% Accuracy
- Easy to use

- Anytime, Anywhere
- No complicated charts
- No messy applicators
- Nothing else to buy
- Sold in over 30 countries since 1995
- Recognized by the OBGYN Community
- FDA Approved for Sale in USA

Menstrual cramps - Dysmenorrhea

Menstrual Cramps, otherwise called Dysmenorrhea, a Greek word for painful menstruation, is classified as primary (from the beginning and usually lifelong) or secondary (due to some physical cause and usually of later onset).

Menstrual cycles last about 28 days (cycles of 23 to 35 days are usually considered normal as well). During this cycle, the hormones estrogen and progesterone send messages to the lining of the uterus. About day 5 of the cycle, the estrogen causes the lining of the uterus to grow and thicken. Around day 14, an egg is released from the ovary. After this, progesterone causes the glands to release nutrients and blood vessels swell to prepare for the possibility of pregnancy. If the egg is not fertilized, it moves to the uterus and is absorbed or disintegrates. Estrogen and progesterone levels decrease and the lining of the uterus breaks up and is shed as menstrual fluid.

The uterus, like other muscles, contracts and relaxes. Most of these contractions are not even noticed, but strong ones can be painful. During menstruation, the uterus contracts more strongly than at other times and produces the uncomfortable feeling we know as menstrual cramps.

There are two different types of menstrual cramps.

Primary Dysmenorrhea

Prostaglandins, natural substances made by cells in the uterine wall, make the muscles of the uterus contract. Strong contractions cut off blood and oxygen supply temporarily and cause extreme pain. This pain is known as primary dysmenorrhea.

Primary dysmenorrhea is not a sign that something is wrong. It frequently begins during adolescence, but could begin later in life. Frequently, it disappears after a full-term pregnancy.

Secondary Dysmenorrhea

This differs from primary dysmenorrhea in that the pain lasts longer than the usual 2-3 days during the monthly flow. It may also occur during other times of the month. This is typically an indication of an underlying cause of the pain, such as endometriosis or pelvic inflammatory disease

The most common causes of infections are endometriosis (tissue from the lining of the uterus implants outside the uterus) and adenomyosis (benign growths in the uterine walls), and adhesions (scarring or adherence of two surfaces).

The treatment of secondary dysmenorrhea depends on its cause. There are a number of underlying conditions which can contribute to the pain including:

- Endometriosis (cells from the uterine lining that have escaped to other areas of the body)
- Uterine Fibroids (non-cancerous uterine growths that respond to estrogen levels)
- Adenomyosis (a benign condition in which the cells of the inner uterine lining invade its muscular wall, the myometrium)
- Pelvic inflammatory disease (PID)
- Adhesions (abnormal fibrous attachments between organs) or
- Use of an intrauterine device (IUD) for contraception

All of these conditions should be first diagnosed by a physician who will then recommend the appropriate treatment.

Premenstrual syndrome (PMS), irregular menstruation, menstrual cramps and a tendency toward miscarriage may be at least partially caused by an imbalance of these two hormones - too much estrogen and too little progesterone.

If a woman begins to experience changes in her menstrual cramps, such as severity, timing, or location, she should consult her physician, especially if the changes are of sudden onset.

Cholesterol

There is a common myth that eating cholesterol causes cholesterol levels to rise, but the truth is that eating too many refined carbohydrates such as sugar and white flour can cause cholesterol to rise. Some 75 percent of our total cholesterol is made from these foods rather than from cholesterol intake per se.

A rise in cholesterol levels has more to do with how much sugar and refined starch we eat, whether we're getting enough fiber, vitamins, and minerals in our diet, how much we exercise, and what our stress levels are. Genetics also play a large part in cholesterol levels.

The body uses cholesterol to assist in the manufacture of hormones or vitamin D and to build cell walls and to produce bile, which breaks down other fats. It is carried through the bloodstream by lipoproteins. Lipoproteins are proteins that wrap around both cholesterol and other fatty materials and transport them through the bloodstream.

High-Density Lipoproteins (HDL)

"Good" cholesterol moves easily through the blood and are actually beneficial to the body. They are stable and do not stick to artery walls. They help to prevent heart disease carrying cholesterol away from the arteries and back to the liver where the process of their removal from the body begins.

Low-Density Lipoproteins (LDL)

"Bad" cholesterol, LDLs contain more fat and less protein than HDLs. LDLs are unstable; they tend to fall apart. Rather than being removed from the body by the liver, they stick to artery walls and contribute to plaque build-up. This can eventually lead to hardened arteries (atherosclerosis) or coronary artery disease. Therefore high levels of LDLs are strongly associated with increased risk for heart disease.

Smaller amounts of cholesterol may travel in very low-density lipoproteins or another type of lipoprotein called chylomicrons (which are rich in triglycerides). Many people with high levels of 'bad' cholesterol also have high triglycerides levels because both types of fats have similar risk factors (e.g. obesity and diabetes).

Cholesterol makes progesterone

Progesterone is made from the sterol pregnenolone, which is in turn made from cholesterol, which is made from acetate, a product of the breakdown of sugar and fat in the body.

Progesterone is needed for the appropriate and balanced supply of all the steroid hormones. From progesterone are derived not only the other sex hormones, including the estrogens, but also the corticosteroids which are essential for stress response, sugar and electrolyte balance, and blood pressure, not to mention survival.

Too much estrogen (estrogen dominance) in our body will cause the retention of fluid made up of sodium and water, and the subsequent loss of potassium and magnesium. Hypertension or high blood pressure is the end product.

Progesterone supplementation can help eliminate this sodium and water influx into cells (intracellular oedema or water retention). In other words, when progesterone is introduced into the body, weight goes down (excess water is excreted), and blood pressure returns to normal.

Progesterone also exerts an anti-spasmodic influence of blood vessels.

In fact, progesterone appears to have a protective effect against hypertension.

Chronic fatigue syndrome – Fibromyalgia syndrome

In the context of metabolic health, hormone balancing is a vital component. Poor metabolic health affects different people in different ways, resulting in a variety of symptoms.

For example, the most prominent symptoms of some people are chronic widespread aches and pains. These people's doctors are likely to give them the diagnosis of "fibromyalgia."

The main symptoms of other people are lethargy and fatigue. Their doctors may diagnose their condition as "chronic fatigue syndrome."

Still other people may have depression, and others poor concentration and memory.

Dr. John C. Lowe, a fibromyalgia, thyroid, and metabolism researcher is a board certified pain management specialist and Director of Research for the Fibromyalgia Research Foundation. He has spearheaded the scientific study of two related subjects: the metabolic bases of fibromyalgia, and the metabolic rehabilitation of fibromyalgia patients.

Dr Lowe's impression is that most doctors and researchers don't know that too little thyroid hormone regulation of cells in the brain stem and spinal cord can induce and sustain pain. When a hypothyroid patient is under-treated or denied treatment with thyroid hormone (the standard provisions of conventional medicine), and his main hypothyroid symptom is chronic, widespread pain, his doctor is likely to diagnose his pain as "fibromyalgia."

After the fibromyalgia diagnosis, conventional treatment will follow. This will entail various medications that don't correct the underlying cause of his pain (hypothyroidism) and that are largely ineffective. Through conventional care, a patient's health is likely to deteriorate further over time – partly from his continuing hypothyroidism and partly from the adverse effects of conventional medications.

As Dr Lowe announced in France, in most cases, fibromyalgia is caused by inadequate thyroid hormone regulation of cell function. The inadequate regulation results from thyroid hormone deficiency and/or partial cellular resistance to thyroid hormone. Rigorous logical analyses of the available scientific evidence, says Dr Lowe, make it clear that this is the most plausible explanation of the cause of fibromyalgia.

Throughout '[The Metabolic Treatment of Fibromyalgia](#)', Dr. John C. Lowe demonstrates that other proposed explanations of the cause of fibromyalgia (such as the serotonin deficiency hypothesis) are false. Other metabolism-impairing factors may also induce and sustain symptoms that lead to a diagnosis of fibromyalgia.

All that is necessary is that these other factors impede the metabolism of the tissues from which fibromyalgia symptoms and signs arise. Such factors include a diet that contributes to impaired carbohydrate metabolism, B complex vitamin deficiencies, the use of beta-blocking drugs, and physical deconditioning.

One such factor may not be enough to induce fibromyalgia symptoms. However, combinations of the factors may be sufficient. The fibromyalgia symptoms of most patients are caused by a combination of such factors combined with inadequate thyroid hormone regulation of their tissues.

Leon Chaitow, ND, DO., Senior Lecturer, University of Westminster, London, United Kingdom, and author of "Fibromyalgia and Muscle Pain" makes the following comments:

"Evidence is growing that a combination of genetic and environmental factors can cause hypothyroidism and/or cellular resistance to thyroid hormone. The metabolic crisis that follows, often in people with apparently normal thyroid function tests, appears to be a key element in the etiology of a wide range of chronic health problems. The existence of cellular resistance to insulin is now generally accepted as an etiological feature of some people's diabetes mellitus, and Dr. John Lowe has detailed compelling scientific evidence for a similar process in a significant percentage of cases of fibromyalgia and chronic fatigue syndrome."

Dr Lowe's latest publication *Your Guide to Metabolic Health* provides the essentials patients need to know to overcome their health problems caused by slow metabolism. The steps to improvement or recover can work whether the patient has hypothyroidism, thyroid hormone resistance, nutritional deficiencies, poor

diet, low physical fitness, drugs that impair metabolism, or a combination of these metabolism-impairing factors.

Guided metabolic rehabilitation is a process in which a patient gets control of, or eliminates, all the factors that are impeding his or her metabolism. Here are the nine most common factors that cause hypometabolism. It's important to remember that the first one can cause or influence many of the others.

- Under-regulation by thyroid hormone
- Too little cortisol
- Sex hormone imbalance
- Nutritional deficiencies
- Unhealthy diet
- Chemical contaminants
- Low physical fitness
- Untreated physical problems
- Troublesome drugs

As you can see, sex hormone imbalance is on this metabolic rehab checklist. Thyroid hormone powerfully regulates sex hormones in men and women, and imbalances of the hormones are common in hypothyroidism and thyroid hormone resistance.

We need also to take into account age-related changes alter the balance of sex hormones. Sex hormone imbalance closely resembles those of hypothyroidism and thyroid hormone resistance.

For example, a progesterone deficiency can cause fatigue, weight gain, irritability, depression, memory and concentration problems, headaches, irregular and painful menstrual cycles, fluid retention, loss of sex drive, and cold hands and feet.

These symptoms are also characteristic of hypothyroidism and thyroid hormone resistance. Some symptoms of estrogen and testosterone deficiencies also resemble those of hypothyroidism and thyroid hormone resistance.

So where do we start?

Proper thyroid function is a key to our metabolic health and hormone balance. The symptoms of hypothyroidism occurring in patients with unopposed estrogen (progesterone deficiency) are reduced when progesterone is added and hormone balance is achieved.

It is also true, thyroid function affects liver clearance of progesterone and should we see excessive levels building up in our body, we need to take appropriate steps to investigate what's interfering with our body's metabolism of progesterone (i.e., thyroid or liver).

Therefore, if we are unsure whether our thyroid is functioning optimally (this can be characterised by an inability to lose weight, puffy and swollen body appearance, lethargy, muscle weakness, dry skin, hair loss and constipation), we might be well advised to ask our doctor to order the appropriate tests.

Dr Lowe suggests the following: (1) a TSH, (2) either a free T4 and possible free T3, or a total T4, FTI, and T3-uptake, and (3) thyroglobulin and thyroid peroxidase antibodies. Number 3, he pointed out, is extremely important; patients who have high antibodies can have debilitating symptoms of hypothyroidism despite all the other test results being within their reference (so-called "normal") ranges.

Blood Spot Testing (TSH, FT3, FT4) collection kits designed to be used at home can help us keep an eye on our thyroid hormone profile and track disorders / treatment. Of course, a full salivary hormone profile is always recommended to ensure we are not putting ourselves at risk, where possible in consultation with a supportive GP who knows what he or she is doing.

Depression

The causes of depression are not fully known. It is possibly a combination of genetic, biologic, and environmental factors at work. In women, the female hormones estrogen and progesterone most likely play a role.

Women experience depression at roughly twice the rate of men.

One in five women can expect to develop clinical depression during their lifetime. Regardless of age, race, or income clinical depression can occur in any woman, and can be serious enough to lead to suicide.

Depression is second only to high blood pressure as a chronic condition encountered by primary care physicians. It is estimated that 10% of people who visit their physician suffer from major depression, although in most cases it goes unrecognized or inadequately treated.

Depression is an illness that can afflict anyone, and it is sometimes referred to as the common cold of mental illness.

Although some evidence suggests the depression has increased over recent decades, one 40-year analysis found the overall rate to be holding steady, although the burden of depression may be shifting to women younger than 45.

Selective serotonin-reuptake inhibitors (SSRIs) are now the first-line treatment of major depression. They work by increasing levels of serotonin in the brain.

SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), and citalopram (Celexa, Cipramil).

Some of the side effects of SSRIs include dizziness, dry mouth, weight gain, headaches, lack of motivation, sexual dysfunction and worsening of glaucoma. Reducing the dose of the antidepressant before stopping it is recommended.

The Dark Side of Prozac

Millions of Americans, and Australians for that matter, are on Prozac to treat everything from serious depression to shyness, obesity, PMS, and back pain. They've been told it has few, or no, side effects.

But what is the dark side of Prozac?

What essential facts must you have if you are already taking Prozac, or are considering taking it?

Dr. Robert Bourignon who runs Securimed, a small company on Avenue Louise that provides doctors with information about drugs, sent questionnaires to doctors, inviting them to note their patients' reactions to Prozac. Eighty responded and reported reactions that included suicidal tendencies and violence.

Many doctors admit that Prozac is not as effective as they had at first believed.

Dr. Guido Peeters, a Flemish psychiatrist who works with the Community Help Service, suggests why:

"It's well known in medical circles that you are more likely to prescribe a drug when it's new. There's a placebo effect that produces hope in the scientific community and among patients. Prozac seemed to work well in the beginning and it can be useful, although it's probably over-prescribed. It's easy for doctors to hand out pills and many patients prefer to go for the 'quick-fix' pill rather than discuss their problems."

Eldred Taylor, M.D. and Ava Bell-Taylor, M.D., authors of '[Are Your Hormones Making You Sick? A Woman's Guide to Better Health Through Hormonal Balance](#)' make the following argument;

"In the body, pregnenolone and allopregnanolone are derived from progesterone. These chemicals behave like sedative drugs i.e. Xanax, Prozac, Zoloft, and barbiturates."

The majority of patients prescribed Prozac and other SSRIs are women between the ages of 25-50. These are also the same age ranges in which women commonly complain about PMS symptoms. A recent study suggests that synthetic SSRI's are helpful in the treatment of PMS because they increase the level of allopregnanolone.

In other words, these drugs are mimicking the effect of progesterone.

"Approximately 36% of women with PMS complain of depression, confusion, crying and forgetfulness. These symptoms are usually found in the most severe cases of PMS. Neurotransmitters (chemicals that transmit messages within the brain and help control mood) decrease with increasing estrogen levels. The

SSRI drugs that are used for depression increase neurotransmitters called monoamines. Estrogen inhibits the synthesis of monoamines. Endorphins are also a group of compounds made in the brain that normalize or elevate the mood. Estrogen excess in the luteal phase decreases endorphin levels in the brain. Studies have shown that low endorphin levels in the luteal phase are common in women with PMS."

Cortisol is a hormone that scientists associate with stress as well as chronic mood disorders. During times of stress, cortisol levels rise and then subside as the stress subsides.

If stress is chronic or if a chronic mood disorder (anxiety, depression) is present, increased cortisol levels may indicate that the brain has become resistant to cortisol's effects, scientists believe.

