

## Thyroid Dysfunction and Libido

BioBalance Podcast — Dr. Kathy Maupin interviewed [Brett Newcomb](#)

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Hi, I'm Dr. Kathy Maupin. Welcome to the BioBalance Podcast. I'm the medical director and creator of BioBalance Health. I'm here today with Brett Newcomb who is going to help me talk about thyroid dysfunction and libido, testosterone dysfunction, as we get older.

BN: Yeah, we're actually having a series of conversations. If you're interested by what you hear today, you can go back to the website and pick some of the other podcasts that we have done and see if they help you find the answer to the questions that you have.

KM: And someday you can read our book that I'm not done with.

BN: But today we are going to start by talking about the last conversation we had. We were talking about testosterone and the cascade of aging events. You were saying that what doctors try to do is go back upstream to find the earliest causative trigger where they can make an intervention.

KM: No actually, that's what I do. Most doctors don't do that.

BN: Right and that is the distinction that you want to make. This is what you do. The research that you have and the experience you have says that the the earliest we now know where that begins is with the decline or change in the sex hormones and in particular testosterone.

KM: That's right.

BN: And so following that conversation, it occurred to me that part of what you were saying is that when people get the testosterone replacement, and they they get it through the pellet method, which is the best method because there are fewer metabolic changes as the body processes it and it endures in a consistent way over time. As that occurs, then the mechanisms of desire and arousal come back and libido resurfaces. So I noticed in your book that we were previewing and editing, that you have some conversations in the book about how does the testosterone pellet increase sexual desire? When that starts to come back, what are the kinds of things people experience, talk about, be aware of, how does that play out? Can you speak to that?

KM: Yes, of course. That's what I do all day long, is speak to testosterone questions. Let's talk about women first, because women are the first to lose testosterone. Usually somewhere between 38 and 50-something we have a critical drop in our testosterone and then it becomes apparent through symptoms, like lack of libido, lack of energy,

weight gain, belly fat gain, lack of the social ability—we don't feel like going out, we don't want to be touched, we don't want have anything to do with anybody else, we're not creative. We drudge through our day, we're so fatigued. That begins at some point and that's the sign the testosterone is at a critical level for that person. Everyone has a different critical level, some were born with more, some less. And whatever feels normal to them is what I'm trying to achieve. So when we give them their testosterone back, one of the first things the notice is they start sleeping, they're nicer, they become more like their usual social selves, they are much more likely to want to go out and do things and not hide at home. One of the later things that happens is that they get their body back, they get their waistline back. But this is not for weight loss because you have to do other things for weight loss after this has happened. This is one of those things that women just get their well-being back. They look in the mirror and they find themselves beautiful again. Without testosterone we look in the mirror and we think we're ugly. No matter what we look like. It's one of those things that changes our neurotransmitters, it changes every cell in our body and when we get back in the right dose, in the right way, then we get ourselves back. Now men are later in losing their testosterone and therefore they don't understand it when we're doing this. They think we're just nuts.

BN: They take it personally.

KM: Yeah. She doesn't love me any more because she doesn't want to have sex and she doesn't think she's pretty and she doesn't listen to me anymore.

BN: And sometimes that whole "I don't want to have sex thing because my testosterone has dropped," they don't know that, they don't know to say that. But they experience that, and yet they still have at that point what you call the "cuddle hormone."

KM: They still have Oxitosen, which is not Oxitocotin. Oxitosen. Its the same hormone that stimulates labor in women but men and women both have that.

BN: And that's about the desire or need to be stroked and to be touched and to cuddle. So they're still willing to do that, but when the guy interprets that as sexual permission, or a sexual come-on, and wants to be sexual and she doesn't, then he feels like there's a betrayal involved in that or that there is some sort of manipulation involved in that.

KM: The woman changed the rules. And you know, in a marriage it's all about the rules that you've become accustomed to. You do this, he does that, you do this, he does that, he does this, you do that.

BN: The whole signaling process. "Are we going to have sex tonight, anytime this week, maybe next month?" How do we know? And so, part of the signaling for that is the touching and the snuggling and the caressing, you sit on the couch and watch a movie, you stroke someone's knee, or you squeeze their leg, you play with their hair or their ear. Something that you do that's an intimate, connective behavior, guys are going to take that as "I'm going to get lucky." This is a precursor.

