Jamie Forward: Hello and welcome. I'm Jamie Forward, one of the co-founders of Feminess. This is the first webinar in our Evolution series aiming to help women learn more about perimenopause and menopause. Today our expert guests will share information about what happens during this phase of life, how you can find help, and what options are available to manage your symptoms.

So, let's meet our guests today. Joining me are two certified menopause specialists, the first is Dr. Nina Ali. Dr. Ali is one of the founding board members of Feminess. Dr. Ali, welcome. Can you introduce yourself to everyone?

Dr. Nina Ali: Yes. Thank you for having me, Jamie. And hello, everyone. My name is Nina Ali.

I am privileged to get to be on the board at Feminess. And I serve as director of our Menopause Center here in Houston at Baylor College of Medicine. And I've devoted my career to helping women navigate this transition, so it aligns so well with what we're planning today. So, happy to be here with you all.

Jamie Forward: Thank you for that. Also joining me is Dr. Jackie Piasta. Dr. Piasta is a women's health nurse practitioner. Thanks for joining us, Dr. Piasta. Can you introduce yourself?

Dr. Jackie Piasta: Yes. Hi. Thank you so much for having me. As you said, my name's Jackie Piasta; I've been a women's health nurse practitioner for almost 17 years now. And I practiced in general OB/GYN for many years, and now I specialize in women's health in my practice, Monarch Health. I'm on faculty at the Vanderbilt University School of Nursing, and I'm also on the board of the National Menopause Foundation. And I'm so happy to be here with you all today.

Jamie Forward: Well, thank you so much to both of you for taking time out of your days to join us. So, we've titled this program The 3 Things You Need to Know. So, let's start with the first one. Dr. Ali, can you just start by defining this phase of life? What is menopause?

Dr. Nina Ali: So, menopause is defined by going one full year without having a menstrual cycle. It's a retrospective diagnosis, and I think that's one of the challenges of it. It signifies a transition from our reproductive phase to our menopause phase. And once a woman

is in menopause, she remains in that post-menopause phase for the rest of her life. That typically is going to happen for women in our mid-40s to mid-50s. So, the defining feature remains that looking for the pattern of your period. It's a little bit harder for someone who doesn't have a uterus and is not having menstrual cycles.

So, in that case, we can use hormonal measures to sort of define when that happens, and we also use that timeframe.

Jamie Forward: Okay. And so, chances are, some of our viewers today are just sort of starting to experience symptoms or some of them may be well into this phase of life. So, you can hear, "I'm in perimenopause," or "I'm menopausal." Dr. Piasta, can you talk about perimenopause and how that's defined and maybe how long it lasts?

Dr. Jackie Piasta: Sure. Of course. It's my favorite subject to talk about. So, perimenopause literally just means the time around menopause. And our understanding of perimenopause has been primarily informed by actually a very long-term study called the SWAN study, or it stands for the Study of Women Across the Nation. And our current understanding is really still evolving, but literally that time around menopause. It can last from anywhere from two to four years to as long as eight to 10 or sometimes even longer. And it's really that lead-up until your final menstrual cycle.

The important thing that I like to teach my patients is, there are often two very distinct phases of perimenopause. There's the early phase where a lot of women don't really experience a ton of symptoms or they don't have a lot of abnormality in their cycles, and so that can be very variable in terms of how long that lasts. And then you have the late perimenopause stage, which really is that last one to three years leading up to that final menstrual cycle where your periods really begin to have longer excursions, spreading out longer than 60 days apart from one another. But again, it's just really that time leading up to menopause.

Jamie Forward: Sure. And so, it sounds like obviously menopause is after 12 months without a period. So, it sounds like you're not in menopause so much as you go right into post-menopause from perimenopause. Would that be accurate, Dr. Ali?

Dr. Nina Ali: Yeah. I mean, technically I guess it's a time point when it's been a year without a period. I mean, we have to have definitions.

But when you look at how we are treating our patients when a woman comes in to see me with these symptoms, a lot of times we're looking at that person as an individual and we do want to see, "Okay. Where are you in this process?" But honestly, the way I treat someone in late perimenopause versus that first early years of menopause, it's really a lot of menopause care and perimenopause care is navigating symptoms. So, that is honestly what matters most.

And whether someone is a year or two years post their last period, many women are – we're not robots and we're not machines, so you might get to 13 months and then have a period again, does that mean we're kind of starting all over? No. We're managing what symptoms are showing up at that time. But everybody is so different, and that's what makes working in this space really fun and rewarding.

Jamie Forward: Sure. And so, for someone that may not know anything about this stage of life, how soon could it start, and what are the early signs? So, you kind of touched on the time period, but, Dr. Piasta, what are the early signs of this?