Copper and zinc are involved in enzymes within brain cells. The balance of zinc and copper are very important in the brain's regulation of mood and reaction to stress.

Vitamin B6 is the vitamin most commonly needed by these particular enzymes, which is why it often is effective in treating depression.

There's an association between high copper levels, low zinc levels, and the rage that can be associated with PMS. Long term exposure to excessive estrogen (and synthetic progestins) can lead to copper and zinc imbalance. Imbalance of these two minerals results in unbalanced activity of the enzymes for which they are cofactors and leads to exaggerated stress reactions, serious mood swings, and depression.

Studies have shown that in countries where large amounts of fish are consumed, rates of depression are low as compared with countries where little fish is consumed. This has led researchers to examine whether omega-3 fats found in the fish are responsible for the decreased evidence of depression.

Low vitamin D may contribute to depression. For most of us, during the winter this becomes an important consideration as we don't receive enough sun exposure to generate the vitamin D we need to provide us with all the health benefits vitamin D has to offer.

Cod liver oil as a supplement is the same as fish oil, but it has natural vitamin D and A. Seasonal Affective Disorder has been treated successfully with vitamin D.

There ARE laboratory tests available to help your treating GP make a more informed diagnosis. A full salivary hormone panel can be ordered to determine whether you are dealing with high or low cortisol & progesterone levels. Also available is specialised reference testing of trace elements copper, zinc, selenium, manganese.

Early Pregnancy - Miscarriage

The levels of progesterone in a woman's body rise and fall dramatically with her monthly cycles. At ovulation, the production of progesterone rapidly rises from 2-3mg per day to an average of 22mg per day, peaking as high as 30mg per day a week or so after ovulation.

After ten or twelve days, if fertilisation does not occur, ovarian production of progesterone falls significantly. It is this sudden decline in progesterone levels (as well as estrogen levels) that triggers a period (menstruation), and another menstrual cycle will begin.

If pregnancy occurs, progesterone production increases and the shedding of the lining of the uterus is prevented, preserving the developing embryo. As pregnancy progresses progesterone production is taken over by the placenta and its secretion increases gradually to levels of 300-400mg per day during the third trimester.

During pregnancy, rising progesterone levels prevent the premature shedding of the uterine lining (pro-gestation). If progesterone levels drop due to inadequate progesterone production, then a premature delivery could result, or bring about a miscarriage in the early trimesters.

Progesterone also influences the development of the breasts during pregnancy in preparation for producing milk after the birth. It has an impact on ligaments and muscles throughout the body as well, essentially to allow the suppleness and expansion necessary for giving birth. This also accounts for some of the problems which may be experienced during pregnancy - backache, constipation, and low-blood-pressure, for example.

Although the data are not entirely clear, it appears that progesterone may also have an effect on transport time of the ovum in the fallopian tube, and it may make the ovum more susceptible to sperm penetration.

Dr. Pritchett and many of the other Moscati Health Center doctors studied extended progesterone use under Dr. Thomas Hilgers of Omaha at the Pope Paul the Sixth Institute.

This Nebraska doctor is the world leader in the study, one reason people come from all over the globe to learn from him. Thirteen years ago, Hilgers used a new technique to help a Hastings woman carry her pregnancy to full term. Today, that mother has four healthy teenage girls including triplets and the doctor is the world leader in using the hormone progesterone.

He explains most doctors only prescribe progesterone for problem pregnancies like Horton's into the first trimester. Hilgers said, though, he has found for many women who miscarry, their progesterone levels are low, so he continues to prescribe the hormone into the second and third trimester. He said it can have dramatic effects.

Although other doctors say extended use of the hormone does not help at all and there is not enough research to support the practice, Dr. Pritchett said success stories are repeated again and again at the centre with this treatment.

"It's been withheld actually probably for too long and we really need to use it. I call progesterone the great, undiscovered, American hormone," Hilgers said.

The Medical College of Georgia researcher and biochemist, Dr. Vadivel Ganapathy, has spent years studying the placenta and how all sorts of substances, from nutrients to street drugs, are transferred from mother to baby by this two-pound temporary organ of pregnancy.

But he's long wondered if the placenta, in addition to supplying a developing baby with the nutrition and oxygen he needs to thrive, was also helping suppress the mother's immune system so the foetus could survive.

"There is the problem about how pregnant mothers tolerate the placenta and the foetus even though the genetic makeup of the placenta is partly different than that of the mother," Dr. Ganapathy said. "The foetus gets half his genetic makeup from each parent, so when this genetically foreign being implants on the uterine wall he should be rejected -- like a transplanted organ -- by the mother's immune system."

A major research finding in 1998 from another team of MCG researchers led by Drs. Andrew L. Mellor and David Munn (see *Tolerance Key to Cancer Survival*) showed that early in pregnancy, at the time of implantation, placental cells express an enzyme (indoleamine 2,3-dioxygenase, or IDO) that locally disables the mother's immune system. "Our IDO mechanism was one that, if you suddenly interrupt it, the foetus can't do without," said Dr. Munn, paediatric haematologist-oncologist who also is a co-investigator on Dr. Ganapathy's study. Dr. Munn has no doubt that the body has multiple mechanisms to protect the foetus and so procreation. "I think we can state with confidence that the mother and foetus use multiple mechanisms to make sure that the foetus is not rejected," he said.

Evidence about at least one other mechanism began showing up years ago when an article, published in a 1977 issue of the *Annals of the New York Academy of Sciences* asked, "Progesterone and Maintenance of Pregnancy: Is Progesterone Nature's Immunosuppressant?" The question apparently didn't get answered then, but with the three-year NIH grant Dr. Ganapathy recently secured, it just may.

Now he is exploring the rather common-sense hypothesis that since high-levels of progesterone are needed to activate the sigma receptor in the placenta and that the high levels occur only during pregnancy, this must be one way the placenta helps control the mother's immune system so the foetus is not rejected.

"It's a very positive hypothesis, but it's still a hypothesis," Dr. Ganapathy said. "There are progesterone receptors in the placenta and in other tissues but to activate them you only need a tiny amount of progesterone. The placenta is producing a ton of it. Therefore the purpose of the placenta-produced progesterone cannot be to activate progesterone receptors," he said.

The work has potential for not only better understanding the mystery of how the foetus survives but also how the immune system works and, possibly, why sometimes miscarriages occur. "Some women who are infertile may have genetic mutations in the sigma receptors so that progesterone is made by the placenta but the receptor is not functional," Dr. Ganapathy said.

Protective properties of Progesterone

Dr. Katharina Dalton is one of the many scientists and doctors who have discovered that progesterone in the natural form protects the foetus from miscarriage.

Her studies many, many years ago lead her to conclude that preeclampsia (also called toxemia, characterized by high blood pressure, swelling – particularly of the hands and face – and protein in the urine) could show up in the middle months, and that when given progesterone, the results were excellent and statistically significant.

After conception progesterone prevents miscarriages resulting from excess estrogen. It is interesting to note the consistency of the research, as in Dr. Peat's study, indication that "pregnancy toxemia and tendency to miscarry or deliver prematurely are often corrected by progesterone." Dr. Peat goes on to say, "My dissertation research, which established that an estrogen excess kills the embryo by suffocation, and that progesterone protects the embryo by promoting the delivery of both oxygen and glucose, didn't strike a responsive chord in the journals which are heavily influenced by funds from the drug industry."

It is a fact that if a pregnant woman produces too much estrogen, her embryo can be suffocated (hypoxia). Dr. Lita Lee cautions that during the ninth week of pregnancy, a woman can lose her baby if she is a "high estrogen producer and/or [is] consuming commercial meat, poultry and dairy products containing synthetic estrogen (DES)."

However, she goes on to say that natural progesterone "has been known to protect against the toxic effects of excess estrogen, including abortion." Make certain, if hormones are prescribed during pregnancy, that they are not the synthetic progestins or estrogens but the natural micronized bio-identical products. We now know that artificial hormones can be dangerous to the foetus during pregnancy.

Pregnant women should NOT suddenly stop using progesterone!

Important Message!

If you have been using progesterone in order to get pregnant and you are successful, DO NOT suddenly withdraw the progesterone cream. A sudden drop in progesterone levels may trigger a miscarriage.

Regular dosage can be maintained and gradually increased to 80mg right through until the last trimester. At this stage the placenta is well and truly producing adequate levels of progesterone to maintain the pregnancy. The baby's placenta takes over the production of progesterone at the beginning of the second trimester, and this is when a miscarriage is likely to occur if this production is not adequate.

Women with a history of miscarriage or premature delivery choose, for their own peace of mind, to continue using progesterone through to the week prior to expected delivery. The placenta is producing such huge amounts of progesterone that any extra progesterone over and above will not harm mother or baby.

Women with a history of 'high risk' pregnancies are encouraged to continue progesterone supplementation up until delivery. However, Dr Lee warns that should you decide to stop applying progesterone, make sure you wean off your dose ever so gradually.

You may be concerned about the safety of using progesterone supplementation in early pregnancy. There is no accurate figure, but well over a million children worldwide have been subjected to such therapy during their mother's pregnancies.

There has never been any pattern of birth defects reported in patients so treated. However, there can be no guarantees that there will be no birth defects since 2% of all births are associated with some sort of birth defect (usually mild). But, there is no reported increase in the rate of birth defects with progesterone therapy prescribed in early pregnancy.

To protect the foetus the body secretes ten to fifteen times more progesterone during pregnancy than during our menstrual cycle. Dr. Lee tells us that the placenta becomes the major source of progesterone. What a great protection we have during pregnancy with this incredible hormone ... and with no known dangerous side effects!

The human-identical progesterone compound we discuss here is identical to the natural hormone produced by the body.

Ectopic pregnancy - Luteal phase deficiency - Miscarriage - Premature delivery

An ectopic pregnancy is usually suggested by the typical triad of a positive pregnancy test, pain, and vaginal spotting.

According to a study done by Dr. Buckley and colleagues and published in 2000 (Ann Emerg Med 2000 Aug;36(2):95-100), they concluded that all patients with an ectopic pregnancy had a progesterone level below 22 ng/ml.

Of the patients with a progesterone level below 22 ng/ml, 10% had an ectopic pregnancy, but none of the patients with progesterone over 22 had an ectopic pregnancy. Of the patients who did not have an ectopic pregnancy, 73% had a progesterone level below 22 ng/ml.

Progesterone therapy is recommended for women who have infertility (or habitual miscarriages) secondary to a problem called luteal phase deficiency.

Luteal phase deficiency is a result of inadequate production of progesterone by the ovaries during the second half of the menstrual cycle. The ovaries continue to make progesterone during the first 8-10 weeks of pregnancy (since the last menstrual period).

If there is insufficient progesterone during early pregnancy, the embryo may not survive. After this 8-10 week interval, the placenta becomes a major source of progesterone and the ovarian hormones are no longer needed.

It is assumed that if the ovaries cannot make sufficient progesterone during the latter half of the menstrual cycle, then they would not produce the required amounts of progesterone during pregnancy as well. In women with luteal phase deficiency, it has been customary to extend the progesterone treatment into the early weeks of pregnancy to supplement ovarian production of progesterone.

If a woman has had four or five miscarriages in the first six or eight weeks of a pregnancy, this is always due to luteal phase failure, says Dr. John Lee.

Progesterone is needed to facilitate implantation and to prevent rejection of the developing embryo, but the follicle may not respond to the ovum with enough progesterone. Dr. John Lee's recommendation: "Wait till you ovulate, and then four to six days after possible conception do a blood test (for HCG) to see if you're pregnant. If you are, start the progesterone; that way you will increase your chance of having a healthy baby."

Blood tests for pregnancy tend to be positive within seventy-two hours of conception, whereas he says urine pregnancy tests are not usually positive until two weeks after conception.

Women can develop luteal phase deficiency after receiving the ovulation medications for In Vitro Fertilization (IVF). Progesterone is prescribed after to insure against luteal phase deficiency. A new vaginal 8% progesterone gel (Crinone) has been developed for luteal phase support following IVF. The polycarbophil base maintains continuous absorption of progesterone, providing high progesterone concentrations within the uterine cavity.

Now, according to one study in New England Journal of Medicine dated June 16, 2003, giving pregnant women the hormone progesterone can reduce their risk of premature delivery by one-third.

"This is really the first innovation that's clearly been shown to prevent or reduce the incidence of premature delivery," said Dr. Charles J. Lockwood, director of obstetrics and gynaecology at Yale University School of Medicine and former chairman of obstetrical practices of the American College of Obstetricians and Gynaecologists.

The study involved women at very high risk of premature delivery. The women previously had at least one baby very early -- at about 31 weeks on average. Full term is considered 37 weeks to 40 weeks. Some of the women received progesterone; a comparison group got shots of an inert oil.

The progesterone proved so effective that the study was halted early because it would have been unethical to keep giving some women a placebo.

"The results are so good that it's surprising," said Dr. Fredric Frigoletto, chief of obstetrics at Massachusetts General Hospital in Boston. "No intervention that we have ever applied has had any measurable effect. This is very good news."

Dr. Paul J. Meis, professor of obstetrics and gynaecology at Wake Forest University School of Medicine said progesterone had been previously toyed with as a preventive treatment for premature births in the 1960s and 1970s, but no one has completed a serious study on the subject.

Endometriosis per se does not cause miscarriage, but those with endo do have a much higher chance of miscarriage as a matter of fact.

The reason is under heavy investigation scientifically, but most in natural medicine field agreed that estrogen dominance plays a big part as the root cause of endometriosis, and if your estrogen is high, it is very hard to get pregnant because your progesterone will be low as a result of the estrogen dominance.

In the case of endometriosis and PCOS, for example, using high levels of progesterone to induce a pseudo-pregnancy state to 'rest' the ovaries has proved quite successful.

Regular periods do not always indicate ovulation. Many women are under the misconception that a regular period each month equals ovulation. Not true. A period can occur regularly in the absence of ovulation.

It's the presence of estrogen in the body that results in the cyclic thickening of the uterine lining in preparation for a fertilised egg. Therefore, a woman with normal or elevated estrogen levels in her body will have a period (perhaps at times irregularly).

The hormone progesterone prepares the lining of a woman's uterus (womb) for a fertilised egg, and maintains the integrity of the uterine lining to promote gestation (pro-gestation). Failure to conceive triggers a drop in progesterone levels resulting in the shedding of the uterine lining (menstruation), and then the cycle starts again.

It's quite common for women to not ovulate every month (anovulatory cycle). This gives rise to estrogen dominance. It also explains why some months you may feel more PMS, and have a heavier shedding (perhaps with clots), indicating a build up due to estrogen influence with no opposing progesterone.

When a woman is physiologically balanced with estrogen and progesterone, ceasing progesterone supplementation can bring on a period within 24 to 36 hours. This is why women are advised to continue taking their progesterone if they suspect they are pregnant because stopping cream and allowing progesterone levels to drop can potentially bring on a miscarriage.

Progesterone may help regulate your periods & trigger ovulation. When used topically, benefits of progesterone supplementation are quite significant in helping regulate periods and bring the body back into synchronisation, and in some cases, triggering ovulation.

Often the introduction of progesterone back into the body can 'crank up' the ovaries, particularly where there has been a considerable shortfall of this hormone in the body. Fertility may follow. If, however, your follicles are depleted, progesterone cannot restore fertility. Appropriate tests can establish your state of fertility.

Endometrial (Uterine) hyperplasia

To begin, let's first examine a woman's reproductive cycle and its two distinct phases:

- Follicular Phase (Day 1 - Day 14)
- Luteal Phase (Day 14 - Day 28)

The hormone estrogen dominates in the Follicular Phase (proliferative - prepares the uterine lining), while progesterone dominates the Luteal Phase (secretory - maintains the uterine lining).

