Midlife Clarity with Dr. Tracy Page

"Clarity Changes Everything"

Hosted by Dr. Tracy Page

Episode # 19 — Thriving Through Menopause

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Hi, I'm Dr. Tracy Page, and welcome to *Thriving Through Menopause*. I can't wait to share this information with you. As a physician, I'm excited because I know what's on the other side. I get to see women every day who, once they have their hormones stabilized, once they understand what's going on, once they work on all the things that affect menopause, feel amazing.

I'm also 60. I have been here — I have done this. I started menopause at 52, so my ten years will end at 62, and I'm now 60. I have to say that I feel better today than I did in my 30s, and I want that for every woman. I want every woman to feel that way. I'm very passionate about this work, so let's get started.

So — Thriving Through Menopause. Who am I, and why should you listen to me? I'm Dr. Tracy Page. I have a functional medicine clinic called Wisconsin Institute of Functional Medicine in Appleton, Wisconsin. I'm licensed in almost 20 states now, so I have patients from the East to the West Coast. I love taking care of patients — I see males and females — but I'm very passionate about female health, because as a woman, I know what it feels like to be hormonally unstable, to be 40 pounds heavier than I am now, to feel like your brain's not working. And I also know what it's like to be on the other side of that.

We're fortunate — we have many providers here, and we get to take care of a lot of female patients. So I have a wealth of information to share with you today, and I hope you'll walk away understanding what's going on in your body and knowing you have options. That's the most important thing—I want you to know you have options and understand what's happening. I focus on women's health, longevity, and regenerative medicine, and I've trained in integrative and functional medicine. I'm triple board certified. Now that we've covered that, let's get started.

We're going to cover a lot today: what's really happening in perimenopause and menopause and how you know which one you're in; the symptoms you're probably having that you didn't know were connected to menopause; what the research says

about your heart, bones, brain, and everything else; and what the 2002 study's headlines got wrong. I'm talking about the Women's Health Initiative. There were two arms to that study, and only one arm made the headlines — the arm about estrogen causing cancer, which is far from the truth. I'm excited to share that information today, because I think it's important for you to understand what's really going on. They took the black box warning off of estrogen — because of the other arm of that study — and we're going to go through that today.

Then we'll cover treatment options: creams, patches, injections, orals, troches, pellets—there are so many options available to you as women. And the benefits that come with hormone replacement therapy — it's not just getting rid of night sweats and hot flashes. It's weight loss, mental clarity, bone health, heart health, brain health. There are so many good things that come with taking care of yourself during this time of life.

Then we'll talk about outcomes — what it looks like if you're a patient in our practice — so you have an overview and something to relate to, whether you're seeing your own provider, come to WIFM to see one of our providers, or do telehealth with us. And finally, how to take the next step — whether that's with our provider or a provider of your own.

Many women come to my office, and they've been told it's in their head, that it's just part of aging, that sleep isn't the same because of something they're doing. But I want to tell you: you're not broken. What you're describing, you're not exaggerating — it's real. You're going to have anxiety. You're not going to sleep. You'll wake up five or ten times during the night. You're going to soak your sheets. All of this is happening because your body is changing. What worked for your body at 30 and 40 doesn't typically work at 50, 60, and beyond. Your body needs answers, and you need to ask different questions.

The brain will always feel like it's one step behind in menopause if you don't get hormonally balanced. I've seen so many women in my practice who were dismissed by other clinicians because they didn't know what to do, or they still believe the black box warning that estrogen causes cancer. Your hormones are changing, and nearly every system in your body is affected. Today I want you to walk away knowing what they are

and what to do. 60 to 80% of women will develop hot flashes and night sweats, or suffer in some way during menopause, and no one ever tells them or helps them. That's sad to me — really sad, because I know it doesn't have to be that way.

Menopause is a transition — it's not a light switch. You can start having menopausal or perimenopausal changes as early as age 35, though it's more typical a bit later, and it carries on until you go into menopause. The average age is 48 to 52.

Most perimenopause symptoms come to light in your 40s. Hormone swings — you don't feel like yourself. I have women in my office who said they were ready to break up with their boyfriend or divorce their husband — and vice versa — because when a woman's hormones are off, everything is off. This is unpredictable, especially in perimenopause. I do a podcast on this, because it's never just "your estrogen drops" — your estrogen is like a roller coaster, up and down. Progesterone is a little more gentle — it's a slow weaning out. But even when progesterone is lost during perimenopause, which is the first hormone to go, you lose sleep, you become anxious, things bother you, you have mood swings. It's real.