Dr. Jackie Piasta: Gosh. As Dr. Ali said, there is no one menopause syndrome, so it can be so variable. I know for me, mine started distinctly at age 36, which is kind of thought to be on the younger end. I think I had the fortune of practicing in this field, so I sort of knew what to look out for. But it was night sweats and severe moodiness and a dip in my libido that was different from my typical baseline and wasn't explained by other things. Dr. Ali mentioned that for women that don't have their periods, that we can't obviously use that period benchmark, so we get hormonal markers. But a lot of times, part of the workup is actually looking at other tests to make sure that these symptoms can't be attributed to other things, and then we go on our path looking at treating the symptoms.

But again, the most common or the most well-accepted symptom of menopause and perimenopause is hot flashes and night sweats. We lump those under a term called vasomotor symptoms. But I hear things anywhere from brain fog, joint pain, tinnitus or the ringing in your ears, electric shocks down your body, vaginal

dryness, dip in libido. There's a myriad or a constellation of symptoms. It's really important for people to recognize that it's not just one thing. Our patients, as Dr. Ali said, they're not the textbook where you don't read the textbook, you can present in a variety of different ways.

Jamie Forward: Yeah. And it's really different for everybody. I know that certainly in my friend group if somebody mentions they haven't slept well, it all of a sudden leads into a libido discussion or a hot flash discussion or a night sweats discussion or even lesser-known symptoms. So, it's just such a confusing time of life because once the conversation starts, boy, does it get going.

So, you're both in the clinic. So, Dr. Ali, what do you hear most often from women?

Dr. Nina Ali: You know, as Dr. Piasta mentioned, often the symptom that we know most about, talk most about are the vasomotor symptoms. But it's really interesting, especially in this early part of perimenopause, oftentimes before those things start showing up, what we're appreciating more and more is that hormone changes, and even sometimes mild changes that aren't enough to affect our period pattern significantly can affect the way our brain functions. So, the sleep patterns, the mood-type things, those are often kind of early symptoms that are showing up, and there's a lot of confusion around what the cause is of those, so that.

And, of course, the brain fog or not feeling like myself, these things that are hard to even express that something's different, but it's hard to put your finger on what exactly that is.

So, I'm hearing a lot about that. And then just general things affecting metabolism like fatigue, gaining weight even though I'm doing all the things, and I'm working really hard and working harder. So, those sorts of things. And then again, referencing back to the SWAN study, an appreciation that different ethnic groups sometimes are more likely to experience different symptoms. So, I found it so interesting to learn that women of Asian background may have more joint aches and those sorts of symptoms more so than other groups who have the hot flashes more dominantly.

So, there's so much that we're learning about it, but myriad of

symptoms. We know hormone receptors are present in all tissues of the body, so we might all have the same hormone change happening but manifest that in different ways.

So, sometimes it's just teasing out what could potentially be hormonal and then the added challenge on our end is, everything isn't because of your hormones, there are also medical things that come up, issues that are natural parts of aging. So, we're trying to just have an understanding and listen and take care of the whole patient.

Jamie Forward: Sure. And I think listening to your body obviously is so important. And, yeah, the cognitive part is so alarming at first when it's like a word recall issue. It's like ...

Dr. Nina Ali: Absolutely.

Jamie Forward: Yeah. It's constant. Good days and bad days though. So, there are also some lesser known symptoms that we often hear about. I know I've heard recently that frozen shoulder might be associated, and even one of our attendees sent in a question asking about sciatic nerve pain. So, Dr. Piasta, do you want to comment on some of the lesser-known symptoms?

Dr. Jackie Piasta: Sure. And I mentioned one earlier, which is tinnitus, which is the ringing in the ears. There's also dry mouth. People can actually have itchiness in their ear or just itchiness all over. It's really important to understand that there are estrogen receptors in every single cell of our body, and estrogen – I'm going to highlight estrogen here, not to say that our other reproductive hormones aren't just as important, but estrogen really influences a lot of our bodily functioning. And so, when estrogen goes down in menopause as we go through menopause, that's going to have some ripple effects on the body, and it's going to create these symptoms.

Perimenopause into the first few years of the menopause transition is really this time of recalibration. So, I like to also reassure patients that for the most part, these symptoms do improve over time. So, while you might be experiencing hot flashes and night sweats or joint pain or something like that.

Or even brain fog tends to be actually one of the ones that tends

to improve with time. Not joint pain so much because joint pain is this little marriage between the effects of estrogen loss and time and aging. So, as Dr. Ali said, many things are linked to menopause and are associated with the decline in estrogen. But it's really important that we don't put the brunt of the labor on it all being estrogen's job to fix when we add estrogen back into the picture if that's something that's part of your care plan because there are certainly things that we know, particularly that estrogen is very good at doing just like we know our non-hormonals are good at doing. And there are things that it's not very good at doing.

Like, let's just take frozen shoulder for an example. Frozen shoulder is really something that I personally in my clinical practice haven't had a lot of luck actually treating with estrogen. Is it heavily influenced by a decline in estrogen? One hundred percent. And inflammation, the inflammatory changes that happen in menopause.

But again it's this sort of, we have to kind of make sense of a lot of the noise out there in terms of what is menopause, what is perimenopause, and then what we're actually able to accomplish with the therapies that we have to give our patients and those people out there realistic expectations of what that looks like. Hopefully you agree, Dr. Ali.