Estrogen is the hormone that stimulates cell proliferation, or the growing phase of the cells in the uterus. Progesterone is the hormone that stops growth and stimulates ripening.

Forty eight hours after ovulation has taken place and progesterone levels have surged, all endometrial cell proliferation should stop. This is nature's way of protecting women against endometrial cancer.

We know that estrogen drives continued proliferation of the endometrium. We also appreciate that the only known cause of endometrial cancer is unopposed estrogen.

In the event a woman fails to ovulate, or her progesterone levels are too low to oppose estrogen's proliferative action on the uterus month after month, endometrial hyperplasia results and, eventually, this can lead to endometrial cancer.

Endometrial hyperplasia means the uterine lining is thickened (due to an overgrowth of mucosal cells). Symptoms often include irregular vaginal bleeding, heavy or prolonged menstrual cycles, and post-menopausal bleeding in older women.

Simple hyperplasia (without atypia) means the lining of the uterus is thick but the basic structure of the endometrium is relatively unchanged.

On a more positive note, simple hyperplasia is the most benign type of hyperplasia, and the least likely to progress to cancer.

When the cells themselves appear abnormal, then the phrase "with atypia" is added. Atypia means that the cells themselves have become abnormal. This is a similar case to cervical dysplasia. Although these cells are not cancerous, there is an increased probability that they will become so. We can think of them of "going towards" cancer, but not yet "arrived".

A diagnosis of endometrial hyperplasia can only be made by a pathologist who examines a sample of tissue removed from the thickened lining by a sampling procedure such as endometrial biopsy or dilatation and curettage (D&C).

The key to reducing our risk is to make sure we have some kind of "bleed" in which the lining of the uterus is shed at least every 3 months, preferably more often.

Possible treatments for endometrial hyperplasia include:

- Hormone therapy. Progesterone can be used to counteract the effects of estrogen on your uterine lining.
- Dilatation and curettage (D&C). This is a minor surgical procedure in which the endometrium is scraped away and removed from your uterus. A D&C can sometimes cure simple hyperplasia.
- Hysterectomy. If precancerous changes are found in your endometrium, your doctor may offer you the option of a hysterectomy (surgical procedure to remove your entire uterus), which will eliminate any risk that endometrial hyperplasia will progress to endometrial cancer.

Dr. Helene Leonetti's study effectively proved that progesterone cream protects the uterine lining (the endometrium) as well as synthetic progestins do. Her study comparing Prempro with Premarin and progesterone cream was published in a major peer-reviewed medical journal (JAMA 2002; 287:216-220. Anasti JN, Leonetti HB, Wilson KJ. Topical progesterone cream has anti-proliferative effect on estrogen-stimulated endometrium. Obstet Gynecol 2001; 97 (Suppl 4): S10).

In Dr. Leonetti's study, uterine tissue was examined before, during, and after using either Prempro (Premarin plus Provera) or a combination of Premarin and progesterone cream. The group using progesterone cream was found to be as well protected as the Prempro group.

We believe the discussion point here is not whether progesterone offers protection against endometrial hyperplasia, but rather HOW MUCH progesterone needs to be administered to maintain a healthy estrogen-to-progesterone balance.

Basing my comments on the limited info presented above, whatever dosage of progesterone you are using, Eloi, it evidently IS NOT opposing your estrogen load. In general terms, women sometimes need to move up to a 10% cream that delivers 100mg per application to realise more positive outcomes.

I can provide you with my own success story. Several years ago, I was diagnosed with endometrial hyperplasia subsequent to a course of HRT (estrogen and testosterone implants coupled with an artificial progestin, Provera). A 'day stay' in the hospital for a D&C and course of 10% progesterone cream got me

back on track and has kept me within normal limits these past ten years. At that moment in my life, I was seriously contemplating a hysterectomy.

The key here is 'opposing' your estrogen load with progesterone, and this, of course, will vary for each and every women. Hence, the need to tailor your progesterone dosage to your individual health needs.

At all times be 'up front' and honest with your treating physician. And make sure he or she monitors you closely while on progesterone supplementation.

If precancerous changes are found in a woman's endometrium that have not responded to progesterone supplementation or other forms of therapy, then perhaps one could argue a hysterectomy is the proper course of treatment. Until then, women might want to hang on to their uterus.

"My doctor said the progesterone I have been using for almost two years is what 'saved' me! She said if I had not been using it, I would most surely have had dysplasia (the treatment for dysplasia IS progesterone!). I had many low progesterone symptoms for years, and painful cramps, and sought out a doctor who helped me with progesterone. I have such a sense of profound relief and gratitude that God led me in this direction, because my doctor believes that without the progesterone, I would have had a different result." ~ Fran ~

Endometrial (Uterine) cancer

Endometrial (uterine) cancer occurs in tissue sensitive to hormones made by the ovaries (estrogens and progesterone).

Generally, endometrial cancer develops during the pre-menopausal years when high levels of estrogen and low levels of progesterone are present. The only known cause of endometrial cancer is unopposed estrogen, though there may be other factors involved.

The initiation of normal cells turning into cancer cells is the same for both the breast or uterus and a man's prostate gland. In these organs, cancer initiation is due primarily to estrogen dominance combined with lifestyle factors and/or toxic insults that predispose estrogen to become oxidised.

Estrogen is the hormone that stimulates cell proliferation, or the growing phase. In other words, estrogen causes cells to divide and multiply. Progesterone, on the other hand, is the hormone that stops growth and stimulates ripening. It induces cell maturation and programmed cell death (called [apoptosis](#)).

Although cells in different parts of the body may look and work differently, most repair and reproduce themselves in the same way. Normally, this division of cells takes place in an orderly and controlled manner. If, for some reason, the process gets out of control, the cells will continue to divide, developing into a lump which is called a tumour. Tumours can be either benign or malignant. Doctors can tell whether a tumour is benign or malignant by examining a small sample of cells under a microscope. This is called a biopsy.

Whilst not a cure for cancer, progesterone can dramatically decrease cell multiplication rates, providing women with a degree of protection against estrogen-driven cancers. Normal levels of progesterone in the body can, therefore, actually help protect you against some forms of cancer.

We know now that progesterone deficiency is linked to an increased risk of cancer. Uterine cancer, for example, is known to be caused by unopposed estrogen. That's why women who have an intact uterus and take estrogen replacement therapy must also be given some form of progesterone to oppose estrogen and reduce this risk. This is generally given in the form of synthetic progestin (that carry health risks) designed to block estrogen effects, but differs considerably from the molecule that is human-identical progesterone.

Endometriosis

While the cause of endometriosis is unknown we do know that it is an estrogen driven disease. And the body's natural anti-estrogen is progesterone.

We know that when a woman falls pregnant, often endometriosis will disappear, only to return again after pregnancy. There is some very strong correlation between the two. This suggests that the sex

hormones are involved and that high progesterone levels produced in pregnancy play an important part in controlling this disease.

That's why progesterone is recommended from days 8 to 26 (just before menstruation) or whenever your normal menstrual cycle ends, breaking from cream briefly to refresh receptor sites. This mimics a pseudo-pregnancy state, and facilitates healing.

Higher than normal doses are required which appear to be well tolerated. Levels around about 60-80mg/day are usually required for pain management. You know you are taking too high a dose if you begin to feel sleepy after applying cream.

Most women will find that they can reduce their dosage of progesterone after 7-12 months, however, attempts to go below 40mg/day progesterone often allows symptoms to creep back in.

Keep in mind that a delayed diagnosis of endometriosis after numerous years of medication and synthetic hormone cocktails often leads to liver dysfunction, adrenal exhaustion, and chronic pain / fatigue which can compromise the uptake of progesterone.

No one is suggesting progesterone cures endometriosis but we certainly know, based on empirical evidence, that it appears to play a major role in controlling its distressing symptoms. We know that women who stopped progesterone felt great for a few months and then suddenly, after progesterone stores had washed from the body, the disease would flare back up.

Most women with endometriosis remain on progesterone cream for maintenance and pain control, and adjust their dose when necessary, increasing when indicated such as in times of stress.

Epilepsy

Progesterone has been used to treat seizures that occur relative to the menstrual cycle. Catamenial seizures, also called catamenial epilepsy, occur in about one-third of all women with epilepsy. Women who have refractory complex partial seizures or generalized tonic clonic seizures are most likely to experience catamenial exacerbation, which occurs most commonly at the time of menstruation. Less often, catamenial seizures may arise at the time of ovulation or may last from ovulation to the beginning of menstruation.

In laboratory research, progesterone, in both its natural form and synthetically made (medroxyprogesterone), has strong anti-seizure properties. The metabolites of natural progesterone have powerful effects on enhancing gamma-amino-butyric acid (GABA) activity in the brain. GABA is an inhibitory neurotransmitter and therefore increasing its activity would be expected to decrease the likelihood of seizures

Progesterone, when used in women with epilepsy to prevent seizures, must be considered a complementary and unproven treatment, used only in combination with standard anti-seizure treatments. It does not appear to be a powerful-enough treatment to be used alone.

Further, it must be kept in mind that hormonal changes only influence seizure occurrence, and menstrual hormonal cycling is not the underlying cause of seizures. Whether using a hormone such as progesterone can prevent these hormonally-influenced seizures remains to be proven.

According to Cynthia L. Harden, MD, Associate Professor of Neurology and Neuroscience and Associate Attending in Neurology at the Weill Medical College of Cornell University in New York, NY., "progesterone is a potentially beneficial complementary treatment for seizure disorders in women who have seizure exacerbations in relationship to their menstrual cycles. Its exact benefit remains to be proven and is currently under evaluation. The neurologist and gynaecologist should both be involved when progesterone is used for women with epilepsy."

Fertility - Infertility - Pregnancy

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You may be concerned about the safety of using progesterone supplementation in early pregnancy. There is no accurate figure, but well over a million children worldwide have been subjected to such therapy during their mother's pregnancies.

There has never been any pattern of birth defects reported in patients so treated. However, there can be no guarantees that there will be no birth defects since 2% of all births are associated with some sort of birth defect (usually mild). But, there is no reported increase in the rate of birth defects with progesterone therapy prescribed in early pregnancy.

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Women with a history of 'high risk' pregnancies are encouraged to continue progesterone supplementation up until delivery. However, the late Dr Lee warned us that should we decide to stop applying progesterone, make sure we wean off our dose ever so gradually.

Lori Ramsey, director of [Beyond Fertility.com](http://BeyondFertility.com) writes, "My history is one of early miscarriage and preterm labour and premature birth. Before I ever knew that progesterone cream even existed I had given birth to my first two babies prematurely and suffered two early miscarriages. It was this reason that spurred me on to learn about human reproduction and in return discovering that progesterone cream is extremely beneficial in preventing early miscarriages that are due to hormonal imbalances. Some experts say that pregnant women produce incredible amounts of progesterone and never need progesterone supplementation. But I feel my own experience proves otherwise. While I am sure that some women will produce enough on their own, other women like me, can save their pregnancies simply by rubbing progesterone cream two or three times a day onto their bodies until the 38th week of pregnancy."

Fibroids (uterine) – Enlarged uterus

We know that estrogen dominance causes the uterus to grow, and without the monthly balancing effect of progesterone it doesn't have the proper signals to stop growing.

In some women this results in an enlarged uterus that presses on other organs, such as the bladder, and often on the digestive system, and generally causes discomfort and heavy menstrual bleeding. In other women estrogen dominance results in fibroids, which are tough fibrous, non-cancerous lumps that grow in the uterus.

Fibroids always shrink at menopause, but the most common course of action a doctor takes when a patient comes in with a fibroid is to remove the uterus.

A number of women have managed to successfully control their fibroids with no less than 40mg/day (4%) progesterone cream as a baseline dose, while others have required an average maintenance dose of between 50-60mg/day.

Overall, an average of seven months on high levels of progesterone (ranging between 60-100mg/day, adjusting dosage accordingly) appears to be an effective timeframe to get some measure of control.

But we need to be aware that the jury is still out over this issue. Yes, progesterone therapy has proved successful for a majority of the women experiencing heavy bleeding associated with fibroids. However, there are a couple of cases reported where fibroids have not responded to progesterone therapy. They, in fact, grew in size.

For this reason, I strongly urge women, working in consultation with a collaborative, open-minded physician, to undertake regular ultrasounds to monitor the stages of fibroid growth, and to determine the success of their progesterone dosage. Saliva assays would be helpful to capture a snapshot of hormones levels.

Just weeks before his death, working with Virginia Hopkins, Dr Lee completed a fully revised and updated edition of his publication [*'What Your Doctor May Not Tell You About Menopause'*](#). In it he pointed out, "Fibroids tend to grow during the years before menopause and then atrophy after menopause. This suggests that estrogen stimulates fibroid growth, but we also know that once they get larger progesterone, too, can contribute to their growth."

I think we need to be aware that the jury is still out over this issue. Yes, progesterone therapy has proved successful for some women experiencing heavy bleeding associated with fibroids. However, there have been reported cases, such as yours, Nancy, where uterine fibroids have not responded to progesterone therapy. They, in fact, grew in size.

It would appear that women with fibroids are often estrogen dominant and have low progesterone levels. In women with smaller fibroids (the size of a tangerine or smaller), when progesterone is restored to normal levels, the fibroids often shrink a bit and stop growing, which is likely due to progesterone's ability to help speed up the clearance of estrogens from tissue.

Women who are, by all accounts, estrogen dominant do appear to benefit from low doses of progesterone supplementation in from Day 12-26 of their cycle.

When treating smaller fibroids we should be thinking in terms of keeping our estrogen levels as low as possible. And when treating large fibroids, all hormones should be kept as low as possible.

For this reason, I strongly urge women to work in consultation with a collaborative, open-minded physician to undertake regular ultrasounds that will monitor the stages of fibroid growth and determine the success of their progesterone dosage. Regular saliva assays will enable your physician to capture a complete snapshot of hormones levels.

Dr. Doris Brownlee writes, "I hit menopause at 48 a few years ago, and a year later, my pelvic ultrasound showed a large ovarian cyst, about 10cm in diameter (that's big!), and that the fibroids were still getting bigger. Two weeks ago, after 12 months on natural progesterone, I had another pelvic ultrasound. For the first time, every fibroid had shrunk, as had the ovarian cyst. I had noticed that I wasn't getting lower abdominal and pelvic discomfort as I used to, and now I know why."

Gallbladder Disease

The gallbladder is a small pear-shaped organ on the underside of the liver that is used to store bile. Bile is made in the liver and is stored in the gallbladder until it is needed to help the digestion of fat.

Gallbladder disease is a common condition that affects mainly women, although men can suffer too. The symptoms vary widely from discomfort to severe pain which mainly begins after food. In severe cases the patient can suffer from jaundice, nausea and fever. The most common reason for gallbladder disease is gallstones.

It is thought that approximately two thirds of patients will have no trouble at all from their gallstones and only one third of patients will at some time experience symptoms. These symptoms can be extremely variable but usually present in one of three ways.

Chronic cholecystitis (biliary colic)

This is a chronic inflammation of the gallbladder and causes:

- sporadic pains in the middle of the upper abdomen, or just below the ribs on the right side.
- pain which becomes worse over an hour and then stays the same.
- the pain may spread to the right shoulder or between the shoulder blades.
- the pain can be accompanied by nausea and vomiting and sometimes excessive wind.
- the attack can last from a few minutes to two to three hours before getting better.
- the frequency and severity of attacks is very variable.
- attacks can be triggered by eating fatty foods such as chocolate, cheese or pastry.
- it can be difficult to distinguish the pain from other diseases, such as: gastric ulcer, back problems, heart pains, pneumonia and kidney stones.