KM: Wouldn't you think that would be over by the time marriage has happened for 20 or 30 years, "I'm going to get lucky." Having to think you're going to get lucky. That it's not a foregone conclusion that that's going to happen. But it becomes more and more, "Oh I need to get lucky because I haven't been lucky for months."

BN: But then we try to study it, to figure out that if I do this will that put her in the mood, if I do that... And so we're sort of unilaterally negotiating it. She doesn't even know that we're doing that.

KM: We use our ability to receive. I remember going home and going "What is he still doing here? Why is still at the house. I don't exactly know why I need him anymore." That was before testosterone.

BN: I have a life insurance policy.

KM: "I'm doing everything anyway..." It makes you feel very independent when you don't have testosterone. But of course mine was severe because I didn't have ovaries, that was a huge drop. When we get it back, we go, "He's looking pretty good now, I'm kind of glad he's here. Maybe I'll make him dinner and maybe we'll go upstairs later." You start thinking about the possibility of having sex. You think about the possibility of just being with somebody, instead of just saying, "get out of my house." That's what lack of testosterone makes you sound and feel like."

BN: And you start flitting around and he's thinking, "I want to watch Monday Night Football."

KM: Right. He's use to the process, by then he's lost his testosterone and then we need to deal with that. That's kind of what it looks like, and with most of my patients I start laughing because they are telling me the same story I went through. They're like, "I know I love him in my head, but I really don't know that I love them anywhere else." "You know, I know I want to be with him, I don't want to be with somebody else, but I just don't feel it." So that's how it looks to us, to the husband when we come home and say "see ya." We quit doing loving things for them. We just don't feel love.

BN: In the book you talk about the science of that, and you talk about when you start to get testosterone back that the receptor sites in the brain change, and there's something called free testosterone. Can you speak to what those things are?

KM: We give testosterone in the pure form, but your body attaches a protein to it and both men and women do this. The protein is to inactivate a portion of it to store that testosterone for later. So the protein's attached to it. Free testosterone means there is no protein attached and it can go to work right away. When it's free testosterone it goes across the blood brain barrier and it actually goes to work and stimulates neurotransmitters. Neurotransmitters change our mood, change our desires, change our motivation. Testosterone is a motivator, it's a mood elevator. It's a social hormone. I always say to patients who haven't had testosterone before, "You know how your husband may stand

in the mirror and look and he may be bald and 50 pounds overweight, and he may have a scar over his right eye and he looks in the mirror and does the “muscle thing” and he goes, “I am so handsome.” That’s testosterone. Without it, when men lose it, it’s really sad because they only have one hormone. But that’s the hormone that makes you feel good about yourself.

BN: In the book you talk about the free testosterone impacting the responsiveness and the size of the clitoris, or the lubrication of the vagina, the sensory stimulability.

KM: When you you’ve been without it, all of your cells that have receptors for testosterone, and the same receptor for estradiol, young woman’s estrogen and testosterone are the same receptor, and these two hormones have to compete to get to that receptor. And as we get older, the number of receptors on our cells dies so the longer we go without hormones, the fewer receptors we have.

BN: Does that occur in the brain, like the neurotransmitters going across the synaptic cleft, or does that occur in other body sites?

KM: Other body sites. The brain is preserved for ten years. Ten years after loss of testosterone or ten years after loss of estradiol the receptors remain and they don’t decrease in number. But the rest of the body usually has a loss of receptor sites. Therefore, that does two things: there are fewer places, or we have to flood the receptors with the hormone to get the same response we got when we were younger. Once we give somebody testosterone. . .

BN: Which is why the dosage matters.

KM: (Right, and let me speak to that in just a second.) . . . and, the receptor sites when you have nothing are standing open. They’re all open waiting for that hormone, so when I first give testosterone and estradiol—one or the other or both—to a patient I say “You’re going to have a hyper-sexuality after this kicks in—it may kick in in two weeks or a month—but when when this kicks in, it’s going to be over the top for a few weeks to a month. You may feel you may have clitoral enlargement, you may have a itching around the vulva because all those receptor sites are now filled with testosterone or estradiol and they are now stimulated. Once your body gets used to it and accommodates, some receptor sites close, and some open, and therefore you come back to normal.

BN: Which is restoration of the natural rhythm.

KM: Right. And the natural response to hormones being present. Now it’s still better than taking something in a pill which goes immediately from zero to a hundred.