Dr. Nina Ali: Yeah. Absolutely. And I think a lot of it – and honestly, we don't have enough research and data into so many of these things. So, it puts us as practitioners and sitting down with your patient, it's a one-to-one, and we have to be very frank and forthright about what we know, what we know well with good evidence, and really what we don't know. And sometimes you're in situations where you might have somebody with a frozen shoulder and it's the timing of when we know they're going through menopause, and it has come on at this time.

And say, "Hey, it's the appropriate time for us to start hormone therapy with you. It's going to help with your sleep and your hot flashes, we know that really well. And we may find out over the next few months if it is also going to help with your frozen shoulder. But if it's not helping, definitely you want to pursue other known treatments." So, it's kind of navigating those areas where we really wish we had more info and hopefully that will be

forthcoming, but we're working with where we are now.

Jackie Forward: Sure. And, yeah, a couple of things to add. One is, it's so nice to hear the cognitive side of it will come back.

Dr. Nina Ali: Yeah.

Jamie Forward: And then beyond that, that really leads into my next question which is, what are some of the common myths you hear about menopause or its symptoms? Dr. Piasta, do you want to comment on that?

Dr. Jackie Piasta: Oh, gosh. Where do we start with myths? There are so many myths out there. One of the myths Dr. Ali addressed at the beginning is, once you're through menopause, you're through.

And this is probably one of the myths that it gets the hairs up on my back when I'm in a public place or I hear women in a group talking about menopause. And they'll say, "Oh, I'm too old for that stuff. I'm through it." Because we know, as much as menopause sort of is this recalibration timeframe where symptoms like vasomotor symptoms and cognitive brain fog tend to get better with time, we do know that there are real health consequences associated with menopause: enhanced risk of cardiovascular disease, neurodegenerative changes, bone changes probably being the biggest one that we can influence with certain therapies if we get on top of that faster.

So, I think the biggest myth, or the one that I want to highlight is that once you're through menopause and then it's over. I think so many women, because in the wake of the Women's Health Initiative trial and women being scared off of hormones, it was kind of this, we kind of sold – we changed our marketing plan towards menopause and sort of said, "Oh, that stuff will only last a couple of years. You'll be through it and then be on the other side."

And it left a lot of women sort of feeling more comfort that their hot flashes were going away, but then not understanding the fullness of what menopause does to your bones, et cetera.

Jackie Forward: Yeah. That's such an important part, the lasting effects as we age for this time period. So, let's talk about the second thing that

women need to know. So, how to find help and support. So, seeking care over these symptoms can sometimes be just as challenging as this phase of life, and sometimes people often leave the doctor feeling dismissed. So, Dr. Ali, why is it so important for women to see a specialist?

Dr. Nina Ali: You know, there are so many reasons why I feel like it's important, but one of them being that – Dr. Piasta just mentioned about the Women's Health Initiative trial. And there are so many things about that trial that have made it difficult to take care of women in menopause just because of the fears that came up out of the initial results of the study.

But one of the big things that we did learn from the WHI and subsequent studies was how important it is to time the care for menopause. So, that timing hypothesis about when we initiate hormone therapy is really important. So, we want to initiate hormone therapy, if we're going to do it, in perimenopause or the early part of menopause. So, that is a short window where you don't want women to miss that opportunity to at least be informed. So, we know there's a few categories of women who are better avoiding hormone therapy, and there are the contraindications.

So, having had a blood clot, having had a heart attack or stroke, having a personal history of breast cancer, there are some contraindications. But vast majority of us, as we go through this transition, at least it's important to know at the right time what your options are.

So, often, you need to see someone who has made the effort to keep up with the latest information, which is hard to do. And I have been a general OB/GYN for many years, and I know how much is expected of our doctors in short periods of time. And really to get into all the different aspects that affect menopause care and the whole transition, you need time, you need to be able to understand the nuances. There aren't, like, blanket ways to manage women, we have to really get into the specifics. And then it evolves, so what works at 48 may not work at 54. So, a specialist is somebody who has devoted the time to understand that well and really enjoys taking care of women through that transition.

So, you want to look at people's credentials and look at that they

have that interest and they have the networks to understand, "Hey, this is something that I'm not comfortable with; I can get you to someone who is comfortable in that space." So, that really helps people get the best care at the right time.

Jamie Forward: Sure. And, I mean, just by the people that have answered our poll here, 82 percent of people feel like they've been dismissed by their doctor. So, Dr. Piasta, what are some signs that maybe a conversation isn't going well with a provider?

Dr. Jackie Piasta: So, I try to, anytime anybody asks me for advice through social media or whatnot, my one piece of advice is to separate the menopause visit from your yearly wellness exam. So, if you are trying to receive menopause care through the most common channel, which is through either your primary care clinician or your OB/GYN clinician, whether that's a nurse practitioner or physician, to separate it from that yearly annual visit.

Number one, that's important for you because it gives it the time that it's due. If we're going through the insurance-based model, insurance dictates how much time your clinician can spend with you. And so, that's what I would do, is separate it.