Acute cholecystitis (acute inflammation or infection of the gallbladder)

This condition results in:

- persistent pain and a temperature lasting more than 12 hours.
- pain and tenderness under the ribs on the right side.
- the pain is made worse by movement or coughing.
- patients with acute cholecystitis may not always have gallstones but usually do.
- the condition must be treated by a doctor and usually requires admission to hospital.
- the treatment consists of a course of antibiotics but if this is not effective emergency surgery may be required to remove the gallbladder.

Jaundice (yellow discolouration of the skin and whites of eyes)

This is caused when there is an obstruction to the flow of bile from the liver. Jaundice is not always caused by gallstones. The symptoms are:

- increasingly yellow eyes and skin.
- the skin can become itchy.
- pale bowel motions and dark urine.
- the condition is often preceded by symptoms similar to those of cholecystitis.
- fever and shaking chills are serious symptoms and must be treated by a doctor - they are suggestive of infection travelling through the bile duct system.

Gallstone disease is the most common digestive disease in the United States. It affects over 20 million Americans, with a million new cases diagnosed each year. Half of those go on to have surgery to remove gallstones or the gallbladder.

Women are twice as likely as men to develop gallstones, probably largely due to unidentified estrogen dominance and the excessive estrogen used in hormone replacement therapy (HRT).

Researchers in Britain are now saying that women on synthetic HRT are 3 times more likely to develop gallbladder problems. Gallstones being composed primarily of cholesterol, the use of estrogen possibly promotes an increase in cholesterol in bile, which leads to gallstone formation.

Women have slower gallbladder emptying than men normally. This effect is exaggerated during pregnancy and may be one reason why many women develop gallstones after having a baby.

Your gallbladder performs some important functions in your body that make it well worth keeping. Possibly the most important is to regulate bile flow to optimize fat, oil, and fat-soluble nutrient absorption. Without your gallbladder, mechanically, this just can't happen properly.

"How to prevent gallbladder attacks" was actually published back in the 1960s and '70s by Dr James C. Breneman, who, at the time, was chairman of the Food Allergy Committee of the American College of Allergists, or ACA (now called the American College of Allergy and Immunology, or ACAI). Dr Breneman's secret for preventing attacks of gallbladder pain? Simple. Don't eat or consume anything you're allergic to.

Dr Jonathan Wright, in his October 2004 'Nutrition & Healing' newsletter tells us that, "this approach is so simple, and yet no medical school to this day teaches how to prevent gallbladder attacks by avoiding your food allergies and (in some cases) other allergies. Instead, they continue to recommend unnecessary gallstone removal surgery. But the truth is, gallstones don't even cause 99.9 percent of gallbladder "attacks": allergies do. Avoid allergies, stop "attacks" of pain, and keep your gallbladder! That's it - that's all there is to it."

Headaches - Menstrual migraines

Almost one in five women has migraines. Often these are related to the cycle, hence the link to hormones.

One theory about the cause of migraine is the blood flow theory, which focuses on blood vessel activity in the brain. Blood vessels either narrow or expand. Narrowing can constrict blood flow, causing problems with sight or dizziness. When the blood vessels expand, they press on nerves nearby, which causes pain.

Another theory focuses on chemical changes in the brain. When chemicals in the brain that send messages from one cell to another, including the messages to blood vessels to get narrow or expand, are interrupted, migraines can occur.

More recently, genes have been linked to migraine. People who get migraines may inherit abnormal genes that control the functions of certain brain cells. And something the person's body is sensitive to in some way triggers the actual headaches.

Headache triggers can vary from person to person. Most migraines are not caused by a single factor or event. Your response to triggers can also vary from headache to headache. Many women with migraine tend to have attacks brought on by:

- lack of food or sleep
- bright light or loud noise
- hormone changes during the menstrual cycle
- stress and anxiety
- weather changes
- chocolate, alcohol, or nicotine
- some foods and food additives, such as MSG or nitrates

While migraine headaches affect millions of people, they are still less common than tension headaches. Tension headaches cause a more steady pain over the entire head rather than throbbing pain in one spot. Most of the time migraine attacks happen once in awhile, but tension headaches can occur as often as every day. While fatigue and stress can bring on both tension and migraine headaches, migraines can be triggered by certain foods, changes in the body's hormone levels, and even changes in the weather.

Migraine headaches are more common in women. In fact, about three out of four people who have migraines are women. They are most common in women between the ages of 35 and 45; this is often a time that women have more job, family, and social commitments. Women also tend to report higher levels of pain, longer headache time, and more symptoms, such as nausea and vomiting.

Hormones may also trigger migraine. Over half of women with migraine report having them right before, during, or after their period. Others get them for the first time when taking birth control pills. And some women start getting them when they enter menopause.

More than half of women with migraine have more headaches around or during their menstrual cycle. This is often called "menstrual migraine."

Migraines are severe headaches that are associated with over-dilation of blood vessels in the brain. An allergic reaction or stress may be the cause. The most common medical treatment involves medication, which may result in side effects of muscle pains, numbness and tingling in the fingers and toes, rapid (or slowed) heart rate, and nausea and vomiting.

Migraine sufferers are always in fear of their next headache.

Women who regularly suffer from migraine headaches only at premenstrual times most likely experience these episodes due to estrogen dominance. In addition to opposing the excess estrogen associated with estrogen dominance, progesterone helps to restore normal vascular tone, counteracting the blood vessel dilation that causes the headache.

Heart palpitations - hot flashes - night sweats

Vasomotor symptoms, such as hot flashes and night sweats can best be described as a wave of heat passing through the body causing much discomfort and 'flushing' of the face, neck and chest, and occur in 85% of women entering menopause.

Depending on the intensity of the hot flash, some women may get headaches, feel weak, dizzy, tired or lose sleep. Some may experience palpitations, skipped or erratic heartbeats.

Some women experience heart palpitations before or as the flash begins and while it's occurring.

Too much white sugar can also cause palpitations.

High levels of estrogen

One of the 'theories' behind the cause of hot flashes and night sweats in industrialised countries is that our brain has become conditioned to high levels of estrogen. When this estrogen is withdrawn - as is the case when we come off HRT 'cold turkey' or as our estrogen levels drop significantly at menopause - our internal thermostat (the hypothalamus) begins "shouting", trying to tell the pituitary to tell the ovaries to ovulate. The inability of the ovaries to respond is most likely due to a final depletion of eggs and their surrounding follicle cells.

This overactivity of the hypothalamus and pituitary signal begins affecting adjacent areas of the brain, which is often referred to as the vasomotor centre (that controls capillary dilation and sweating mechanisms), and women experience a hot flush.

It is argued that women experiencing perimenopause in third-world countries tend not to have such high levels of estrogen therefore, changing hormone levels will not necessarily cause their internal thermostat to go into hyper-drive

Rhonda writes, "I suffered for 5 straight years with heart palpitations, chest pains, nervous leg syndrome, the list goes on ... Drs. had no clue what was wrong with me ... I was finally introduced to natural progesterone in June of 2003 and I cannot get over how it has changed my life. I live a very happy productive life and have now gone on to educate other women about natural progesterone and what it can do to their lives."

Does diet play a role?

Although the hot flash is the most common symptom of menopause, there is a wide variation in its frequency among women in different parts of the world. In Europe and the United States, 70-80 percent of menopausal women experience hot flushes, in Malaysia 57 percent, in China 18 percent, and in Singapore 14 percent.

One of the most striking dietary differences among women in these areas is their intake of dietary (fermented) soy protein and its phytoestrogen properties. One of the 'theories' behind the cause of hot flashes and night sweats in industrialised countries is that our brain has become conditioned to high levels of estrogen.

Research has shown that Asian women who consume large amounts of plant estrogens, especially the isoflavones in soy, have fewer menopausal symptoms and less osteoporosis and cardiovascular disease than women in the West. However, actually studies conducted using isoflavones in the form of a pill vs. a placebo (a dummy pill) have, to date, proved inconclusive. So it's up to you to try them out. See if they actually work for you.

Other ways to ease hot flashes

- Stop smoking
- Limit your intake of caffeine, alcohol and spicy foods
- Try eating more Soy or Red Clover
- Take vitamin B6 & E supplements
- Acupuncture has also helped some women
- Participate in a regular moderate exercise program

Heavy bleeding

Progesterone will often help with heavy bleeding because it balances the effect of estrogen upon uterus (and breast) thus reducing the amount of menstrual bleeding ... but it is not a quick fix.

Heavy bleeding occurs as a result of many aspects within the body, and often it requires an individualized treatment plan such as vitamins, minerals, iron & B12 supplements, diet and stress management, and specific herbs. We have found selenium combined with vitamin E of great value.

These two work synergistically - each one improves the function of the other. Vitamin E will help to reduce and prevent uterine scarring. Selenium offers powerful anti-oxidant and anti-inflammatory properties. Phytoestrogens have a balancing effect on estrogen levels.

There might be underlying anaemia which can aggravate further heavy bleeding or the possible presence of fibroids, not forgetting one of the bigger players here - estrogen dominance, whether due to estrogen replacement therapy, progesterone deficiency, obesity, incorrect foods, exposure to toxins or stress. It's always advisable to get blood work done and an ultrasound, and other appropriate tests to eliminate all such possibilities.

Progesterone will help over a period of time but usually it requires high doses and then a gradual reduction. It takes some time for the body to settle down. We have known women to take between 8-18 months to combat heavy bleeding problems before they've actually found a position of comfort and success with progesterone usage.

Often the doctors will encourage women to undergo artificial progestin therapy, or advise them to have a curette, or recommend a hysterectomy to stop bleeding once and for all.

If heavy bleeding is actually caused by estrogen dominance alone, you should realize relief from a premium progesterone cream, along with other estrogen dominance reduction measures. Some women suffering estrogen dominance find that just by reducing their weight they were able to reduce their bleeding significantly.

Where there is a sudden appearance of a heavy bleed, a stat dose (once off) of high levels of progesterone (10%) has worked dramatically for some women to reduce and control bleeding.

Note intra-vaginal application appears to have significant impact in helping to reduce heavy bleeding where topical application at physiological doses has been marginally successful, or they have been successful in controlling their condition and then suddenly find they are facing out of control bleeding.

Keep in mind, every woman is individual. Rules vary here. Some women also fluctuate with low doses for months needing to increase for a 3-4 month period then dropping back. Stress and worry are huge players in heavy bleeding concerns. Of course, please seek medical attention in cases of unexplained heavy bleeding.

Hepatitis – liver disease

Hormones taken orally in pill form enter the bloodstream from the small intestine, and go directly to the liver. Because the liver is not accustomed to receiving large amounts of hormones, it begins to break them down, leaving only a small percentage of the ingested hormone available to cells.

This is called first pass loss (or first-pass metabolism) through the liver.

By comparison, transdermally delivered hormones like progesterone are up to 80% more bioavailable than equivalent doses administered orally. This has been proven by salivary hormone testing.

In other words, oral delivery systems provide only a fraction of biological activity in comparison to the same dosage of steroid hormones administered from a transdermal delivery system (TDS).

A variety of medications can cause organ damage, and anyone who has a history of liver disease should check carefully with their doctor before starting new medications. Steroid-based medications can result in hepatitis-like side effects, as can oral contraceptives, antibiotics, analgesics, and any medication designed to alter liver function.

Many women with a fatty / dysfunctional liver often cannot cope with potent doses of oral hormone replacement therapy as it overloads the workload of the liver. And this can actually aggravate weight problems and obesity. These ladies usually do quite well with natural progesterone transdermal cream.

Dr Martha Howard maintains that "oral pharmaceuticals can be harmful to the liver and gall bladder. Oral administration is outmoded. Plant-derived creams fit better in the body's receptors. I prefer transdermal delivery systems - it's safer and more natural."

Bioidentical progesterone, therefore, delivered transdermally has a significant safety margin and carries none of the side effects or health risks of synthetic progestins.

Having had a history of hepatitis would not preclude someone from using progesterone cream. There are plenty of more toxic substances being dealt with by the liver than progesterone.

The liver metabolises not only hormones, but numerous other toxic body wastes, ingested chemicals such as alcohol, caffeine, prescription, recreational and over the counter drugs to name a few. Chances are, your liver will have dealt with far more toxic substances in the intervening years.

Hives - Neuro dermatitis

Neuro dermatitis is believed by some authorities to be a psychogenic disorder - a condition of localized itchy skin [related to eczema] said to be mental or emotional rather than physiological in origin.

Neuro dermatitis tends to be associated with people who are nervous, tense and restless.

Now, my guess is that, in some cases, allergy symptoms such as hives, rashes, asthma or sinus congestion can be related to estrogen dominance. So too are depression, anxiety and agitation.

Sleep deprivation doesn't help matters either!

Catherine writes, "I remember sleeping with a scrubbing brush next to my bed during my mid thirties - a period in my life I now associate with pronounced hormone imbalance. It left me sleep deprived most days and, as we say here in Australia, "climbing up the bloody wall". But I don't have this problem anymore. In fact, since using progesterone, my skin looks soft and healthy."

We think it's reasonable to review your hormone levels to ascertain what's going on. Make sure you're under the care of a GP who will keep a watchful eye on your health.

Your GP might also include a Functional Liver Detoxification Profile (FLDP) to determine an efficient liver which is necessary for the processing and excretion of hormones, drugs, chemicals etc. Inefficient liver function can lead to "metabolic poisoning", a nondescript term referring to the build up within cells, tissues and organs of metabolites which have not been processed by the liver and excreted. Recently, function liver challenge tests have evolved which can allow routine assessment of the liver's detoxification abilities ... at home!

Also, we recommend you lotion your body head to toe every day. We're amazed by the number of women who don't see the need to incorporate a body moisturiser each day to replenish natural oils and protect against dry, flaky skin.

Devise ways to de-stress yourself, particularly given that high cortisol output is a major contributor to hormone imbalance.

Bioidentical hormone replacement therapy appears to have resolved her sensation of crawly skin inside three cycles.

It seems very hard to imagine that itchy skin can be related to hormone imbalance, yet Rhoda-Ann's case bares this out.

Rhoda-Ann writes, "I would like to pass the word that I am in my 3rd month of my natural hormone prescription and my itchy skin is almost gone. I finally get a good night's sleep and I can sit down and read a book without scratching my self to distraction...Thanks for all your encouragement. Menopause is the cause of my itchy arms! Now I am almost itch-free."

And Nancy has an interesting spin on things, "After many years and many doctors I discovered that my itchy arms were caused by an allergy to horses that was shown in a skin test when I was a child. I discontinued [Premarin](#) and was cured! So much for doctors - in my case at least eight."

We know the personal accounts generously provided by Rhoda-Ann and Nancy are going to reassure the ladies who've written to us citing a similar reaction to their progesterone cream.

And how incredible is Nancy's discovery that her itchy skin while using Premarin (PREgnant MAREs urINE) correlates with an allergy to horses? Who would have figured? Obviously not her treating physicians!

If you ARE experiencing a 'reaction' to your cream, make sure you select a cream that's free from additional hormones, herbs and alcohols, and contains NO animal by-products or petrochemical based ingredients.

Libido (sex drive)

Is your sex drive not what it used to be? Well, the good news here is that progesterone is usually the best hormone to start with to improve your sex drive. Indeed, one of the first things women notice when they begin applying progesterone cream is that their libido returns almost immediately.

The hormones that improve libido are progesterone and testosterone. From an evolutionary point of view this makes sense since progesterone is the dominant hormone at ovulation when a woman is most fertile.

Sometimes doctors recommend testosterone but even slightly high levels can have masculinising effects and can make libido more intense than most women want. If you want to undergo testosterone supplementation, please do so in collaboration with your treating physician.

Progesterone is often referred to as the "happy hormone" because it appears to be the treatment of choice to modulate and enhance our moods, and into the bargain restore our sexual appetite!

Menopause (change of life)

Menopause is the cessation (end) of menstrual bleeding signalling that estrogen production has fallen to a very low level, preventing the build up and shedding of uterine tissue every month (menstruation). It is the mark of the end of reproduction.