BN: So initially it’s like the desert blooming when the one rainfall a year comes.

KM: That’s true. And then some of the receptors sites become quiet and some stay open and wait to receive.

BN: To restore the natural rhythms. Right, but that first surge—I can never get that back for anybody. That's never going to happen again, thank God for some and some others want me to do again, do it again. That was really cool. I can't do that. You've only got the receptors sites that you got. I can only work with what you have, and when you come to me, it matters how long you been without it. If you've been on Lupron, that shut all the receptor sites down early in your life and that sometimes gets rid of some of them so I work with what you have. The next thing is that none of the doctors get is that when I give testosterone, I have to give three times as much. A woman has three times the level that she would have normally so that she can compete with estradiol. So if I give somebody testosterone, I'm not giving them a tiny little bit because that means estradiol will always take the receptor; it's ten times as sticky as the testosterone. It competes better. Estradiol goes for the receptor site, so for me to compete with the normal estradiol level I have to give three or more times the normal testosterone level. So when the doctor looks at this they go, "Yeah, your estradiol is perfect. But your testosterone is in the male range." But you don't feel male; your voice hasn't dropped the clitoral enlargement goes back down—they freak out and they scare my patients.

BN: Physicians that have not been exposed to the training you've had misinterpret that data. Because they're not familiar with it.

KM: And you have to read Molecular Endocrinology to understand. I find that hard to read but it's there. Molecular Endocrinology is not like the normal endocrine journal that you get every month; it's a specialized journal. And that's where it speaks to the competition between estradiol and testosterone. There is a great book called Interventional Endocrinology by Mark Gordon who's just an amazing anti-aging guru from California. He's on The Doctors program. And he has this all written out in graphs and all the feedback patterns.

BN: Right up there with Tom Clancy and Popular Mechanics.

KM: That's right, for me it is. I would rather read him. That sounds awful. In any case that's why many of the things I do are misinterpreted. I get the estradiol perfect for female within the range of 60 to 350. Somewhere in there the patient is going to feel normal. Normally it's about 100 and that's safe. But, there's no cancers that testosterone causes in women, and it's not having any effect if it's competing with the estradiol, so it's not hurting anything. And we deal with the DHT, which is one of the metabolites of testosterone, that can cause you to have facial hair or thinning hair on your head. We deal with that if that's the case. If there's a lot more of that, we give a medication that stops it.

BN: So there are ways to adjust or compensate for that if it happens.

KM: That's really the only downside; getting fuzzy.

BN: And it's the exception?

KM: It's the exception. And actually most people get little more facial hair, but it's usually blond, and facial hair is nothing compared to getting your life back, in my mind.

BN: I would agree.

KM: So when we go to men and we try to get the normal—now men aren't competing with the estradiol. So we try to get the normal, young healthy dose for that man. Now here's another place where medicine falls down in terms of saying what's normal for men. Men are not sexually functional generally if their testosterone is below 400. They're mentally functional, but not sexually functional. If the testosterone total drops below 400 then most men are non-functional sexually. They may still have desire but the performance is impaired. And then the free testosterone should be above 130. Those two numbers are what we're looking for in men. There are no such numbers in women. They have never determined exactly what number a woman needs. So I have to figure that out per the woman.

BN: You say in your book too that a lot of those measures that are standard measures or measures that are normed on the values for men. This is kind of a segue into the whole thyroid issue.

KM: Well in terms of testosterone, the men's levels they write down, it's not about women and men there, it's just that they give you the average level of testosterone for any man of any age, they don't give the normal testosterone level for young healthy man, which is what we're trying to bring people back to. This is one of the problems with looking at levels. If we did bones this way, like bone density and osteoporosis, no one would have osteoporosis because osteoporosis is common and is normal for people as they get older. Instead, we measure women's bones against 29-year-old healthy females. We do not measure them against 70-year-old females. Otherwise there would be no illness. Nobody would be having a problem we wouldn't treat anybody because...

BN: They'd all be in the normal range.

KM: Yeah. But really normally is not average. Normal is young healthy. So when I'm taking care of men, I want to bring them to their young healthy. And generally that is somewhere between 400 and 1,100. Some people need more than others, and so that's kind of the art part of it. Now women, generally the free testosterone is going to be around 30 to make them feel normal and to compete with their estradiol.