And then maybe preempt that conversation, especially if you're going to somebody that you've had a relationship with a considerable amount of time, send a portal message to that nurse, the person's nurse, or that person before the appointment and just say, "You know what? I'm having these symptoms. I'd really like to schedule some time with you to go over these. Is this something that you'd be comfortable sitting down and discussing my options with me? Or is there somebody that you feel like might be a better fit for this?" Because that keeps us from, Jamie, these situations where we feel like we've been dismissed. Because then you're not putting your clinician on the spot, sort of setting you both up for failure.

And you're sort of feeling out that relationship ahead of time. But I think, of course, back to your original question quickly, is just if somebody says, "Oh, this is just something that women go through. Oh, it's just a part of getting older. It'll get better with time." Like Dr. Ali said, we don't want to suffer, we don't need to suffer. Actually, the data shows that starting treatments early leads to better health outcomes. So, that's what I would say about that.

Jamie Forward: Yeah. That's such an important point to share. So, of course, how can you find a specialist? I know that through The Menopause Society website they have a way to find a specialist. Do you guys agree that that's probably – Dr. Ali, do you agree that that's one of the best ways to do that?

Dr. Nina Ali: I mean, I think it's an amazing resource, it has been so helpful for so many women. I mean, the hard fact is that we have, one, a shortage of providers for women's health nationwide in general, and then when you kind of get to the level of, we're looking at a specialized type of visit, it's hard to find.

And I think those of us who are in this space often have the challenge of having long waitlists to get in. So, I think telemedicine and these platforms have really been helpful in that regard, so there are a lot more ideas for better access, hopefully, forthcoming. But yes, I think The Menopause Society database is a great way to at least see who is certified in my area, and how can I get in with that person?

And then also using the relationships you have, your own primary care, your own OB/GYN, and seeing at least where they are in their comfort and if they have a person they particularly were – like, I have my osteoporosis person that I like to send patients to because I know she does an amazing job. So, using the networks that you have as well is another good place to start.

Jamie Forward: Sure. And, of course, we're all working with limited time, right?

The women you're treating are working with limited time, you guys are working with limited time, of course. So, Dr. Piasta, what sort of questions should people be asking so that they can make the most of the appointment time? I love your idea of sending them a message first to sort of give them the heads up. What else would you add?

Dr. Jackie Piasta: So, I probably would say something to the effect of, "Given what you know about my medical history, what options am I the best candidate for? Or what symptoms am I having do you think we can attribute to menopause, and which ones maybe are –" like Dr. Ali said before for frozen shoulder, we can give this and see if it gets better and we know that biologically it's plausible, but we don't

have outcome studies to say, "Definitely this is what we can expect from this therapy."

So, I think really, it's just – another little pro tip is to go online and put in the search engine the menopause rating scale. That's the most validated screener that we have. And to print it out or get it on your phone in a digital format and map your symptoms with that. And that will rank them on a scale of mild to, really, just horrible. And you can show that, use that as a tool with your clinician to say, "This is what's really interrupting or affecting my quality of life." Almost 70 percent of women have symptoms that severely affect their quality of life. And so, that is a communication tool for your clinician and to let them know exactly what areas need to be prioritized.

Because again, I might think that hot flashes are the most distressing thing for that patient, but that patient might come to me and say, "No, it's actually joint pain. Or it's brain fog. Or it's low libido that are the most distressing." So, I would say, use the menopause rating scale as a communication tool for your appointment.

Jamie Forward: Yeah. Great. So, that's really good advice. I had not heard of that, so thank you for sharing that.

Dr. Jackie Piasta: Yeah.

Jamie Forward: So, just to alight any fears we have, some people may have a long relationship with their doctor, right? They may have had delivered their babies, they have these long relationships. So, as a clinician, Dr. Ali, can you share your perspective on changing doctors?

Dr. Nina Ali: Yeah. And, you know, that is a really tricky one, especially in my space of OB/GYNs. When you have gone through pregnancies and deliveries with your doctor, it is very personal and I myself, I have patients who will come see me and be like, "Is Dr. So-and-So going to know that I came here? Because I don't wat to hurt their feelings," type things. And I totally understand and get that. And I think at some point, women, and we maybe don't do this naturally, but have to prioritize ourselves. And it's not a statement against any other provider that you're looking to seek care.

And I myself, if I see a patient and they may not agree with my plan

and they go get another opinion from another specialist, that is what we want for our patients. We want them to feel fully informed on all their options and have their different recommendations, and then they get to decide. We have ownership over how our care is managed.

So, I think that there's more – and I would say also within OB/GYN, providers who are not comfortable or don't have time or for whatever reason don't do as much care of menopause and this space, usually are grateful to have someone to refer to who will be able to provide that full care. And we also share. So, I may have some patients where I just do their menopause care, and they still continue to see their primary for their annual exams and their preventative health.

And so, there are so many models on how it can work, it just depends on that particular situation. But I think as healthcare providers, we are not going to fault any patient for wanting to get more opinions and kind of making informed decisions about their care.