The drop in levels of estrogen is due to the inability of the ovaries to manufacture the sex hormones estrogen and progesterone. A woman is never totally deficient of estrogen, although her estrogen levels drop below a point that creates monthly menstrual cycles.

In other words, menopause is a marker of ovarian failure, because the body can no longer ripen and mature the remaining follicles into eggs for fertilisation. This happens around about age 50-55, although women are entering menopause much earlier now.

It is the follicles within the ovaries that produce the vast majority of estrogen and progesterone which is produced after the ovary has popped (ovulation).

Symptoms of Menopause

Menopausal symptoms are triggered by the drop of estrogen, and varying in intensity. These are the most common:

- absence of periods
- hot flushes / flashes
- aches and pains - joint, neck, backache
- dizziness
- headaches
- vaginal dryness or itching
- bladder problems - stress incontinence, other irritations, prone to infections
- dry and aging skin - loss of elasticity
- crawling or itching sensations under skin
- poor sleep patterns - commonly waking 12pm, 2am and 4am
- foggy thinking
- emotional changes - anxiety, irritability, depression, loss of self-esteem, lacking confidence, panic attacks, and many more
- physical exhaustion

As we age and enter menopause, our hormone levels abruptly change, heralding a degree of discomfort (and risk) for some. But let's state for the record that not every woman requires hormone replacement therapy. A vast majority of menopausal problems can be avoided by good nutrition, avoidance of toxins, regular moderate exercise, some lifestyle changes and regular salivary hormone profiles to ensure our hormones continue to fall within an ideal reference range.

If you experience any of the symptoms listed above (associated with estrogen dominance), then supplementing with natural progesterone cream will certainly help.

Progesterone therapy will *not* cause a woman to go back into monthly cycles if she has truly entered menopause because it is estrogen - NOT progesterone - that sets the scene for the monthly cycles. The build up of the endometrial tissue is under the influence of *estrogen*. It is the drop of estrogen that signals menopause and stops your period.

A woman can have stopped ovulating, and be infertile many years before her periods stop.

In the event progesterone doesn't resolve hot flashes and vaginal dryness, then small doses of estriol cream can make a difference. In fact, compounding pharmacists, in consultation with your GP, are equipped to individualise a BHRT treatment plan around whatever hormones need replacing based on your salivary analysis.

Menstruation (menstrual period)

Menstruation is a woman's monthly bleeding. It is also called menses, menstrual period, or period. When a woman has her period, she is menstruating. The menstrual blood is partly blood and partly tissue from the inside of the uterus (womb). It flows from the uterus through the small opening in the cervix, and passes out of the body through the vagina. Most menstrual periods last from three to five days.

Menstruation is part of the menstrual cycle, which helps a woman's body prepare for the possibility of pregnancy each month. A cycle starts on the first day of a period. The average menstrual cycle is 28 days long. However, a cycle can range anywhere from 23 days to 35 days.

The parts of the body involved in the menstrual cycle include the brain, pituitary gland, uterus and cervix, ovaries, fallopian tubes, and vagina. Body chemicals called hormones rise and fall during the month and make the menstrual cycle happen. The ovaries make two important female hormones, estrogen and progesterone. Other hormones involved in the menstrual cycle include follicle-stimulating hormone (FSH) and luteinizing hormone (LH), made by the pituitary gland.

The levels of progesterone in a woman's body rise and fall dramatically with her monthly cycles. At ovulation, the production of progesterone rapidly rises from 2-3mg per day to an average of 22mg per day, peaking as high as 30mg per day a week or so after ovulation.

After ten or twelve days, if fertilization does not occur, ovarian production of progesterone falls significantly. It is this sudden decline in progesterone levels (as well as estrogen levels) that triggers a period (menstruation), and another menstrual cycle will begin.

If pregnancy occurs, progesterone production increases and the shedding of the lining of the uterus is prevented, preserving the developing embryo. As pregnancy progresses progesterone production is taken over by the placenta and its secretion increases gradually to levels of 300-400mg per day during the third trimester.

During pregnancy, rising progesterone levels prevent the premature shedding of the uterine lining (pro-gestation). If progesterone levels drop due to inadequate progesterone production, then a premature delivery could result, or bring about a miscarriage in the early trimesters.

Progesterone also influences the development of the breasts during pregnancy in preparation for producing milk after the birth. It has an impact on ligaments and muscles throughout the body as well, essentially to allow the suppleness and expansion necessary for giving birth. This also accounts for some of the problems which may be experienced during pregnancy - backache, constipation, and low-blood-pressure, for example.

During the menstrual period, the thickened uterine lining and extra blood are shed through the vaginal canal. A woman's period may not be the same every month, and it may not be the same as other women's periods. Periods can be light, moderate, or heavy, and the length of the period also varies. While most menstrual periods last from three to five days, anywhere from two to seven days is considered normal. For the first few years after menstruation begins, periods may be very irregular. They may also become irregular in women approaching menopause.

Period problems

Women can have various kinds of problems with their periods, including pain, heavy bleeding, and skipped periods.

Amenorrhea - the lack of a menstrual period. This term is used to describe the absence of a period in young women who haven't started menstruating by age 16, or the absence of a period in women who used to have a regular period. Causes of amenorrhea include pregnancy, breastfeeding, and extreme weight loss caused by serious illness, eating disorders, excessive exercising, or stress. Hormonal problems (involving the pituitary, thyroid, ovary, or adrenal glands) or problems with the reproductive organs may be involved.

Dysmenorrhea - painful periods, including severe menstrual cramps. In younger women, there is often no known disease or condition associated with the pain. A hormone called prostaglandin is responsible for the symptoms. Some pain medicines available over the counter, such as ibuprofen, can help with these symptoms. Sometimes a disease or condition, such as uterine fibroids or endometriosis, causes the pain. Treatment depends on what is causing the problem and how severe it is.

Abnormal uterine bleeding - vaginal bleeding that is different from normal menstrual periods. It includes very heavy bleeding or unusually long periods (also called menorrhagia), periods too close together, and bleeding between periods. In adolescents and women approaching menopause, hormone imbalance problems often cause menorrhagia along with irregular cycles. Sometimes this is called dysfunctional uterine bleeding (DUB). Other causes of abnormal bleeding include uterine fibroids and polyps. Treatment for abnormal bleeding depends on the cause.

At what age does a girl get her first period?

Menarche is another name for the beginning of menstruation. A girl can begin menstruating anytime between the ages of 8 and 16. Menstruation will not occur until all parts of a girl's reproductive system have matured and are working together.

Women usually continue having periods until menopause. Menopause occurs around the age of 51, on average. Menopause means that a woman is no longer ovulating (producing eggs) and therefore can no longer become pregnant. Like menstruation, menopause can vary from woman to woman and may take several years to occur. Some women have early menopause because of surgery (hysterectomy) or other treatment, illness, or other reasons.

Estrogen dominance

Estrogen dominance is a term coined by the late Dr John Lee in his first book on natural progesterone. It describes a condition where a woman can have deficient, normal, or excessive estrogen but has little or no progesterone to balance its effects in the body. Even a woman with low estrogen levels can have estrogen-dominance symptoms if she doesn't have any progesterone.

And how do we become 'estrogen dominant'?

All too often our food chain is laced with toxic pesticides, herbicides and growth hormones - a sea of endocrine-disrupting chemicals that mimic estrogen in our body. If we are overweight, our body's store of excess fat can be converted into estrogen. Insulin resistance leads to estrogen dominance. A visit to our GP for the odd hot flash, missed period or PMS discomfort can result in a prescription of estrogen pills, patches or implants.

And yet unopposed estrogen in our bodies results in all sorts of hormone-related health problems such as PMS, endometriosis, uterine fibroids, infertility, weight gain, increased blood clotting, thyroid dysfunction, even cancer, in both men and women.

Progesterone can dramatically decrease cell multiplication rates, providing women with a degree of protection against estrogen-driven cancers. Normal levels of progesterone in the body can, therefore, actually help protect you against some forms of cancer.

Ovarian cysts - Polycystic Ovarian Syndrome (PCOS)

Polycystic Ovarian Syndrome refers to multiple small cysts on the ovaries (polycystic ovaries) and a host of other problems that go along with them, including lack of ovulation, menstrual abnormalities, excessive facial hair, male pattern baldness, acne, and sometime obesity. Some women may also have varying degrees of insulin resistance (increased incidence of Type II diabetes), low bone density, and high triglycerides.

Other names for PCOS are polycystic ovarian disease (PCOD) or the Stein-Leventhal syndrome.

Symptoms include:

- menstrual periods - abnormal, irregular or scanty
- absence of period - usually but not always, after having one or more
- menstrual periods during puberty - then it stops
- obesity - beginning tummy, hips, upper body
- infertility
- increase body hair growth, unusual growth and distribution of body hair
- decreased breast size
- aggravation of acne

PCOS is where there are multiple cysts (more than 10 small follicles per ovary, lined around the edge of the ovary), whereas in a normal ovary they are distributed more evenly throughout the ovary. It is a condition of hormonal imbalance and it is characterised by excessive amounts of male hormones and irregular menstruation. Women are often predisposed to it, and it is strongly linked to inherited factors that may be triggered by stress and weight gain. Polycystic ovaries can be detected by an ultrasound of the pelvis, and blood results showing high levels of testosterone.

What causes PCOS, and how is progesterone used in the treatment of this disease?

PCOS occurs when a woman fails to ovulate, which results in a disruption in the normal, cyclic interrelationship among her hormones, her brain and her ovaries. If ovulation is unsuccessful, and a lack of progesterone is detected by the hypothalamus, the ovary is stimulated to make more estrogen and androgens (male hormones), which stimulates more follicles towards ovulation. PCOS occurs when these additional follicles are unable to produce a mature ovum or make progesterone. These eggs won't 'pop' and progesterone isn't made. The menstrual cycle is then dominated by estrogen and androgen (testosterone) minus the production of progesterone.

High levels of testosterone not only cause male-like features but interfere with the pancreas which disturbs insulin production. This in turn will interfere with blood glucose metabolism, accounting for the incidence of excess weight gain, particularly upper body weight, thereby creating a vicious cycle. Reducing weight helps control this problem, and enhance hormone balancing. Progesterone also assists in modulation and balancing.

There are suggested links between exposure to environmental pollutants that mimic estrogen and the developing baby's tissue. Laboratory experiments, wildlife studies, and the human DES experience link hormone disruption with a variety of male and female reproductive problems that appear to be on the rise in the general human population - problems ranging from endometriosis, testicular cancer, infertility, and in there somewhere is PCOS.

It is argued that if a female embryo's ovarian follicles are compromised through exposure to these chemicals, this damage will not be apparent until after puberty.

Other factors that can contribute to PCOS:

- stress - high cortisol levels, long term
- lack of exercise - overweight
- poor nutrition - too much sugar and highly refined carbohydrates
- Birth Control Pill - shuts down normal ovary function
- prescription drugs - that may impair the functioning of the limbic brain

Natural progesterone appears to be proving to be a major player in the successful treatment of PCOS. The reason behind this solution - if your body isn't producing enough progesterone then progesterone supplementation is going help maintain the normal cyclic pattern each month.

The way you can tell if you're on the winning side of progesterone therapy and may reduce your dosage is by the fact that you haven't continued to gain weight, your lower abdomen is no longer swollen or tender, your sugar cravings are under control, your facial and body hair has reduced significantly, and your periods have regulated.

If your symptoms appear to be getting worse, you need to check out your testosterone levels, glucose intolerance, and ultrasound results, all of which may indicate that progesterone therapy is not enough, or you need to increase your dose. Do this only under your doctor's supervision.

There are some very helpful natural supplements on the market to help reduce and stabilise high blood sugar levels and insulin resistance in the treatment of PCOS.

Addressing weight problems is very important in the treatment of this disease. Reducing weight is imperative to a favourable outcome with or without progesterone therapy. Continued weight gain leads to continued storage of upper body fat which, in turn, generates higher levels of male hormones, and further hormone disruption and insulin resistance results. This cycle becomes vicious, and the disease worsens.

What else can I do to improve PCOS symptoms? Pay particular attention to diet and nutrition, avoid all refined carbohydrates and sugars, get plenty of exercise, drink lots of filtered water, reduce weight, learn to manage your stress levels, and rest up.

Perimenopause (transition into menopause)

Years before the end of your periods, a woman goes through a transitional time that is called perimenopause. This transition - puberty in reverse - occurs as your hormones are gearing down from the high levels needed to reproduce. This transition can take between one and 10 years, but averages about three years. After a full year without a period a woman is proclaimed menopausal.

Hormonal changes are responsible for the onset of perimenopause. As a woman reaches the end of her childbearing years, production of her ovarian hormones begins to fluctuate. During perimenopause, many cycles are anovulatory (do not include ovulation) and estrogen levels can sharply rise and then quickly drop. This causes menstrual periods to become shorter, then more and more irregular until they stop.

In the United States, the average age of menopause is 51.

The variations in hormones that occur during perimenopause are responsible for many of the symptoms. Luckily most of the symptoms only last for a few months. About one-third of women have no symptoms, while a third have mild ones and a third have severe ones.

Here are some of the commonly mentioned symptoms:

- Fatigue
- Insomnia
- Irregular menstrual periods
- Heavy bleeding
- Irritability
- Hot flashes and night sweats
- Memory difficulties (fuzzy thinking)
- Mood swings

Although perimenopause is perfectly normal, some symptoms should probably be checked to make sure that they are not the sign of something else. This is particularly true for persistent heavy bleeding, persistent palpitations (especially when accompanied by chest pain or shortness of breath), severe depression or fatigue.

Extreme variations in hormones make testing hard. The FSH test, which checks the blood level of the follicle stimulating hormone (FSH), is only valuable after you have been without a period for a year, by which time you will have probably figured out that you are in menopause.

Premature menopause

Premature menopause is technically defined as menopause that occurs before the age of 40. You stop ovulating and your periods stop completely years before the "normal" age of menopause. When you're going through early menopause, you'll notice symptoms that are the same as those for women in perimenopause -- hot flashes, changes in your period, night sweats, mood swings and the like. But you'll notice these symptoms at a much younger age -- in your 20s, early 30s, even late teens. Your estrogen levels drop; your FSH levels rise in an effort to jumpstart your ovarian function -- but you stop ovulating and, ultimately, your periods stop altogether decades earlier than usual.

The role of progesterone

Progesterone has a comprehensive role in a woman's body. And when levels drop, your body is going to react in a big way. We now know that if we allow estrogen to dominate the hormonal environment, there is significant risk of breast cancer and reproductive cancer. So one of progesterone's most important roles is to balance or negate the effects of estrogen.

At menopause, a woman's estrogen level will drop by 40-60% (or can be lower in cases involving thin women). Just low enough to stop the menstrual cycle. Progesterone levels, however, may drop close to zero in some women.

This wouldn't have bothered a woman at the turn of the 20th century who rarely lived beyond her reproductive years. But these days a woman can expect to live to 85 years and beyond. She needs to give some thought to how she's going to rejuvenate her 'ageing' endocrine system. Natural hormone replacement will become a vital anti-ageing tool for both men and women, and progesterone supplementation is a good place to start.

Post partum (natal) depression

One of the factors of post natal depression is the sudden drop of progesterone once the baby is born.

When you consider that a woman in her last trimester of her pregnancy is producing up to 400mg of progesterone via the baby's placenta, after the baby is born and the placenta is expelled, the progesterone factory is literally turned off. This drop in progesterone is necessary to stimulate another hormone to bring on lactation.