Then you go into menopause, which is defined as one full year without a period. You can also determine menopause by your FSH — follicle-stimulating hormone. Typically, if that number is over 60, your ovaries are not coming back. I joke with my patients that they're packed and on their way to Florida — if it's over 60, they're not coming back. Typically, FSH over 10 up to 60 is the perimenopausal window, but don't quote me on those exact numbers — I have patients whose FSH is 52, and they haven't had a period in a year. There's no hard, fast rule on FSH. Twelve months, no period — you're in menopause.

I always tell patients it's like jumping into a pool — you're in the menopause pool for about ten years, and that's where the postmenopausal period begins. So: perimenopause, then no period for a year and you're in menopause, a ten-year window, then postmenopausal. You can have symptoms anywhere from four to seven years at least — I even have women ten years out who are still having symptoms. Symptoms typically fade after that ten-year window, but bone, heart, and brain health

keep going — those are still vulnerable organs we need to protect. Menopause is often treated as if it's a single moment, but it's really a decade-long shift, and we follow our patients through it because things are going to change, and we want to keep them healthy and well.

Think of it like a thermostat — that's how I describe it to patients. Estrogen isn't a light switch, on and off. It's a thermostat that starts drifting — up and down, up again, down again — and you can't regulate the temperature like you can at home. It takes years before it finally settles. That's why one week you feel fine, and the next week you don't recognize yourself — and those around you don't recognize you either. Your symptoms aren't steady; they're not fixed. So if you get treated or have your labs checked, it's not a one-and-done.

I can tell you from my own experience — I'm 60, and I went through the change at 52. I didn't start all my hormones right away; I didn't need to. I had my labs checked — I needed progesterone, a little testosterone, and I'll tell you more about that. It wasn't until about two years in that I needed estrogen, because I had always been estrogen-dominant and heavier than I am now, so my body fat was carrying estrogen for me — I didn't need supplementation. If I were doing the same regimen at 52 as I am at 60, I wouldn't feel the way I do today.

It's important to know your hormones are going to change — not so much the fluctuation, because we do want to stabilize you so you're more like a gentle wave instead of a roller coaster — but what I needed at 52 is different from what I might need at 55, 58, or 60, and the same is true for you. It's really important to get your levels checked. We always treat the pattern in our patients — what's going on in your life. We look at more than just your hormones; we look at metabolic function, cardiovascular function, whether you need to lose weight, whether you're sleeping. So many things affect your hormones. That's the difference between managing menopause and truly having great vitality, versus just enduring and getting through it. I hope no one out there is just enduring, without getting the help they need.

There are more than 30 symptoms associated with this change, and some will be very familiar — the ones you already expect. But some are surprising, like recurrent UTIs. When we lose estrogen in the vaginal area, the microbiome changes — it becomes less acidic, which is a breeding ground for bacteria. The tissue also becomes dry, so it's easily damaged or injured during intercourse, which can lead to infections. I've had patients who were prescribed an antibiotic to take after every time they have sex with their partner — and that is not good care. You don't need an antibiotic every time you have intercourse; you need some estrogen in the vaginal area, whether it's estradiol or estriol. It helps with bladder incontinence, bladder frequency, and vaginal or perineal dryness and atrophy. It works quickly — I have patients use it nightly for two weeks, then once or twice a week after that.

All of this relates to your hormonal shift: brain fog, word-finding difficulty, trouble sleeping through the night or getting deep, restorative sleep. Anxiety is huge during this time because we lose our calming hormone, progesterone. Hot flashes, obviously. And libido — I have so many women come to my office and say, "I have no libido. I'm not interested in sex. I love my husband, I love my boyfriend, but I just don't care." And deep fatigue that you can't fix with sleep or food alone — that's from the loss of your hormones.

There are more than 30 recognized symptoms—these are just a few. Others include tinnitus (ringing in the ears), hair loss, dry skin, dry eyes, dry mouth, histamine reactions, and constipation you never had before. All of these can be related to your hormones.