Jamie Forward: So, let's move onto the third thing that women need to know, probably why everyone has tuned in today. So, how to manage symptoms. So, it sounds like perimenopause is the phase where the most sort of troublesome symptoms occur. So, Dr. Ali, can you just give us an overview of the treatment options available?

Dr. Nina Ali: Yes. So, I would agree. Perimenopause is, I always tell my patients this too, this is the harder part for us to navigate and manage because it is so different for each person, the pattern is by definition unpredictable. And based on what priorities that particular patient has, you know, we kind of look at what are we going to target as far as management? And so, we do have to consider contraception for women who are still having periods, so that is an important piece as well that we don't want to forget about.

And oftentimes, our contraceptives are able to both prevent pregnancy and also just sort of even out those fluctuations that are going to be happening, that we know are happening in perimenopause where you might have ovulation on top of ovulation which can really kind of make all sorts of symptoms worse including bleeding patterns and migraine headaches and

mood and all of it. So, for women who get relief of both sides of things as far as bleeding pattern and the symptoms that go along with that through a low dose contraceptive, that is actually a great option.

It's not for everybody, there are plenty of people who come in and see me and say, "I don't want anything to do with contraception or birth control pills anymore," or "I already had a tubal ligation, and I don't need that." But that's one thing to keep in mind as kind of a simple and easily accessible way to manage perimenopause. Of course, we have all of our options of menopause formulations of hormone therapy, different forms of estrogens, different forms of progesterones.

And sometimes we're bridging, we're kind of using some contraceptive with maybe a transdermal estrogen patch. For example, the Mirena IUD does a great job of managing the heavy periods of perimenopause and providing uterine protection, and we can also give a different form of estrogen that may not be a contraceptive with that. So, there are lots of ways to be fun and creative, basically, is one of the things about perimenopause. And then there are, of course, nonhormonal options as well.

So, if most of the symptoms aren't necessarily – are more kind of on the mood side of things, there may be ways that don't involve hormones that we can really help kind of navigate through those symptoms as well. Or for women who cannot or do not want to take hormone therapy, there are prescription and nonprescription nonhormonal options. So, there's quite wide a gamut of things that we get to talk about.

Jamie Forward: Yeah. And, Dr. Piasta, what would you add to that? I've heard about SSRIs, for example, being good for hot flashes. Is there anything you have to add as far as treatment options go?

Dr. Jackie Piasta: Yeah. Yeah. Well, I think in menopause and particularly in perimenopause, we get ourselves in a little bit of a mess because we have so many options to choose from. You know, how many times have you gone in for a blood pressure check and said you had high blood pressure and belabored over your options to treat your high blood pressure? So, this is a difficult conversation, and it sort of bleeds into a little bit of the why I've been dismissed and why maybe it's hard to find somebody, because options are very

nuanced. Dr. Ali was talking about before, certain contraindications.

So, we do have some individuals that maybe are not the best candidates for hormone therapy. I would be remiss if I didn't say that we do have to recognize that hormone therapy is the gold standard across the board for menopause treatment. It can get a little messy, and we do have to be creative in a perimenopause space, but it's the gold standard for the vast majority of women in menopause, particularly if it's started early.

But there are wonderful nonhormonals. SSRIs have been used, we have one that is FDA-approved and that's paroxetine (Paxil), and then the rest are used in a way that we call off-label. The most effective tends to be venlafaxine (Effexor XR), which tends to kind of be the next-preferred. SSRIs can be, and SNRIs can be great for some people, particularly those that struggle with their mood during this time. We also have a newer class of nonhormonals called our NKT therapies. And those therapies work on this set of neurons in our hypothalamus, which is the central part of our brain that regulates our thermostat, essentially.

And they're these little neurons called kisspeptin, neurokinin, and dynorphin, not to get into the weeds too much, but they literally regulate our temperature, and they kind of play this little piggyback with estrogen.

So, those therapies can be really impactful. And the newest one, elinzanetant (Lynkuet) actually has shown pretty good data for sleep as well because it hits on a different substance in the brain that's implicated in our sleep cycle as well. So, we have SSRIs, we have these NKT therapies, we also have gabapentin (Neurontin) and – oh, gosh. I can't think of the trade name for it, but the branded name would be Lyrica, which sometimes we can use for different symptoms. And then we have oxybutynin (Ditropan), which is actually an old-school bladder medication which is on the list of medications for nonhormonals as well. And then there is some data to support certain complementary alternative therapies like Chinese medicine and cognitive behavioral therapy and certain forms of black cohosh and soy products.

But again, it's why you have to individualize care. It's why I always ask patients, "What are your goals, and what do you hope to get

out of this visit? And in a perfect world, what would your treatment plan look like?"