Most women will be familiar with the term 'baby blues'. With the sudden withdrawal of progesterone, depression can be triggered, known as post-natal depression. This can vary for every woman in the time

of onset, severity, and duration. And for other women, it can be insidious, undiagnosed and left untreated for many years after the baby is born. But it's now recognised that women generally do go through a brief period of depression following the birth of their child which they usually get over in no time. Now, with the discovery of progesterone supplementation, it has been such a breakthrough in defeating post-natal depression.

For mild to moderate depression, natural progesterone has proven quite adequate in small doses for approximately 4 months uninterrupted. We suggest you start at lower doses and assess to see if your depression is lifting, and only increase if you feel you are not responding at that dosage. Give yourself a week to feel the benefits.

Unlike women who have to wait 6-8 weeks to reach saturation level in the body to feel the benefits of progesterone, new mothers don't need to go through this process because their body, being familiar with this hormone, will respond very quickly with the reintroduction of natural progesterone.

Moderate to severe depression may require higher doses, then wean back gradually. We suggest you make your GP aware of the fact you have chosen to trial bioidentical progesterone and seek his support, rather than resort, at this point, to traditional anti-depressant drugs that might expose you and the baby to these substances.

Our observation has been that progesterone has provided women with a 'happy' and safe solution for mum and her baby, and has not interfered with her milk production.

Some women have even commented that they've been able to relax, cope better and enjoy the experience of motherhood for the first time, where their previous accounts battling depression and their refusal to resort to medication, or the side effects of the medication they were encouraged to take may have left them feeling quite cheated of the whole mothering experience.

Women share with us their feelings of shame and failure associated with post-natal depression, particularly when it has not been explained to them that post-natal depression is the result of a hormone imbalance of which they have no control over.

There are cases where post-natal depression is very severe and requires you to be under the care of a specialist. If you wish to incorporate natural progesterone using high doses, you will need to find a doctor who will support this therapy. Dr Katharina Dalton is well known for her work and research in the treatment of post-natal depression (and PMS) using very high levels of progesterone (100mg-300mg) daily. Here in Australia, however, there are doctors who will incorporate troches and pessaries at high levels.

Note, please take precaution during lactation that you do not become pregnant. Breast feeding in conjunction with natural progesterone is not a substitute for contraception.

Rosacea

Rosacea (pronounced roh-ZAY-sha) is a relatively common, chronic skin disorder.

The classic symptoms of rosacea are patchy flushing (redness) and inflammation, particularly on the cheeks, nose, forehead, and around the mouth.

Rosacea typically appears between the ages of 30 and 50 and affects more women than men.

No one knows for certain what causes rosacea. Although rosacea can affect all segments of the population, individuals with fair skin who tend to flush or blush easily are believed to be at greatest risk.

Researchers have suggested several factors that may be related to its development:

- A disorder of the blood vessels that causes them to swell, leading to flushing.
- A genetic predisposition combined with certain environmental factors that may irritate the skin.
- Clogging of the sebaceous gland openings with skin mites called *Demodex folliculorum*, which live in facial-hair follicles.

Rosacea affects the eyes in many patients, and may result in a watery or bloodshot appearance, irritation and burning or stinging. The eyelids may also become swollen, and styes are common. This condition is known as ocular rosacea.

Does progesterone help ease the symptoms of rosacea? It appears to, though no one knows by what mechanism this is achieved.

Feedback to this site from women using natural progesterone cream, more often than not, includes the general comment, "my skin has improved".

Progesterone appears to aid repair and hydration of the skin. Even sensitive skin, seems to tolerate progesterone cream when applied sparingly to the face at intervals during your cycle.

Premium cosmetics have been using progesterone in their products for over half a century. So it comes as no surprise to read that progesterone may help reduce dry, blotchy skin while improving elasticity and diminishing fine lines for a radiant youthful complexion.

When applied directly to the face, including the affected skins areas, good outcomes are generally recorded.

"I am 51. Did not have a period for 5 years and didn't know about the P/E ratio. I started to get a painful sunburned look on my face during stress, a glass of wine, etc. My GP and dermatologist both said rosacea. I got the Rx's and they didn't work. I stumbled across NPC, started using it 1.5 weeks ago ... no red face, even under stress!" ~ Lorraine ~

Stress

What happens when the body experiences stress?

Five things happen simultaneously:

- Sugar is released into the bloodstream. If more sugar is released than is needed, a disharmony occurs.
- The thymus gland contracts. This large gland is in the centre of the chest behind the breastbone and is related to the immune system in adults. Sustained contraction inhibits the production of blood cells and adds to the feelings of anxiety.
- Muscles tense. Sustained muscle tension will cause cells to break down, toxins to accumulate and oxygen and nutrient supplies to diminish, causing a lack of oxygen at the cellular level.
- Capillaries dilate, under sustained tension, lymph movement is slowed down and plasma and proteins accumulate between the cells, causing a build-up of toxins, pressure and swelling, as well as inhibiting the cell's supplies of nutrients and oxygen.
- Cells release toxins. Our cells are releasing toxins all the time as a natural part of their regular activity. Under stress, their activity increases. The natural process is for these toxins to be washed clear by the plasma and carted off by the lymph system to be discharged through perspiration, respiration and elimination.

When sustained tension inhibits the cleansing of the toxins they build up locally, poisoning the local cells and finding their way into the bloodstream through different capillaries, where they can effect the brain and the glands.

Why does stress upset my hormonal imbalance?

The cortico-steroid hormones are made from progesterone. Therefore, stress forces progesterone to be used in the body in a different way, taking the hormone down another steroid pathway (see the Hormonal Cascade diagram in Chapter 5), thus depriving the body of it's usual supply of progesterone and cascading benefits.

High cortisol production which occurs with stress of any kind, including trauma, inflammation or inflammatory diseases, emotional and even chemical stress, can induce high levels of cortisol and this leads to significant reduction of progesterone, resulting in estrogen dominance. While there are high levels of cortisol, the cortisol is actually taking over the progesterone receptors, thereby competing with progesterone.

Over time, repeated triggering of stress hormones (cortico-steroid hormones) can deplete your body of energy and leave you less able to respond.

Stress can be a factor in the development of cardiovascular disease, hypertension, cancer and many auto-immune disorders such as lupus and multiple sclerosis. Additionally, stress can contribute to irritable bowel syndrome, thyroid dysfunction, headaches, sleep disturbances and many skin conditions.

Chronic stress depletes many nutrients from the body, including most B vitamins, antioxidants, zinc and other minerals necessary for immune-system function.

Clearly, long term stress and constant output of cortisol causes nasty consequences to the body. We make mention to the importance of stress management in maintaining hormone balance throughout our book.

And in recognising extreme stress, be it high pain levels, chemical, illness, or emotional, always accommodate by slightly increasing your progesterone dose to cater for the body's need for additional progesterone supplementation to assist in the manufacture of this stress hormone, and help compete for access to the progesterone receptors.

Teenagers

Is progesterone treatment appropriate for a girl aged, say 15, who is suffering from severe cramps for first 2-3 days of her period as well as water retention, mood swings, craving sweets and other PMS symptoms that require pain management?

We would suggest you first determine, via her treating physician, your daughter's baseline salivary hormone levels. From these results, you can more accurately determine hormone imbalance.

But that's only one approach. You still need to figure out the 'why'. What is it in your daughter's environment (that includes diet & lifestyle) that is causing what appears to be estrogen dominance?

She should be thoroughly checked out by her physician and, if there is nothing remarkable wrong with her, and her hormone levels are within the normal reference range yet her symptoms persist, you might consider dabbing a little progesterone on from Day 12-26 to gauge the result, in consultation with her doctor if possible.

We're ought to be cautious when it comes to our teenage daughters. If they complain of headaches, mood swings, acne, heavy painful periods, or a craving for sweets, we can open up discussions around what might be contributing factors. More often than not it can be tracked back to stressors or apprehension in the classroom, or they are not getting enough rest, maybe skipping meals and eating way too much processed food.

Basically, we should encourage our daughters to listen to the message their body is sending them. When they unravel the 'why', the need for any medication is markedly reduced.

There is a considerable safety margin with progesterone supplementation given its low toxicity, however, it may be irresponsible to embark on progesterone replacement therapy without due care, especially at such a tender age.

For young teenage women, Vitex (Vitex Agnus Castus, also called Chaste Tree or simply Vitex) is definitely a good starting point to correcting and maintaining hormone balance.

When hormone replacement therapy IS medically indicated, we suggest you *insist* your daughter be prescribed human-identical hormone replacement therapy.

Tubal Ligation (tubes tied)

Tubal ligation, commonly known as "getting your tubes tied," is a surgical sterilization technique for women. This procedure closes the fallopian tubes, and stops the egg from travelling to the uterus from the ovary. It also prevents sperm from reaching the fallopian tube to fertilize an egg.

Will a tubal ligation affect my hormones? Usually "yes", it's just a matter of when.

A number of women reported a variety of problems subsequent to a tubal ligation. Irregular, heavy menstrual bleeding, for example, that has, on occasions, resulted in a hysterectomy. These women reported increased period pain, longer periods, painful intercourse, severe PMS. Even endometriosis has been known to occur after surgical sterilisation.

These women post tubal ligation often go into early menopause, or experience perimenopausal problems such as hot flushes, sleep disturbances, anxiety attacks and all the estrogen dominant symptoms that are commonly listed.

Some common characteristics to consider. Overall, these women reported hormone imbalance 6-7 years after their tubal ligation. However, occasionally, a woman reported insidious side-effects virtually the day after she had surgery.

After a tubal ligation, women often enter the circuit of 'doctor hopping' in search of answers for their failing health.

Women who have had a hysterectomy (or tubal ligation) leading to dysfunction of the ovaries generally enter into a state of estrogen dominance where a woman can have deficient, normal, or excessive estrogen but has little or no progesterone to balance its effects in the body.

Many women claim, time and time again that, had they been given more information, they certainly would not have journeyed down the path of a tubal ligation. They also feel that had they known how it was going to affect their hormonal profile, in many cases their libido, then perhaps they would have looked at other forms of contraception.

Can progesterone help? We believe so. Particularly in the treatment of symptoms associated with premenopause and perimenopause.

Julie writes, "I am 48 and had my tubes tied. I've never taken the pill. My hormonal health is much better since going on progesterone. I don't have the PMT and long sleepless nights like I used to."

Vaginal dryness / atrophy

In the event progesterone cream alone does not resolve hot flashes and vaginal dryness, then small doses of estriol cream can make a difference. In actual fact, compounding pharmacists, in consultation with your GP, are equipped to individualise a BHRT treatment plan around whatever hormones need replacing based on your salivary analysis.

Women who are currently on a program of estrogen replacement therapy should perhaps give consideration to estriol cream as a safer alternative in the treatment of vaginal dryness and/or atrophy, severe hot flashes, urinary incontinence, painful intercourse, and other associated symptoms.

We know that estriol does not induce endometrial proliferation to the extent of the other estrogens. However, we do need to include a progesterone cream to balance the estrogenic effect of estriol.

Estriol is able to be excreted easily from the body in the urine. It is water-soluble and as such does not need to be broken down by the liver; thus it does not build up in the body. For these reasons the safest estrogen to use is estriol applied to the vulva and lower vagina every day (except during cyclic breaks).

As a treatment for osteoporosis, estriol significantly improved Bone Mineral Density by inhibiting bone resorption and therefore, estriol might be effective for use in HRT in elderly patients.

Please note, bioidentical progesterone, estriol and/or testosterone replacement therapy can be purchased from your compounding pharmacist as individual transdermal creams. But make sure you buy each hormone in a separate dispenser since you'll need to adjust dosage according to periodic salivary hormone profiles.

It is recommended that estriol levels be measured when supplementing with a compounded preparation of bioidentical estrogens (e.g. "Biest" preparations contain estriol and estradiol, OR "Triest" preparations containing estriol, estradiol and estrone).

Les shares her story, "I've now been taking progesterone cream for 3 months, started to eat healthy balanced meals (no more vegan!) and I stopped taking the pill. The hot flashes stopped the very next

day, no more mood swings, no more weeping, my skin has improved, I've lost 15lbs and kept it off. Another plus is that my libido has returned, and no more vaginal dryness."

Weight gain

Hormone imbalance can often contribute to unsightly and unhealthy weight gain, particularly around the tummy, hips and thighs. And to add insult to injury, by simply being overweight your body is converting that extra body fat into a form of estrogen called estradiol that will further compound your estrogen dominance.

Older women who are obese have a much higher risk of breast cancer because their fat cells release too much estrogen, according to latest research. An international study comparing obese women to women of normal weight confirms what doctors have long suspected - that fat cells release the hormone into the blood, allowing it to help turn normal cells cancerous.

"There was clear hypothesis that the mechanism for the effect of obesity might be high blood estrogen levels, but no one has been able to test that directly," said Dr. Tim Key of the Cancer Research U.K. Epidemiology Unit at Britain's Oxford University.

The researchers, who reported their findings in the Journal of the National Cancer Institute, said they are good news - giving women a way to reduce their risk of breast cancer.

"Women's risk is affected by many fixed factors - a family history of the disease, the number of children they have, the age they have their children, when they start their periods and when they stop," Key said. "But obesity is something that women have a level of control over. Put simply, maintaining a healthy weight avoids extra breast cancer risk for these women."

Key and colleagues in Britain, Italy, Japan and the United States studied eight different groups of women who were past menopause - when the risk of breast cancer rises dramatically.

None of the women had cancer and none were taking hormone replacement therapy when their blood samples were first taken. The researchers then watched the women for between two and 12 years to see which ones developed breast cancer.

More weight equals more cancer.

Certainly, there's an inseparable connection between fat and estrogen. And the good news is that progesterone - our body's 'natural' anti-estrogen - will help your body convert fat into energy.

A natural diuretic, progesterone will further assist weight loss by regulating sodium imbalance within the body, correcting fluid retention and helping you eliminate excess fluid from the body. However, it may initially exacerbate estrogen dominance symptoms which can have the appearance of weight increase which is usually only temporary.

Some women actually stop using their progesterone cream after they gain a little weight thinking, incorrectly, that progesterone is the culprit. They failed to understand the other factors that contribute to weight gain once progesterone is introduced.

But correcting female sex hormone imbalance is only part of the picture. We need to focus squarely on optimal metabolic health.

Will progesterone cause you to put on weight? Progesterone will *not* cause you to put on weight. In fact, it will do the opposite. Progesterone will help the body convert fat into energy. However, it may initially exacerbate estrogen dominance symptoms such as fluid retention which can have the appearance of weight increase which is usually only temporary.

Synthetic progestogens, on the other hand, routinely used in hormone replacement therapy do put on weight that, according to our network, is very difficult to shift. This may be due to incorrect dosage or combination HRT (estrogen) for the individual's body type, or because it overloads the liver.

Metabolic health

So what is metabolic health? Well, Dr. Lowe defines metabolic health in this way: A state in which the chemical processes in our cells are sufficient to provide us with at least two things: (1) resistance to sickness and disease, and (2) the vigour, stamina, and well-being needed to fully engage in all aspects of life.

Metabolic rehabilitation is a process in which a patient gets control of, or eliminates all the factors that are impeding her metabolism.

Here are the nine most common factors that cause hypometabolism. It's important to remember that the first one can cause or influence many of the others.

- Under-regulation by thyroid hormone
- Too little cortisol
- Sex hormone imbalance
- Nutritional deficiencies
- Unhealthy diet
- Chemical contaminants
- Low physical fitness
- Untreated physical problems
- Troublesome drugs

You can see from this list that adding progesterone may or may not assist in weight loss despite resolving female sex hormone imbalance. We have to consider the 'whole' picture that is you.

Some pretty straight-forward tests ordered by your doctor can better determine what's going on with your body, and from there he or she can suggest an appropriate course of treatment. This may include thyroid hormone therapy in combination with bio-identical hormone replacement therapy (BHRT).