I describe estrogen as scaffolding. While it's up, you never notice it. You take it down, and the building still looks like it's standing — but every joint, every beam, every wire starts working harder to stay level, because you've removed the scaffolding. Bone remodeling speeds up, so you break down bone faster, which can lead to osteopenia or osteoporosis. There's a direct correlation between low estrogen and elevated cardiovascular disease risk — cholesterol, blood pressure — and we'll get into that. Brain, sleep, memory, mood, even temperature regulation — all affected when you lose estrogen.

Symptoms are what bring patients to my practice — they're the noise you hear. The structural changes — brain, bone, heart, neurological disease, autoimmune disease — are what I'm trying to prevent long-term. That's the aging you don't want. We're going to talk about health span, and what it means to have a great health span, not just a lifespan.

Now, your heart connection: 45% fewer heart attacks in women who began hormone therapy in their 50s. 30% lower all-cause mortality in that same age group. This is where the Women's Health Initiative comes in — I'll talk about that in a minute, because it's important. Many women had fatal heart attacks or strokes that didn't have to happen, because they were afraid to take estrogen, or couldn't get it. Cardiovascular disease is the number one cause of death for women in the United States — higher than all cancers combined. One in six women will have a heart attack or stroke — that's higher than all cancers combined that affect women. It's huge. One in eight for breast cancer.

Timing matters more than almost anything else, and I'll explain what that means, because there's no age at which you categorically cannot have hormones. We've been taught: started before 60, or within 10 years of menopause, therapy looks protective. Started at 65, it does not — I'm going to explain that sentence, because I put it up there for a reason. 65 doesn't mean you cannot have hormones — it depends on the patient, the situation, the history, and what's used.

Your bones are losing ground right now. If you're watching this and you're in perimenopause or menopause, your bones are already affected because your estrogen is changing. One in three women will be affected by postmenopausal osteoporosis—a weakening of the bones because you lose their architectural structure; they're not as thick or dense. Bone loss happens fastest in the two to three years after your final period — that's important to know as your hormones change. There's a 20 to 40% fracture risk reduction across all sites of the body when your hormones are in place. Recovering from a broken bone isn't fun. Vertebral fractures from osteoporosis are horrible — I know people who've gone through that, and it's changed their lives. They can't walk on their own, they can't exercise, they hurt constantly, and they're afraid of

the next fracture, so they're very limited. You don't want that life. You can't feel bone loss — like blood pressure, it's a silent process. There's no symptom until you actually break a bone, which is exactly why the decision about hormone therapy is so important and needs to be made sooner rather than later.

This isn't a short-term issue. The median duration of hot flashes and night sweats is 7.4 years, and they continue on average 4.5 years past your final period — for some women, up to 14 years. And that's just two of the symptoms I mentioned; remember the 12 I had on screen, and the 30-plus symptoms overall. It affects quality of life, and it follows you. I have professional women in my practice — CEOs, heads of HR, finance, accounting — who run businesses, and they come to me and say, "I'm drenched — I just had a hot flash during my meeting," or "I'm not getting any sleep, so I can't function the next day." I hate to say it, but there are women in my practice who had already quit their jobs because they couldn't get through the symptoms of menopause. I'm here to tell you that doesn't have to be the case — you do not have to suffer like that. This isn't vanity, and it isn't just discomfort — it affects years of your career, your life, your relationships. It's a very important topic.

Now, what the 2002 headlines got wrong — the Women's Health Initiative. The study had two arms. The arm that got reported was: hormone therapy causes breast cancer and heart disease, and you can't have hormones — and that's where the black box warning came from, covering breast cancer, cardiovascular events like heart attack and stroke, and dementia. That warning has since been removed. In February 2026, the FDA officially removed the black box warning from estrogen.

When that warning went on, the use of estrogen dropped. 40% of women were using it in 2001, and that fraction dropped almost overnight—they either stopped using it or couldn't get it. I've seen numbers as high as 80 to 85% in terms of the drop-off — essentially no access to hormones for an entire generation. And this is the sad part — based on the numbers, more than 50,000 women are estimated to have died prematurely from heart attack and stroke because they didn't have their hormones. Think about that — more than 50,000. And that's just the ones we know about.

Here's what we actually know about the second arm of the study, which never got reported. The arm that made headlines involved older women — 63 on average — past that initial ten-year window. They used oral estrogen along with progestin, which is not the same as natural progesterone — it's synthetic. Those women did have more heart attacks, strokes, and breast cancer. But the other arm — women who got estrogen alone, nothing else — had a 23% reduction in breast cancer. The reanalysis by age tells a very different story for women in their 50s: they actually had less breast cancer on estrogen. So the study wasn't wrong — the headline was. It reported only one arm, not both, and applied it to the wrong women, at the wrong age, with the wrong formula.