Jamie Forward: Sure. And it sounds like this is kind of a moving target, right? As you guys have been discussing, it sounds like you're going to have to keep having conversations like this with your doctor as you move through the various phases. So, let's talk about sort of what women can do, right? I know our little Feminess team is always joking about, on top of all of our other responsibilities including eating enough protein and lifting heavy weights, we have to be taking care of ourselves in other ways. So, what can women do themselves to support their bodies during this phase of life? Dr. Ali?

Dr. Nina Ali: Yeah. I mean, I think that part is a lot of things that we all know in our brain. Me personally, I know I need to be getting a certain amount of sleep, I need to have a healthy diet, I need to be active. So, those things, really trying to be in your very best health as we go through this transition is kind of the bigger goal. And our lifestyles are not really set up to make those changes easy, so you do have to really think about it and make an effort, but it is things that we have been told. You need to have a certain amount of fiber, you need to have a certain amount of protein, we need to generally eat more vegetables and less red meats.

And kind of pay attention to these things that we have, all of us, hear about and know about, but when you actually want to go and implement that into your workday and make sure you're eating properly and getting up and moving and working your muscles, we know from a scientific perspective that in perimenopause and menopause, we rapidly lose bone strength and muscle strength, which compounds a slowing metabolism and increases our risk for various metabolic problems.

So, thinking about that and implementing practical things that can be done, I think those are kind of the basic parts of optimizing health, and really important. And we all would love quick fixes and love to have injections and supplements to take the place of those things, but really nothing is going to be better than sort of implementing those things into your life. So, we want to emphasize that.

And also, talking to other people, like, whoever is on here and

listening and getting this information, I think being informed and having spaces where you can discuss with other people who are going through the same sorts of transitions like we all are or will at some point is really helpful and really important as well. And so, women tend to be good at that, but we need to find spaces where it feels comfortable.

Jamie Forward: Great. And I'm getting the feeling, Dr. Piasta, you might have something to add to that, but I just want to remind everyone that we're going to leave a few minutes here for Q&A at the end, so if you have any questions, just put them into the Q&A box on your toolbar. Dr. Piasta, did you want to add anything there?

Dr. Jackie Piasta: I agree with everything Dr. Ali said. I usually try to impress upon my patients that this is really a time to take stock of you being able to put your oxygen mask on before helping others and sort of assess. You know, a lot of women enter into perimenopause into what we call that sandwich generation, right? But a lot of women, they had been taking care of their families for many years prior, and so perimenopause is an excellent time to sort of reassess areas of your life where you can really kind of add. And it doesn't have to be anything cosmic. A lot of times I'll just say, "What can you add to your plate? Or what little movement snacks can you add? If you can't devote 45 minutes to a strength training class, can you park 20 spaces further away in the Target parking lot than you would have?"

Something, just little – our goals should be smart, they should be attainable and realistic and all those things. So, certainly it's a good time to sort of reassess. And community, find community. I have a group of patients that sort of are all friends, and they see me and it's sort of this running joke that one of them will see me, and they'll go have their little coffee date and then sort of mind share. So, that's so valuable because I might say one thing that I don't say to another one. And so, finding community, going on those Facebook mom groups and seeing who's going through this where you can share those lived experiences.

Jamie Forward: Yeah. Of course, that's really important. Yeah. Really great advice. Thank you for that. So, I wanted to get to your questions. So, we'll just take a few minutes for that. So, we did receive this one in advance, so I think this is probably top of mind for many people.

But this person says, "What's the most recent research on HRT for menopausal women with a family history of breast cancer?" So, Dr. Ali, do you want to take that one?

Dr. Nina Ali: Yeah. You know, this is actually one of – you know when we talked about myths earlier? And I think this is one of the most pervasive myths is that if I have a family history of breast cancer, I'm not a candidate for hormone therapy. And I think we have great sort of risk calculators on what breast cancer risk is for that individual, and family history is an important part of that. The hard part is, breast cancer is very prevalent, it's been that 1 in 8 number for decades, and that pretty much hits most families and most friend groups. So, most of us will know a close person in our life that has been affected by breast cancer.

But having a family history is not a contraindication to you being able to take hormone therapy, but it does mean you may have a higher baseline risk than the next person who doesn't have that family history. So, I think those kinds of conversations, again, are the things that need to be discussed and also weighed. So, every person's going to have their threshold of risk that they're comfortable with and risk that they're not comfortable with. And if you decide, "Hey, I've heard about the numbers and what we know and I feel like I would benefit from hormone therapy even in the short term for a few years," that might be a great choice.

The next person with the same history and the same numbers may look at those and say, "I really don't want to worry about that, and I would prefer to use one of our great nonhormonal options that will also manage those symptoms really well." So, again, it is nuanced for those reasons.

And then one thing that didn't come up in our conversation is the genitourinary syndrome of menopause and the local hormone therapy that we use, whether it's vaginal estrogen creams or tablets or ring or there are a few different options there too. But those are local and can be used for women who have contraindications to the systemic options like breast cancer personally or blood clots. So, I did want to just plug that in because that's another common misconception.

Jamie Forward: Yes. That was actually one of the questions that we received.

Dr. Nina Ali: Oh, sorry. Sorry.