BN: The 400 to 1100 thing, is that that ectomorph, mesomorph, endomorph thing?

KM: It's really different. It's more genetically what you are given. You know how there's some guys in college or high school that have much more sex drive than others, some that are hairier than others, everybody's a little different. There are some women with higher testosterone than others and they have a higher sex drive. That's part of the genetics they received that turned on their ovary that made a certain amount. For women, I have to find what's normal for them. They don't feel good when they're too high or too

low, so we have to find the normal there. Now, thyroid is different. Thyroid test has a whole different problem. Thyroid test has the problem of. . . we have a much more sensitive test nowadays and they're still using the normals from 30 years ago. So it's not really the normals that they should be using and all the normals are from 29-year-old males.

BN: So doctors are taught to interpret the thyroid lab test against a standard that is a 30-year-old standard that was normed on young males.

KM: Right, in fact that was young male medical students, and they've used the same normal forever and women have a different normal. We've known this for over 10 years.

BN: It's just a thing that mainstream medicine hasn't looked at?

KM: You would think an endocrinologist would get this, but there's only one endocrinologist this city that actually understands the difference between the gender difference. It's been a gender-specific medicine. It's been in the Journal of the AMA. Actually it's on the lab tests in California so I don't know why it's not on the lab tests here, because I trained doctor in California and her lab tests have the gender difference. So the idea is thyroid is so integral to our bodies, and here's why. Thyroid hormone has to be high enough to stimulate a body temperature of 98 or above, because everything in our body runs on enzyme systems, and the enzyme systems were for warm-blooded human beings that are 98 and above. And if you're basal temperature, the temperature you put, you take before you get out of bed in the morning is less than 98 then you aren't running warm enough to repair your cells, to actually think, to lose weight, to grow hair on your eyebrows.

BN: So thyroid malfunction can be a precursor to, and look like testosterone drop.

KM: Right.

BN: And not be.

KM: Right, but testosterone has a few extra things.

BN: It can be co-morbid.

KM: It can be together. And thyroid dysfunction in young women often causes infertility, but rarely is it caught. When we do those basal temperatures with infertility... I remember now, now I know a lot more than I did then, a lot of women who had basal temperatures of 96.5. Well, clearly, their thyroid wasn't working and that's why they weren't getting pregnant or they were miscarrying over and over again. I intimately understand this problem because I've had it since I was in my 20s and my daughter has it, she got it in when she was 15. My mother had it her whole life. It's in our family; it runs in families, so we have had to replace it. Now if you don't look at the right level, you're not replaced. So your system is not going to heal itself. Your bowels don't move.

BN: And the doctor's don't look for it. And the lab tests don't norm it for women.

KM: If you just are a doctor just doing screening test and you just look down—they usually put it in a different column if it's abnormal or they make it a different color. So if you're just looking down there and you're not really thinking about each test and that there is a different normal, you are going to say they're normal. The patient is going to get a letter in the mail saying your normal. Then they come to me, and I ask them about basal temperatures, and I do their TSH, and I do their T-3 and T-4. That's important to do all three of them because TSH goes up when the thyroid's down. Women, if the TSH is above 2.0 or 2.5 depending on the study, then their thyroid is usually low. If their T-3 is low—that's the active form of thyroid—some people can't make the inactive form into the active form, and so their T-4 looks normal. Which is what we replace. Synthroid, we can give all the synthroid in the world, but if you can't make T-3 out of it, you're just making making your lab test look different.

BN: It's like having a zip file you can't open. The file's in the computer but you can't read it.

KM: So the test looks good but your T-3 is low and you're not getting anything out of it and your temperature doesn't go up. In the old days, long before when I first was diagnosed, you just did your temperature. You increased your thyroid until your temperature came to 98 and then you were done. And that may not be a bad idea, but it's an old-fashioned idea.

BN: It's what they could do at that time. But now they could do more. You know. The fascinating thing about these conversations is that there is never a place to stop.

KM: But, I'm getting the "hook".

BN: But, I'm going to make you stop. What we are going to do is say to people again, if you have questions and if our conversation stimulates a question or identifies a concern, you can contact Dr. Maupin on her website, and we will try to reference those questions and answer them. Either you will get an e-mail back from her, or we will put it on the blog, or we will address it in one of these podcasts as we do more. So please come back and listen to us again.

KM: We'd love to hear your questions. Thank you very much.