Those women were 63 — and please don't hang your hat on that number, because I'll explain later why someone at 63 could still have hormones. But these women got synthetic hormones, already had heart disease, and had other risk factors that made them the wrong candidates for this therapy.

The "window of opportunity" is typically described as within 10 years of menopause — whether you go into menopause at 50 or 52, as I did, you have that ten-year window, with lower mortality, favorable cardiovascular vessel health, maximum bone protection, and brain health benefits. There's a gray zone further out, where individual benefit is still possible, but the risk calculation changes, and we weigh it carefully. The risk is not as great as you might think — it's often compared to being overweight or drinking alcohol, things we do every day without a second thought. At 65 and beyond, you can still start hormones, but it depends on the patient and the situation. Starting at that point is associated with higher coronary and stroke risk in certain patient populations, but it's not a door we categorically close — I'll explain more about that.

It's far easier to keep a house warm than to reheat it once it's gone cold. It's far easier to get your hormones balanced and prevent disease right as you enter menopause than to wait another 10 or 12 years. But I do have women who come to me having been through menopause for 10 years, starting hormone replacement for the first time — they're a particular patient population.

What hormone therapy actually does: hot flashes and night sweats improve — estrogen is the most effective treatment for that. Sleep and mood improve — mood is directly tied to sleep, and progesterone is your sleeping, calming hormone. It increases GABA. Taken orally, it passes through the liver; you can also take it as a troche under the tongue, which works very well. These hormones have to be balanced together. Fewer night wakings, steadier mood — even your family notices when you start hormones. I typically start progesterone first; it regulates your estrogen receptors. If you need both, I usually start estrogen about two weeks later.

Bone and fracture risk decreases 20 to 40% at all sites during those fast years of bone remodeling right after menopause. Genitourinary symptoms — frequency, incontinence, pain with intercourse — all of that improves. If you do nothing else, you can get a prescription for a vaginal estrogen tablet, 10 micrograms — it has no systemic effect, so it won't affect the rest of your body, but it makes that area feel much better. It works because the vaginal area is supposed to be acidic, and the microbiome changes with estrogen loss; putting estrogen back makes the tissue soft and pliable, and helps with bladder contraction — we have receptors and muscles around the urethra. It really helps with urinary incontinence, frequency, pain with intercourse, and vaginal dryness. Any woman at any age — even 70 — can use vaginal estrogen to treat these genitourinary symptoms.

Muscle and bone composition: hormones support lean mass and strength when paired with resistance training. And cardiometabolic markers — there's a direct relationship between declining estrogen and cardiovascular disease. Five risk markers you should know about: lipoprotein(a), apolipoprotein B, LDL particle number, myeloperoxidase, and oxidized LDL, along with small LDL particle number. Those are among the most important parts of a lipid panel — not just the standard lipid panel. If you haven't heard of these, visit my website, WisconsinFunctionalMed.com, and episode 5 of the podcast covers the five cardiovascular risks you might have without knowing it.

The questions everyone asks me: Does it cause breast cancer? What about clots and stroke? Do I have to be on it forever? Should I just tough it out? On breast cancer — in the Women's Health Initiative's estrogen-only arm, breast cancer risk was not increased;

it actually decreased by 23%, as I mentioned. The small increase seen with combined therapy — estrogen plus progesterone, not progestin — after about five years in menopause shows a slight uptick in breast cancer risk. Almost all of my patients are on the combination, and I haven't seen that happen clinically — it is reported in the research, but I'd put the magnitude of that risk on the same order as lifestyle risk factors women already accept, like drinking more than two alcoholic drinks a week, which is also a risk factor for breast cancer that most people don't think twice about.

What about clots and stroke? That's exactly why we don't use oral estrogen — it passes through the liver first and increases clotting factors. In our practice, we use only transdermal estrogen—cream or patch. If a patient doesn't respond to that, we use an intramuscular (IM) injection of estrogen. We don't worry much about clot risk in our patients because we don't use formulations that increase it.