Jamie Forward: No, no, no. That's great. It's great. It ties right in. So, one of the people that wrote in said, "Can you please expand on the use of vaginal estrogen for perimenopausal women?" So, it seems like there is a role there in certain cases. Great. So, here's the next question. So, Dr. Piasta, this person wants to know, how does perimenopause affect endometriosis state?

Dr. Jackie Piasta: Oh, well that's a difficult question. So, we thought for many, many years that actually endometriosis goes away in menopause.

But again, our – maybe that's going to be the theme of today, this evolving nature of understanding just ... welcome to women's health. But our understanding of endometriosis is rapidly changing. We thought for a while that it was always just retrograde endometrium where it was the lining of the uterus sort of implanting itself outside of the uterus. Well, now we have a differing understanding of what it is and the inflammatory component and the potential autoimmune component. So, the answer to that question is, we really don't have a full understanding of the interplay between endometriosis and perimenopause and menopause.

We know that most likely, it does not go away with age and that symptoms can morph. They can turn more from pelvic pain and pain with intimacy to more of bowel symptoms and IBS-type symptoms. And so, I think, again, not to send people on this quest to find a needle in a haystack, but it's really important that if you are somebody that has endometriosis, that you're working very closely with an endometriosis specialist or at least somebody in menopause that has a very hefty gynecologic background and can really shepherd you though those choices.

Because it's not – again, it's one of those very yellow light areas. Endometriosis, like having a family history of breast cancer, is not a contraindication to utilizing hormone therapy, but there are more complex decisions that we have to make when somebody has that history and we need to make menopausal, particularly in this situation, hormone therapy discussions. So, again, this is an area that needs so much more funding and so much more studying.

Jamie Forward: Sure. Well, thank you for that. So, one of the other questions we received which I think a lot of people are facing, so what can we do about the estrogen patch shortages? Do you know if this will keep happening, or will production catch up? Who wants to take that?

Dr. Nina Ali: Oh, my goodness.

Jamie Forward: Dr. Ali?

Dr. Nina Ali: Well, it has been such, such a beast to navigate with the shortages, as you can imagine, running a menopause clinic. But, I mean, we don't know. As far as, like, updates on how long this is going to go on, I really have not heard anything definitive about when to expect relief here. But in my practice, we have been sort of switching to different modalities, which is not ideal, but we've had women on goose chases all over the city trying to get to one pharmacy or the other and getting one box here and one manufacturer there.

So, I've been kind of favoring new starts with the daily gel to try to help them avoid that situation, which also is a transdermal form, it comes in several dosing options. So, hopefully there are not going to be shortages on that as well, but it's a blessing we have so many different ways to prescribe your hormone therapy.

So, for me, that's kind of what has been working, is either switching over to the once weekly patches if the twice weekly have been more hard to get filled or switching to a gel. There's also a vaginal ring that is amazing, but it's harder to get it covered by insurance for many women. So, that one I haven't been utilizing as much. And there's also a spray, which is great, but from the beginning, for years, that one's been a little bit harder to get filled. So, it is a challenge, but I think for most people we're able to at least figure out some way to navigate.

Jamie Forward: That's great advice.

Dr. Jackie Piasta: I'd also like to add, if I could take the liberty to add – I also want people to understand too, especially if you're an otherwise very good candidate for hormone therapy, you're well within that window, you don't have any excessive risk of blood clot or cardiovascular disease, that the oral estradiol can be a really good

option particularly if you're somebody where your gynecologist has said, "Oh, birth control pills are a great option for your perimenopause."

The ethanol estradiol, or the estrogen in a birth control pill is a lot more potent than our menopausal hormone therapy estrogen form. So, don't automatically rule that out as an option. It's very inexpensive, very easy to take. And again, it's not just a patch shortage, the patch is hard because some people really can only tolerate one brand of patch. So, it can be very tedious. It's not as easy as saying, "Oh, well I can get this brand." So, as Dr. Ali said, it's really challenging, but I always put a plug in for, particularly my really, really excellent candidates for hormone therapy, don't automatically rule out oral estrogen either.

Jamie Forward: Yeah. I think that's a great point. And it's really, as we've been talking about this whole time, it's really about having a discussion with your doctor about what's right for you. I think that that's what we can all take away from today. We've received this question from one of our viewers. So, what are your thoughts on HRT for women 10 years post-menopause who are having symptoms and signs, osteoporosis, for example? Dr. Ali?

Dr. Nina Ali: That's a great question. And it's a clinical question that comes up not infrequently in our practice. And again, I think we have to look at what the goals are and look at that person and see what medical issues they're coming in with. Most of us, by our 60s – you know, being 10 years from menopause, we're talking about mostly women in their 60s – are going to have other medical conditions that we need to consider. And if you look at, I mean, there are certain things that estrogen, we know, helps with. So, whatever age of your life you start on estrogen, it's going to help your bones. It's not that it stops helping bones for women in their 60s.

So, yes, it will help prevent osteoporosis, there's a good amount of evidence that it actually improves women who actually have osteoporosis, so that, we know that, that's really not a debatable point.