Anatomy of the spirit

A message from Catherine

We would be doing the women a disservice if we didn't disclose the inner soul and inner spirituality of what we believe is the progesterone journey from a holistic point of view, covering not only the physical benefits and usage of progesterone, but the spiritual and the emotional side of progesterone. I believe that they are all interactive and there is no clear defined line between what is hormonal, what is emotional and what is spiritual. They all interplay, and they all have a place of importance and need to be acknowledged and recognised.

I believe that to give a woman back her essence hormone - progesterone - you give her back an opportunity to reconnect with herself.

Many women have become so hormonally imbalanced that they have no clue as to what their true essence feels like. Often stress, a very busy lifestyle, or family can and do distract her. However, the one thing in common with every woman who has approached this website, or I have spoken to personally, is that once a woman gets her hands on this vital hormone, she begins an incredible journey. Often she doesn't even understand what's going on herself but it's so powerfully obvious to those people, often loved ones, witnessing the transformation.

We know that as soon as a woman who is in need of progesterone supplementation introduces this hormone into her body, there's an incredible physiological reaction. It's as if this hormone resonates immediately, and she can tell progesterone is central to her renewed health, not necessarily because of what she's read but how it intrinsically feels in her body. It's as if she's coming home to herself.

Even for those women who may experience incredible discomfort for the first 10 days to 2 weeks, when estrogen receptors actually wake up and estrogen dominance symptoms are exacerbated, she is determined to keep applying progesterone cream because she wants the end result. There is an intuitive 'knowing' that something good has been introduced into her body and she wants it to stay.

Unfortunately, some women abandon progesterone at the point of discomfort, not knowing how to get through the debilitating stages of estrogen dominance, which can occur at any stage. It is our hope this ebook helps you work through the setbacks so that you can stay with progesterone long enough to enjoy the true essence and benefits from both a physical and metaphysical viewpoint.

It is likewise acknowledged that some women commence synthetic HRT and, feeling dreadful in the initial period, give it up because they know intuitively, judging by the way their body reacts, it feels 'bad' for her. Often women don't even get to the point of opening that packet of HRT, or it sits in their handbag, the script unfilled. Clearly, there is something that just doesn't feel right for these women. I'd recommend women honour their intuition, listen to their innate intelligence; use their discernment.

Women in their 40s and 50s with families, careers, a wealth of experience and knowledge, and tremendous gifts to offer the world appear to lose all semblance of their true self because of incorrect or untreated hormonal imbalance.

Within months of progesterone use and balancing various aspects of their life (which we talk about in our ebook), and benefiting from our encouragement that a woman acknowledge herself and honour her body, these very same women start to 'plump up' spiritually. They find their voice, begin to once again express an opinion, exude a renewed confidence, and reclaim their self respect.

Husbands contact the website distraught and desperate, looking for solutions to their wife's behaviour; her inability to cope, recall, focus, communicate, socialise.

These fuzzy-headed, tentative women, once they get 18 months into progesterone therapy, often end up being in a position to stand up for themselves and, if need be, their husbands. They become assertive and reclaim their independent, and finally learn how to say "no" as appropriate.

Women write to this website obviously in a very vulnerable state. They are out of tune with their bodies and their needs. They have become distraught, exposed, and fragile. They are exhausted physically, emotionally and spiritually. One can sense tears of frustration and isolation behind their cry for help, for it is indeed a relief and validation for them to have finally found an outlet - Natural-Progesterone-Advisory-Network.com

Hormonal imbalance seems to weaken the emotional profile of a woman. In other words, it has a way of bringing to the surface grief, sadness, depression, conflict, anger, resentment, guilt, and shame, and a ton of tears. Basically, it's an emotional roller-coaster.

Hormone imbalance appears to be a catalyst for visiting painful and hurtful conflicts and memories, thus isolating and alienating us into further despair and depression, or triggering anxiety and panic attacks. There is this overwhelming helplessness and distortion of reality that is compounded by hormone imbalance, but seems to be easily addressed once progesterone is introduced. Mind you, progesterone doesn't mysteriously make the problems disappear. It just seems to give most women the ability to tackle her problems with a different perception and a more methodical approach.

We all too often tend to fob off our outbursts as hormonal, that it's our hormones talking and that we're not normally like that. Perhaps - perhaps not. Maybe when your guard (hormones) is down you are, for once, speaking the truth!

First address hormonal imbalance. Get your progesterone levels back up where they should be such that you ground yourself. Get your nutrition and exhaustion in hand so you're feeling stronger in yourself and physically better able to cope with stress, infections and all the traumas your body is exposed to on a daily basis. Then deal with the emotional issues that arise, or need closer examination. You may find that you now have to revisit events that you thought were resolved and in the past. It's not uncommon to discover that conflicts grow worse, even uglier and more out of control and irrational because you hormones are all over the place.

If there are issues there - grief, unresolved conflicts, burdens, sadness, relationship issues - then allow them to surface and use your hormonal imbalance as an excuse to have a damn good cry. Tears are for healing. Tears are the way of cleansing the soul. And then get on and deal with it.

Hormone imbalance creates emotional instability, but I also say emotional issues often create hormonal imbalances. There's always a connection with the adrenals when stress is involved (adrenal exhaustion can cause hormonal imbalance, hormonal imbalance can create adrenal exhaustion). A shock such as a death in the family, kids leaving home on bad terms, a sudden divorce, a husband running off with a younger woman can send your hormones into a tail spin! This goes to show how stressful situations can cause our body to lose balance, rhythm and connectivity. It demonstrates how powerful the mind-body connection is and, when turned against ourselves, can throw the whole endocrine system upside down.

This is a time of shedding. It is a time of re-building your body. A time a women can perhaps re-build her persona. These are women who may be suffering from the empty nest syndrome, or where the husbands are busy with their careers or have retired, abandoned or passed away and suddenly they ask themselves, "Who am I? What have I become?" They feel this emptiness, this ambivalence of self over and above their labels as a mother, a lover, a wife, cook, friend, work colleague, confidante, and all those other magnificent skills which are too often take for granted. But they cannot comprehend who they really are therefore they have great difficulty serving themselves after a lifetime serving others. It's almost as if they are silently screaming out, "What about me? Give me some attention. Isn't it my turn?" Alas, in some cases, no one's listening or if they are they're not interpreting the signs for help very well. If she cannot ask precisely for what she needs, her needs manifest as symptoms. These get the focus, not her. Surely this is an obvious cry for help. She knows she's floundering, and she's desperate for help, but she's had little to no experience asking for it!

Truly, it is sad to stand witness to a woman who asks, "How do I love myself? How do I nurture myself?" Ready to fill so many wonderful roles in her lifetime, and give from the bottom on her heart with all she has to give, a woman, when it comes down to it, perhaps does not know how to look after herself, does not know how to ensure her needs are met. Little wonder, is it not, that women particularly in Western cultures are crying in silence, suffering such bleak emptiness. Their pronounced loneliness, confusion, sense of loss and anger and frustration are all tied to their inability to take the necessary time to listen to and honour their own inner child. Is it not time we women, for health's sake at the very least, became more self-nurturing without feeling 'guilty'.

When a woman becomes pregnant, her progesterone levels skyrocket becoming the most predominant hormone to promote & sustain gestation. Have you ever noticed how a pregnant woman automatically knows how to protect herself, how to nurture herself, keep herself stress-free? All these things ensure the baby's survival. The world could be falling around her while she remains a picture of calmness. Pregnant women (who's body via the placenta is making huge amounts of progesterone) absolutely flourish, and they radiate an inner glow.

If a woman's body is so starved of this vital hormone she will literally glow once the body settles down. It's not 'out there' to state that just introducing progesterone alone can do absolute wonders for a woman's spirit and sense of cohesion.

When women start this journey they enter an 'awakening' period (some are more aware than others). This period can offer an opportunity to nurture and develop your inner child if you haven't done so before now.

There's no doubt progesterone can help you rediscovered yourself and your place in the world. Invariably, women reassess their values, their beliefs, and their position in life. They also learn how to redefine their boundaries and to abandon things that no longer serve. This may even be marriage or relationships; we have observed women actually come to a point of realising that their marriage is no longer appropriate, or may require 'time out'. Women arrive at this decision with confidence.

Women become more selfing (not selfish), they learn how to respect their needs rather than put themselves last. To realise that they need to recover and get well, that they need to spiritually nurture their souls, to heal their tired, stressed-out bodies. They need to take some responsibility for their own health. They are advised to acknowledge their need to devise strategies that will target improved health, diet and nutrition, and make appropriate lifestyle adjustment that will serve them, and carry them through to old age. Take up a new hobby and/or interest. Basically adopt a whole new way of thinking and approaching your remaining years.

Often we see women on the hormonal balancing journey going back to school, undertaking new careers, embracing huge challenges, or returning to society. We see these women starting to look for the greater meaning of life. In tribal times these same women would have been revered and respected for the wisdom, knowledge and guidance they represented. Within these tribal times, women anticipated this milestone as both an honour and measure of their worth within their community. Sadly, Western society does not venerate this epoch.

Instead, in our Western culture, women enter their menopausal years fearful that they will be looked upon as redundant, withered, and without value. And we bought the package! Just keep in mind that women (that's you and me!) lose our own value only if we BUY into this unfounded social myth surrounding hormonal imbalance and menopause.

From observation I have seen that this may not be the case once a woman finds help balancing her hormones and there is an infrastructure in place that supports her. Anything and everything seems possible! Nothing surprises me anymore when it comes to women's personal growth. Amazing, wonderful and phenomenal things are happening to many, many women worldwide as they discover, and learn to use this wonderful multi-factorial hormone called natural progesterone. As each woman gets reacquainted with herself, there's an internal shift of power and renewed energy which vibrates within her soul and is reflected in her energy field.

Don't underestimate the power of progesterone on levels other than just the physiological. There is a truly magnificent side of progesterone that I don't think we fully understand. For every woman has her own special journey with progesterone. In time, you will probably take it for granted and it won't be so significant. But guaranteed, over the years, you will find that perhaps progesterone has had some impact. Was, perhaps, in a way, responsible for both your growth and your journey, or at least it supported you.

You may look back, reflect, and realise that progesterone marked a significant milestone in your life. Whatever you do, don't miss this opportunity to acknowledge the importance of your hormonal persona, and how it plays out in your life. Don't trivialize those momentous and fleeting moments to grow beyond where you are right now! Empower yourself with each milestone.

Often we hear that menopause covers the best years of a woman's life, of newfound freedom and awareness. I really believe that this can happen, but sadly, with so much exposure to hormonal disruption caused by exposure to xenoestrogens in our foods and the environment, and the constant presence of stress in our daily lives - chemically, internally, and through the demands the world puts on us, or the speed at which the world is going, and the fast foods that are part of our lifestyle now - that we won't get past all these dreadful symptoms. Symptoms that keep us locked in our diseases, rather than realising the greatness that awaits us.

Without dealing with all the issues, a woman's treatment in hormonal balancing and health will be compromised. The Natural-Progesterone-Advisory-Network.com website seeks to help women become very aware of their bodies through charting, and through education of progesterone usage and how to get

the best results, combined with attitude adjustment, dietary, nutritional, and lifestyle modifications. Of equal importance is her spiritual and emotional journey.

Hormone disruption later in life is not to be treated as a disease but rather a transition, a rite of passage if you will. If menopause arrives prematurely, then it's a signal either your lifestyle is not right or your eating habits are inadequate, perhaps your ovaries have been damaged through some unfortunate incident, or what you're doing to your body here and now is impacting your health. Whatever the reason, there's no escaping the metaphysical and psychological aspects that go hand in hand with the physical changes of hormone imbalance.

On a closing note, I'd like to extend my blessings, limited wisdom and love to all my readers on your personal journey towards empowerment and awakening.

In light & love,

A handwritten signature in cursive script that reads "Catherine".

Catherine P. Rollins
Director, Making Plans Pty Ltd
www.natural-progesterone-advisory-network.com

Medical References / Studies

Study proves relief of menopausal symptoms

A well-designed new study of women using progesterone cream has added greatly to the mounting evidence that natural hormones work as advertised.

Nearly every day we receive e-mails from women who ask what to tell their doctor when he or she demands studies proving that natural hormones are safe and effective. Granted, using natural hormones as recommended by Dr. Lee mimics closely what the body would do naturally, and granted there are hundreds of physicians happily using natural hormones safely and effectively, but it's always good to have studies to point to.

We do have the studies of Helene Leonetti, M.D. showing that progesterone cream reduces hot flashes, and that it protects the uterus from the effects of estrogen. In Issue 4 of the Hopkins Health Watch, Virginia Hopkins told us about what's being called the "Bassett Healthcare Study," led by researcher Anne Hermann, M.D., which showed beyond a shadow of a doubt that progesterone cream is very well absorbed and utilized by the body. Ironically, this study is now being used as a justification for making progesterone cream a prescription item because (surprise, surprise) it really works!

Now we have a newly published study from researchers at the College of Nursing and Health Sciences at The University of Texas at Tyler, led by Kenna Stephenson, M.D., which clearly shows that 30 women using 20 mg of progesterone daily, in a cream, had relief of their menopausal symptoms and didn't have the side effects associated with the progestins such as Provera. The study was published in the November 2004 issue of *Blood: The Journal of The American Society of Haematology*.

According to a press release published on www.womeninbalance.org, Dr. Stephenson said, "In our study, we tested progesterone cream for safety, efficacy and any short term benefits or harmful effects, by looking at biomarkers. Biomarkers will show up right away as an indication of such serious diseases as cancer, heart disease, infections and dementia. With natural progesterone cream, we found no markers for inflammation or clotting—indicators for most of the serious diseases related to use of traditional hormone replacement therapy, like Provera and Prempro."

Specific Biomarkers Look Good

Stephenson added that in women with higher than normal cortisol levels, there was a marked decline in the level of cortisol to normal range while they were using the progesterone cream as compared to placebo. Stress activates cortisol, and an abnormal cortisol pattern has been associated with an increased risk of heart attacks, cancer, obesity and other diseases.

The study specifically looked at night cortisol levels, and found that these decreased with the use of progesterone. Those of you who have read Virginia's interviews with Dr. David Zava of ZRT Lab will remember that high night cortisol is one of the risk factors for breast cancer.

Because PremPro and Provera have been shown to increase the risk of strokes and heart attacks, Stephenson and her team also looked specifically at blood factors that would predispose women to clotting (strokes, heart attacks), and to blood vessel spasm (heart attack). They found that these parameters remained normal in the women using progesterone cream.

"The results of the study are encouraging," Dr. Stephenson said, "because it is clinical evidence of the viable option of bioidentical progesterone cream for menopausal women in their search to relieve menopause symptoms."

The Abstract of the Stephenson Study

Stephenson, Kenna, Price Carol, Kurdowska Anna et al, "[Topical Progesterone Cream Does Not Increase Thrombotic and Inflammatory Factors in Postmenopausal Women](#)," *Blood*, Volume 104, issue 11, November 16, 2004.

Postmenopausal women have an increased risk of cardiovascular disease, and heart disease is the leading cause of death in postmenopausal American women. Conventional hormone replacement therapy has been shown to result in an increase in thrombotic events in large prospective clinical trials including HERS I, and the recently halted Women's Health Initiative.

One possible mechanism for this observed increase is the unfavourable net effects of conjugated equine estrogens and medroxyprogesterone acetate on the hemostatic balance and inflammatory factors. An estimated 50 million American women are peri or postmenopausal and clinical therapies for menopausal symptoms remain a significant challenge in light of the known thrombotic risks.

In this prospective blinded study, we examined the short-term effect of topical progesterone cream on menopausal symptom relief in 30 healthy postmenopausal women. Potential adverse effects of topical progesterone on hemostatic and inflammatory factors and cortisol levels were also examined. Subjects were randomized to first receive either 20 mg of topical progesterone cream or placebo cream for 4 weeks.