Do I have to be on it forever? No — there's no required stop date. I've had patients who stopped and later came back because their quality of life declined; they stopped feeling as good, started gaining weight, and couldn't think as clearly. I'm not saying you have to come back or that you can never stop — but that's what I see in practice. I'm 60, I went through the change at 52, and I plan to be on my hormones for the rest of my life, and I'll explain why.

Should you just tough it out? It's not just the symptoms you'd be toughing out — it's the bone loss, the cardiovascular disease risk that could lead to something like a stroke or heart attack, and the dementia risk and quality-of-life impact on your brain's function — which leads into health span. You could choose not to do hormones — I never tell my patients they have to — but there's a path of potential effects from not having your hormones that affects your quality of life. Every one of these points belongs in a real conversation with your provider. These aren't headlines — they're conversations you need to have to decide what's right for you.

The door doesn't close at 65, and here's why: researchers studied 10 million senior Medicare women from 2007 to 2020, comparing those who never used hormone therapy or stopped it. Women who continued estrogen alone beyond 65 had about

19% lower all-cause mortality. They looked at estrogen alone, estrogen plus progesterone, and progesterone alone — and it wasn't just about breast cancer. The data showed estrogen use beyond 65 was associated with lower rates of breast, lung, and colorectal cancer, heart failure, blood clots, atrial fibrillation, heart attack, and dementia. That's why I said I'll probably stay on it for the rest of my life. Outcomes were best with low doses delivered transdermally or vaginally — and as I mentioned, we only use transdermal, though vaginal estrogen can be used systemically at a higher dose than what's approved just for local vaginal use. Combined therapy with progestin carried a higher breast cancer signal — one reason the formula matters. No synthetic progesterone, no synthetic hormones — bioidentical is what you want, and bioidentical hormones are FDA-approved and available at your regular pharmacy. We use Prometrium (oral progesterone) and estrogen patches — I wear patches I get from my pharmacy; it's the same estrogen your body makes.

The Menopause Society's position is that age alone is not a reason to stop or withhold hormone therapy. If you're 62, 63, 65, 68 and listening to this — go talk to your provider, schedule a telehealth visit, and find out whether your quality of life could improve. None of this is automatic — it's individualized. Your history, risk factors, goals, symptoms, and current medications all play a role. There's no standard dose, because there's no standard woman. As I said, I didn't start estrogen for at least two years — not because I was deficient, but because I had plenty of estrogen already in my system. Your story matters, which is why it's important to go over your cycle history, sleep, mood, sexual health, and family history — it's more than a 10- or 12-minute visit.

We check a wellness panel that includes nutrients, vitamins, minerals, iron, cardiometabolic health, insulin, and cortisol. We also look at thyroid, because thyroid, cortisol, and hormones are all connected. We also look at GI health because gut health plays a huge role in estrogen metabolism. We look at your risk profile — clotting history, breast cancer history, whether BRCA runs in your family. Those things help guide our decisions. Was a prior breast cancer ductal? Was it hormone-driven or non-hormonal? If it was non-hormonal, hormone therapy may still be an option — it depends on the type. I want to caveat that a patient with a breast cancer history is a

different patient population, treated very differently from what this presentation covers, because there are real risks to putting hormones into a patient with a cancer history — and it's not only breast cancer that matters here. We won't extrapolate on that today; just know that's a separate population.

You should have follow-up if you go on hormones — get your levels checked, and I'll explain our baseline process at WIFM. Two women the same age with the same lab values can have completely different care plans, because of their history, labs, environment, and daily habits. How the hormone is delivered matters as much as the dose.

Quickly running through the options: Progesterone comes as an oral capsule; if your gut has issues, I won't give you the oral form — you'd use a troche that dissolves under the tongue instead. Progesterone doesn't come as an injection, and I don't use progesterone pellets — there's a pellet option, but I don't use it currently; I may in the future once there's more research. Estrogen comes as a transdermal patch, a cream, or an intramuscular injection if a patient doesn't respond to the others. I don't use oral estrogen due to clotting risk. Injections are predictable — we use this for testosterone and sometimes estrogen; we can give small, precise doses on a set schedule, usually once or twice a week, which is easy to manage. Pellets are small — about the size of a grain of rice, maybe a bit bigger — placed under the skin. I don't typically start with pellets unless a patient has already used them or specifically wants them because they can't use creams or patches. Pellets are usually changed every three to four months depending on the patient, and give a slow release of hormone over time — we usually check peak levels around six weeks. They're a bit more expensive and more invasive, but they're available. Pellets come in estrogen and testosterone formulations.