It treats hot flashes whenever we try it for hot flashes that are due to menopause, estrogen is the first-line treatment. The part that's more of a gray area and why we have that kind of 10-year guidance that we try to stick to is that after your body has adjusted

to a long period of time of not having hormones present, certain changes occur in our vasculature, how the arterial flexibility and stiffness evolves. And reintroducing estrogen at that point after that has happened can have new deleterious effects, so new negative effects on the blood vessels, perhaps increasing cardiovascular risk. And the important area is that all of us are really interested in how to keep our brains functioning in the long term and in our later years.

So, we want to live longer, but we want to live longer with our cognition intact, right? And that's the space where there's been a few well-done studies showing that actually reintroducing estrogen has a negative impact on cognitive function. And for many people and for me myself, that is a scary thought that you could be introducing something that could have that impact. So, we definitely want more information, again, about this. And then the other caveat is women who were started on hormone therapy in that early phase and would like to continue through their 60s and beyond, that's sort of a different category.

And that we feel much safer and more comfortable about because they've had estrogen present through that entire window. So, for them, unless they develop a contraindication or a reason to come off, that's always a discussion, you know, "Do you want to continue? Do you want to taper down?"

But that patient who comes in who went through menopause at 52 and now she's 65 and she heard about how great it is to be on hormones, for that person, you really have to make sure she has a good understanding of the pros and cons. And her cons may be more significant than we appreciate, and so we don't want to minimize that. But there are still some pros even for her, she could certainly start on vaginal estrogen for her genitourinary symptoms, that we can start and stop at any point because it's not systemic. And I wouldn't say that it's always a no, but it has to be really well thought-out and informed. I guess I would leave it at that.

Jamie Forward: I think that's great guidance. Thank you so much for sharing that. So, Dr. Piasta, I wanted you to take this question. So, we had someone that wrote in that said that they started perimenopause at 31 based on some health issues, and they've had sort of trouble explaining it, finding people to relate to, talking to their partner

about why it's happening so early. So, do you have any advice for those of us who are outside of the normal perimenopause timeframe?

Dr. Jackie Piasta: Well, this is a really challenging area because as we saw earlier in the poll, 80 plus percent of people that, I'm just assuming they went through a typical experience of menopause got dismissed, now we have to take an atypical experience of menopause and expect not to be dismissed. So, there is about 5 percent of the population that goes through menopause early. And so, there's premature ovarian insufficiency and premature menopause, and then there's early menopause, and this is any menopause prior to the age of 40. And so, like we said earlier in our conversation, perimenopause can last an expanse of years, upwards of 10 years.

If you're somebody whose body is programmed to go through menopause at a younger age whether that's through your genetic features or environmental features or through health consequences, it's a very challenging experience. And I don't know that I have great recommendations outside of continuing to just be a part and actively engaged in the typical community because that's where most of the resources are. And attending webinars like this and bringing your significant other with you to have these conversations is really important in finding those resources.

And I do know that there are a lot of support groups out there that are aimed more towards sort of these more niche communities that through lived experiences. And so, without having a direct answer to this question is just continue – you know your body better than anyone else.

And just because you've gotten a disappointing answer from one person, we just have to be our own best advocate and try to use the channels that Dr. Ali and I have kind of already spoken about, and finding a menopause, ideally menopause certified, and then somebody that devotes a very, a lion's share of their clinical practice to menopause, is probably going to be your best bet to get the most up-to-date care for the atypical menopause experience.

Jamie Forward: That's great advice. I think that's really just, again, being proactive. Well, thank you to our audience for submitting such

great questions. And, of course, thank you to our experts for such thoughtful responses. We'd also like to thank our sponsors today, Astellas and Bayer whose support helped make this educational program possible. So, Dr. Piasta, as we close out, you're caring for women every day facing some of these challenges. So, what do you want them to take away from our discussion?

Dr. Jackie Piasta: Oh, gosh. Just know your body. And not feeling like yourself is very much a valid symptom. We know, we've got a paper published on it, we had a whole study, Women Living Better, about it.

So, know your body, know that this is a time of rapid change and that you deserve to feel good, and you deserve to have a clinician that's willing to partner with you in order to meet your goals.

Jamie Forward: Yeah. Well, thank you for that. So, Dr. Ali, what would you like to leave the audience with? What's the most important message you'd like people to walk away with from today's discussion?

Dr. Nina Ali: Well, I love the things that have come up. I think we've hit so many of the important, big points in our conversation. I think one thing for women to remember is that you know your body and your situation. And in this space, there are going to be options for you even if you are somebody with contraindications, if you're somebody with reservations about this or that, talk to your doctor about it and know that there are going to be some options to help you navigate through.

And you really shouldn't feel like that you have to do this by yourself. So, hopefully people were able to learn a little more about what those options are, but there are options for everyone.

Jamie Forward: Yeah. I hope people walk away knowing they can get the care and support that they're looking for. Well, thank you both for joining us today and sharing your expertise.