Following a subsequent 4-week washout period, subjects were crossed over to either placebo cream or active drug for an additional 4-week period. In each case, progesterone and cortisol levels were monitored by salivary sampling. Baseline values, 4-week follow-up values and end-of-study values were also obtained for the Greene Climacteric Scale, total factor VII:C, factor VIIa, factor V, fibrinogen, antithrombin, PAI-1, CRP, TNF α , and IL-6.

For subjects receiving 20 mg of topical progesterone cream for 4 weeks, Greene Climacteric Scale scores were consistently and significantly improved (decreased) over baseline, demonstrating significant relief from menopausal symptoms.

In addition, in a subpopulation of hypercortisolemic women, topical progesterone was associated with a favourable decrease in nocturnal cortisol. Surprisingly, and in sharp contrast to earlier studies with conventional hormone replacement therapy, topical progesterone had no effect on any of the hemostatic components examined: total factor VII:C, factor VIIa, factor V, fibrinogen, antithrombin, and PAI-1 levels were all unchanged. Levels of CRP, TNF α and IL-6 also remained unchanged.

From this study we conclude that administration of topical progesterone cream at a daily dose of 20 mg significantly relieves menopausal symptoms in postmenopausal women without adversely altering prothrombotic potential. Since the thrombotic complications that are typically observed with conventional hormone replacement therapy do not seem to occur with topical progesterone, this treatment should be seriously considered as an effective and safe alternative clinical therapy for women suffering from menopausal symptoms.

Current research on natural hormones

Helene Leonetti, M.D. is recruiting older women for a study on Progesterone and Bone Density

Helene Leonetti, M.D. who has been a pioneer in clinical research of natural hormones, has gotten approval from Lehigh Valley Hospital in Bethlehem, PA to begin a major research study titled "The Role of Transdermal Progesterone Cream in Increased Osteoblastic Activity and Delay of Osteoporosis in Women over 70 Years of Age."

Dr. Leonetti is looking to recruit 200 women, 70 years and older, living within a few hours' drive of Bethlehem with the following qualifications:

- Non-smokers
- Not be taking thyroid replacement, hormone replacement
- Not taking anti-resorptive drugs (e.g. Fosamax, Actonel, Evista)
- Must be independent and responsible enough to commit to this regimen for at least one year.

Each woman will receive a baseline bone mineral density test and have blood drawn to measure TSH, FSH, and for a lipid profile.

If you're interested in participating, please call Dr. Leonetti's office at: (610) 882-3100.

Participate in a Bioidential Hormone Study

Kenna Stephenson to conduct further research on natural hormones.

One of the goals of [Women in Balance](#) is to advance research on the safety and efficacy of natural hormones by supporting medical professionals in doing scientifically sound clinical research.

Kenna Stephenson, M.D., Associate Professor and Scholar in Residence at The University of Texas at Tyler, is putting together a clinical research study to evaluate perimenopausal and menopausal women who are using bioidentical hormones. If you are interested in participating in the new study and if the following apply to you, you may be eligible:

- Perimenopausal
- Menopausal
- English-speaking
- High School educated, with the ability to read and write
- Currently taking bioidentical hormones
- Age 30 to 59

If you qualify for the study you will be interviewed at a location that is mutually agreed upon. The interview will explore your personal experiences of taking bioidentical hormones. There is no compensation for your time and travel. As a participant you will be provided a copy of the study results at the conclusion of the research project if you request it.

If you have further questions or are interested in participating in this study, please contact the study's principal investigator NaRisa Waldo, RN, BSN, at 903-566-7019 or e-mail her at Texasbarnhouse@aol.com.

Latest scientific medical research

Understandably, we don't have a hope of winning over the medical profession without some sound clinical evidence, i.e., randomised controlled trials. So, to that end, we put the question to Ms Candace Burch, Director of Education and Outreach at ZRT Labs who very kindly provided us with the following scientific reference papers.

General Progesterone References

<http://www.natural-progesterone-advisory-network.com/PDFs/BreastCancer.pdf>
<http://www.natural-progesterone-advisory-network.com/PDFs/GNLProgesteroneweb.pdf>
http://www.womeninbalance.org/current_studies.html
http://www.womeninbalance.org/hor_resource_estro.html
http://www.womeninbalance.org/hor_resource_andro.html
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http://www.salivatest.com/store/saliva_ref2.html
http://www.johnleemd.com/store/resource_references1.html

Medical Papers - Research Material - Drug Information Sheets

<http://www.natural-progesterone-advisory-network.com/PDFs/progest.pdf>
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<http://www.natural-progesterone-advisory-network.com/PDFs/drlowe.critique.replacement.studies.pdf>

What customers are saying about our body of work ...

"Catherine Rollins has made educating women (and men) on the safe and effective use of natural progesterone her passionate cause. She shares her knowledge in a delightful, down-to-earth manner. Bookmark this website. You will refer to this information over and over for guidance and support."

Dr. David Zava, Ph.D., Hormone expert and Co-Author, "What Your Doctor May Not Tell You About Breast Cancer" .

"Patients would be shocked to see how little time we spend in medical school on the female endocrine system. I remember about a week in second year, six weeks in the third year. That was for the entire subject of obstetrics and gynaecology. Needless to say, 99% of docs enter the "real world" totally unprepared to answer questions, or provide guidance to our patients. For many docs, their chief source of information, is the pharmaceutical industry. This is really a conflict of interest. That is why I fell in love with the NPAN. I feel I can find any information I need. I can share ideas and problems, and get credible and timely, evidence based solutions to my problems. Thanks for the wonderful job you all do! "

Dr Robert W. Patterson, Sanford, NC 27330 USA

"I am a naturopathic doctor and want to increase my ability to help my patients. Your information contains the real life knowledge rather than just book knowledge. This is extremely helpful. Thanks for the great work. I will continue to use this site as a resource and I look forward to receiving your newsletters in the future. With much thanks,"

Dr Virginia Keilty, USA

"Sites such as Natural-Progesterone-Advisory-Network.com provide informed comment and seek to bridge the gap between patient and healthcare professions. It's one of a number of good places to start educating one's self as to the merits or otherwise of progesterone. Time will tell if the type of "coal-face" information being offered by the Natural-Progesterone-Advisory-Network.com will be in the medical textbooks ten years from now. "

Michael Buckley, Principal Pharmacist, Lawley Pharmaceuticals, Western Australia

"I'd like to compliment you on an amazing web site."

Carol Petersen, Women's International Pharmacy, Madison, WI. USA

"I love the new 'Guide' ebook. It is so user friendly and informative. You have done a fabulous job with this and are providing such a wonderful service for women. From my point of view it is one of the essential resources for all the women I treat." "

Dr Doris Brownlee, Katoomba, NSW, Australia

"This is an excellent compilation of information from women who have been using transdermal progesterone for more than five years. Virtually every question ever asked by women experiencing hormonal flux is answered in a clear, concise manner. From "Why are my symptoms returning after seven months?", to "How do I talk to my doctor about progesterone?", as well as specific descriptions of how progesterone works in the body and what you can do to enhance its effectiveness. We highly recommend this information to everyone who is considering using transdermal progesterone."

Bill of Karuna, a Division of Kevala, California, USA

"Your ebook is WONDERFUL!! I feel as if it is a Godsend for me. I am so glad I went ahead and bought your book. It not only reinforces what I already know, but has so much more to offer. Thank you SO much for all the time and passion you have put in your book. I will be spreading the word to my estrogen dominant sisters."

Julie of Appleton, WI, USA

"Thanks to my Angels for helping me find you!!!!!"

Alison Dubens, Australia

"I had my first child at age 32, at age 38 due to emotional problems I was put on Premarin. From there I was given Ogen and Provera at age 40. I was diagnosed with CFS also at age 40, and was very sick for 12 years. I lived in Saudi Arabia, and I believe it was God's blessing that I was not treated with any drugs for CFS. I first heard about Progesterone cream on Television. I bought the cream for my daughter who was at University and having trouble with PMS. Doing some research about the cream I felt very strongly that I need to go off the HRT and use the cream, that was the best decision I have ever made. I feel so much better, on the monthly score sheet (taken from your ebook) to determine progress I went from scores of 39 to 3. What a difference in my life and joy. I have just been diagnosed with osteoporosis in my spine, so much for HRT. I can't wait to see what the Bone Density test shows in two years. I thank you for your web site and E-book. Keep up the good work."

Montie, Michigan, USA

"I think that your ebook is awesome ... there's nothing like it on the net."

Jany, Canada

"I wanted to let you know that I have received my e-book and am delighted. I have read a tremendous amount of information and find that yours is especially useful as it incorporates the real experiences of women."

Donna, New York, USA

"Catherine, thanks a million for helping me find a compounding pharmacist in Santiago!"

Carmen Mikulski, Santiago, Chile

"I wanted to thank you for all your efforts for getting me signed up, providing this information to all the women who desperately need it. I have read the sections on usage and know now what I need to do - take breaks from the cream. Your ebook has the info I have sought and not found elsewhere. Thanks soooooo much!"

Jeanne, USA

"I received my membership and successfully logged in. I think it's an awesome accomplishment and really a service to womankind."

Janet, Portland, USA

"Received my ebook this past weekend and just LOVE it! Thanks so much for an absolutely wonderful resource!"

Susie of Neosho, MO, USA

"I was looking for more info about progesterone cream after reading Dr. Lee's book and came upon your website. I have read your ebook and think it has so much information about progesterone cream and it's

practical usage. I was one that felt the initial 2 week of changes, no acne, pigmentation in my face lightening and headaches gone. Then as time went on and I took my first break from the cream the acne came back. I am now in beginning my 4th cycle and since I read your info a month ago I have been using more cream and did not take a break from the cream last cycle. I feel it was a god-send. I have had a great increase in my moods and my period was shorter and not nearly as heavy this last week. Now my headaches have started so I went back on the cream and they are gone. I also get an allergy like symptoms that disappear with the cream. I am sleeping better at night. I just wanted to thank you for your help. This information has truly proved to be a GREAT help in my life."

Mary, a registered nurse, Washington, USA

"Thank you so much for helping me. I have started to read your ebook and I love what I have read so far. This info is really going to help me on using and understanding NPC. I can't thank you enough for thinking about us women when we need the help at these most crucial times. Thanks you again, and thank you for your time."

Lisa, USA

"I sell a natural, water based progesterone cream and I have found that your site is one of the best and most informative and also 'safest' sites available."

Diana, PA. USA

"Thank you so much - was just about to email you and let you know that I have finally "arrived" at the inner sanctum of your book! :-) I got into the ebook and only had time to look briefly so far, but it looks great. Can't wait to read further. I admire your work and can't tell you how crucial it is for women - so many women suffering and seeking alternatives from doctor's deadly drugs. My hat is off to you for helping them Catherine. You are one of the true heroes of our time - or rather heroines of our time! :-)"

Robin, New Mexico - Santa Fe, USA

"You cannot imagine how much your insight and concern mean to me. I cannot bear to deal with another doctor or gynie telling me I am imagining these symptoms. Thank you so much for your advice and assistance. I have no doubt that I want to go the natural route. This information is a gift to me as I have searched high and low for the information which I have so readily found in your ebook. Catherine, keep up your wonderful work. This is making such a remarkable impact on the lives of so many woman. Kindest regards and warm wishes."

Cathy

"Thanks for all the work you are doing and thanks for introducing me to a resource which is bringing such an enlightenment in healthcare not to mention the primary means to restoring my health. It is a sterling piece of work you are conducting, thank you. Peace, love, light"

Gail S, UK

"I'm finding your ebook incredibly up-to-date and helpful, particularly being able to benefit from others' feedback about realistic dosage, estrogen backlash."

Noelle M.

"I enjoyed your ebook a lot and got all my questions about natural progesterone answered. Thank you for your efforts and energy to inform women all over the world."

Marianne N.

"Congratulations on your ebook, I think it is very informative and well worth the money. Thank you."

Bev, Aussie in Texas

"Catherine, I am so thankful for your ebook. I refer 'lots' of women to it. Also included it on a list of 'websites of interest' when sharing about progesterone."

Sande, Columbus, USA

"I am a RN and have found your site to be absolutely magnificent. I have shared so much of the information with several physicians, colleagues, and friends."

Jane M, RN

"Thank you so much!! I find your ebook fascinating and educational! I am in the process of bio-identical hormones after getting tested to see what I need. My prescription is at the compounding pharmacy now to be picked up tomorrow. I am 59 and have so many symptoms that I knew was caused by hormone imbalance. No one would listen until I found this great gyn female doctor who recommended it for me!! I did a lot of research but your ebook is the best!!! Thanks. "

Margaret (Peggy) Wiedle

"THANK YOU, THANK YOU, THANK YOU for your ebook!!! I know it takes time and work to provide it, and I want you and your staff to know it is a TRUE SOURCE OF HELP!!! You have NO IDEA how your site has helped me to realize I'm not crazy and has helped my husband, TOO!!! You've strengthened our family by making this information available. I recommend it to EVERYONE!!!"

Robin H. Thorpe, Jacksonville, Florida, USA

"I have been using natural progesterone for 3 weeks now and have noticed a decrease in the redness on my upper chest and face. It is wonderful. I also feel I can focus better and am less tense and "bitchy". I believe it is definitely doing good things for me. I am so glad for your research, thank you. "

Angie (Buderim, Queensland).

"Dear Catherine, I'm a couple of months on now from my last email, I have since found some great help and have been using progesterone cream as well as other supplements. I feel like a new person and my health is slowly balancing out again. I just wanted to send you a quick thank you - your words really encouraged me to find help when I felt so despondent. Thank you for taking the time to advise me."

Ingrid, United Kingdom

Earn money by telling others about our website

When you join our [free affiliate program](#), we'll pay you 20-50% commission for every sale you refer to us.

Our ideal partners are cream distributors and/or owners of websites, message boards, or newsletters that focus on women's health issues.

We are focused on the quality of our relationships, not the quantity. When you submit your application, we will contact you by email and work with you to maximize the return on your affiliate marketing efforts.

We can develop the following tools to assist you...

- Text and Graphic Links - We can help you implement these simple but effective promotions to refer visitors to our website.
- Shared Content - We'll provide articles and other content for your website or newsletter.
- Co-Branded Free Reports - We have PDF reports that can be customized with your affiliate link and given away on your website.

If you would like to learn more, we invite you to complete the (3-minute) [application](#) on our website. We'll contact you to answer any questions you have and begin working with you to develop an effective affiliate offer.

In light & love,

A handwritten signature in cursive script that reads "Catherine".

Catherine P. Rollins
Director, Making Plans Pty Ltd
www.natural-progesterone-advisory-network.com

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Acknowledgements

There are just too many women to thank individually here, but each of you knows who you are. Your unique contribution is indelibly imprinted upon these pages ... and my heart.

I am honoured and forever grateful to have shared part of your journey. Your contribution to the Natural-Progesterone-Advisory-Network.com website is invaluable, and continues to touch other women in need.

Indeed, you are the 'essence' of the knowledge shared.

This ebook is as much about my family as it is women, therefore, I'd like to acknowledge my husband - Melvin - for his enduring support, encouragement, conviction, loyalty, insistence, inspiration and endless hot cups of tea through the long hauls.

To my children - John, Dominique & Cara - I send all the cuddles & kisses they missed out on while I plodded away, morning and night, on my computer. Thank you, from the bottom of my heart, for allowing me the personal space in which to write this ebook ... and continue over the years to spread the word via the Natural-Progesterone-Advisory-Network.com website!

I thank the 'Universe' for this awesome opportunity to be of service to others. And to pay it forward.

In light & love,



Catherine P. Rollins
Director, Making Plans Pty Ltd
www.natural-progesterone-advisory-network.com

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