Estrogen doesn't work alone — we'll cover all the hormones. Vaginal estrogen addresses dryness, painful intercourse, and recurrent UTIs, with minimal absorption into the bloodstream at typical prescribed doses. Transdermal estrogen — patch or cream — skips the liver, so there's no added clotting risk, and it's a natural delivery method. Progesterone protects your uterine lining — if you're in menopause and still have your

uterus (haven't had a hysterectomy), you need progesterone if you're on estrogen, because estrogen grows the uterine lining and progesterone keeps it from overgrowing.

Important note: if you're a woman not on any hormones, it's been a year since your last period, and you have vaginal bleeding — you need to get that checked out. Any vaginal bleeding off of hormone therapy, after menopause, is considered endometrial cancer until proven otherwise — don't sit on that. But if you are on hormones and experience some vaginal bleeding, that can happen, and if you're not on progesterone, that could be the cause. Sometimes it can also be a fibroid, or a very thin, fragile uterine lining — I've seen this in clinic, and sometimes we need to add some vaginal estrogen to stabilize the lining so you can continue your systemic estrogen. It can be tricky, because sometimes it looks like too much stimulation of the lining, when actually the bleeding is because the lining is too thin and needs some vaginal estrogen to stabilize.

Last hormone: testosterone. Yes, women make it too, and it's often the missing piece when women get their hormones balanced, but no one has discussed testosterone with them. It affects motivation, drive, energy, focus, concentration, libido, muscle building, fat burning, stamina, and mood. Get your levels checked — it's easy to replace and inexpensive; a little goes a long way. For comparison, a typical male testosterone cypionate dose is 200 mg/mL strength, and men often use a third to a full syringe. Women don't use even a tenth of that—our doses are much smaller, often around 5 to 10 units (about 0.1 mL) of a 100 mg/mL formulation. The doses are tiny but effective — restoring the ability to have orgasms, interest in libido, and sex. The biggest thing I hear from women starting testosterone is that they feel like themselves again — and I hear that with all the hormones.

Hormones work as a system, not individually — estrogen, progesterone, and testosterone all work together. Think of it like a three-legged stool: if one is missing, it's hard to stabilize. I always start with estrogen and progesterone first — estrogen sets the tone for temperature regulation, sleep, mood, brain health, blood vessel health, vaginal health, skin, and hair. But estrogen is like a teeter-totter, a yin and yang — you need progesterone to balance it. If you have a uterus, you absolutely need it; even without

one, you still need it to balance estrogen, so you don't get breast tenderness, overstimulation, or estrogen dominance and weight gain. Testosterone drives motivation, muscle recovery, and brain function — I can't tell you how many patients have said, "You woke up my brain." You need all three to be optimized. At WIFM, we look for optimization, not just "normal" — who wants to just be normal? We want vitality. I feel amazing at 60, and I wish I'd known all this at 30 — but I know now, and I want to teach you.

Hormones are the foundation, but not the whole house — what you do matters too. Strength training: I used to be a gym rat, working out six days a week with cardio and everything. Now I do strength training for 30 minutes, three times a week — that's it, and I'm stronger and recover better than ever because I'm not overtaxing my body. I do compound movements that work all muscle groups — it doesn't take much equipment. Find an app you like; we recommend several to patients and build out 3–4 day-a-week programs. I always tell patients to start where they are — 20 minutes, once a week — then once you've mastered that, add another 20-minute session on a different day (not consecutive), and build from there gradually. Small wins help you stay consistent; going from zero to six days a week doesn't work for most people.

Protein is a must for women in midlife — most of us don't get enough. We run body composition scans (InBody) to see muscle mass, body fat, and water composition, because we care about skeletal muscle mass, which drives your basal metabolic rate (BMR). Muscle burns calories continuously; without it, you're not. Cardio feels good and releases endorphins, and I do some myself, but it doesn't burn calories around the clock the way muscle does. Muscle also produces myokines, which benefit the heart, lungs, brain, and more throughout the body. I recommend 30 to 35 grams of protein per meal, which adds up to roughly 90-plus grams a day.

Sleep: if you're not prioritizing sleep, hormones alone won't make you feel better. Most women don't get enough sleep because they put everyone else first. Aim for seven to nine hours — protecting that sleep is vital. Once you start hormone therapy, better sleep often becomes possible. My sister, who's a bit younger than me, was struggling without my knowing — she reached out for another reason, and we ended up

checking her hormone levels. She recently texted me — I was reading it to my husband on the way to church — saying she couldn't thank me enough, that I'd given her back decades of life she thought she'd never have. She could use lawn equipment again after years of not being able to. She'd had a lot of pain and discomfort and wasn't sleeping. All it took was starting her on some progesterone and an estrogen patch after checking her labs — it's not complicated, and she feels amazing. I can't wait to see how she's doing in six months.

Many women don't realize that pain in their body can be hormone-related — we have progesterone and testosterone receptors in every joint, and these hormones play a role in pain relief and injury recovery that we don't fully appreciate when levels are low. Metabolic health — blood sugar, blood pressure, lipids — is all part of the full picture of vitality, optimization, and menopause care. Whoever you're seeing should be checking all of these things.

What getting better actually looks like, here at the clinic: in the first two to six weeks after starting hormones, things start to settle — my sister told me after a week she was sleeping like a baby, something she hadn't experienced in years. Most women say it's the first time in a while they start to feel like themselves. Around month three, sometimes sooner, mood and mental clarity really steady out. Libido and energy usually follow after that, because sleep and mood need to improve first. Around six months, strength and body composition really start to shift — I've had women who were already exercising and not losing weight, and once we balance their hormones, things fall into place; the body responds when it has what it needs. By one year, bone density and metabolic markers show real improvement.

I tell patients the first year involves the most visits and testing — we see you more often, then after that, we typically see you twice a year and make adjustments. Nobody feels everything at once; it happens over time, in layers, and sometimes you don't notice the shift until you realize you feel better. That's the part I love most — getting to see patients on the other side. This is also why follow-up matters: you never want to start something without checking your labs first, or continue without rechecking afterward.

Lifespan is how long you live. Healthspan is how well you live. You can have two women, both 88 — one spends her last 15 years managing fractures, fragility, pain, and dementia; the other does her own grocery shopping, plays pickleball, plays with her grandchildren, and travels. I want to be that second woman, and I think most women do too. Same lifespan, very different health span, depending on the choices you make.

What are we protecting when we balance your hormones and look at your health overall? Your bones, so you can keep standing and using them. Your heart and vessels, so you don't have a heart attack or stroke. Your muscles — the single best thing to help you get up off the floor if you fall. Independence after 70 usually comes down to brain function and the ability to take care of yourself. A brain that stays sharp, sleeps well, and repairs itself can keep functioning well into your 80s and 90s. The decisions you make today, at 50 and 60, shape your 70s, 80s, and 90s. Let's make good decisions.

What your first visit actually looks like at WIFM: You might never come here — this information alone might be enough for you to take to your own provider and get on the right path, and to me, that means I've done my job. But if you do come here — and again, I'm licensed in almost 20 states, so we see patients across the country by telehealth — you'll spend a full hour with a provider, whether that's me or someone else at WIFM. We go through your history, medications, supplements, daily habits, and blood sugar. We try to get your labs done before that visit because by the time you meet with us, you're ready to make changes, and we want to hit the ground running — so we gather your history and labs, then build your care plan. We typically see you back around 12 weeks, or about three and a half months, to recheck labs and make sure what we're doing is actually moving the needle — you don't want to guess; you want to test.

We have structured follow-up: in the first year, we typically see patients three to four times, depending on how much work there is to do together, then move to about every six months after that. If a patient is doing great by their second visit, we might space out to six months sooner — I don't want to waste their time, or mine. You'll leave every visit knowing exactly what's happening in your body, why, and what we're doing about it — we're careful not to overwhelm you, even though we get excited, because whether

we're taking care of you or you take your care elsewhere, we want you to know exactly what you need.

Every menopause journey is different. If you want to figure out yours, you can schedule a visit with one of our providers, or with me. Your plan is built around you — your symptoms, history, and goals — and your goals matter a great deal. We help you learn how to maximize your health, because we don't just look at hormones — you're a whole system, so we look at cortisol, thyroid, and gut health, because gut health is so important to hormone metabolism. Everything is connected.

We love the work we do. I hope this webinar helps you in your menopause journey, and that you learned something from it. Thank you for joining.

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