

## 66 - Progesterone and PMS

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

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KM: Welcome to BioBalance health Cast. I'm Dr. Kathy Maupin, they call me the hormone queen.

BN: And I'm Brett Newcomb and I'm not any kind of queen.

KM: Fortunately.

BN: But we are continuing our conversation in this podcast that we began in the last podcast about the hormone progesterone, and the theories around the replacement of that. In particular referencing the issue of PMS. And in the last podcast we talked about PMS and the cultural myths that surround it and why they're myths. Today we're going to continue that conversation and we're going to begin by talking about stress and natural adaptations to stress. In the previous podcast we were discussing that anthropologist have known for a long time that in primitive cultures especially in nomadic hunter gatherer societies, when food supply's diminish, when there is a drought, or when the animals move on and they can't find enough protein to support the tribe, that women stop having menstrual cycles, they stop getting pregnant, they stop having babies and that has been known forever, but we haven't known the science of it we've just known the theory and the reality. The evidence is that this happens. And when they get to a place where food supplies are more abundant they start having periods again they start getting pregnant again, and you have clusters of children that are all the same age, because they follow the food cycle. And Kathy was explaining in the previous episode that they don't just follow the food cycle, they follow the hormone cycle of the women and this is connected because of the natural way that the body works. So if you'll go back and review that for a minute and particularly in terms of what we call PMS then we can talk about it.

KM: When we are stressed or when we are starving, those are stresses.

BN: It stresses me out.

KM: Women stop making progesterone first. And when we stop making progesterone, the hormone that is secreted from day 14–28, then we are no longer fertile. So it takes away our fertility. It also takes away the stability that progesterone gives us. It gives us mental stability. It works on our neurotransmitters. It is the inciting incident of depression and anxiety when we don't have any. So it normally stabilizes our brain. So it does work neurologically, it's just the first thing that makes the neurotransmitters unbalanced when we don't have enough progesterone. So anybody at any age can have

PMS unless they are premenstrual or menopausal. You don't have PMS then because you don't have cycles. If you don't have cycles it doesn't affect you in the same way.

BN: So if you're too young or too old, it's not an issue.

KM: Right, you're not going to have PMS. And you're not going to require progesterone. There are a lot of people that think you should have progesterone your whole life. They're giving progesterone to men. Men never have progesterone. There's just no reason for that. And I don't understand the theory.

BN: I don't remember the last time I was pregnant.

KM: I know and you guys just don't make it. So why would I give it to you? It's really not that great for guys. So I can tell you that is not what you want to do. So there's only a few people in my population of menopausal women who require progesterone and those are people with uterus's. And it's only to protect their uterus from estrogen, to keep it balanced, just like it does before we're menopausal. And second kind, there's a few people who just psychologically need that to boost their neurotransmitters. So instead of giving them anti-depressants or anti-anxiety agents, I give them progesterone. So even if they have no uterus I'll do that and I can figure that out not by labs, but by symptoms.

BN: So when you give somebody progesterone, there are as in all of the hormone replacement issues, there are different methodologies of delivery. And you were explaining in the previous podcast that you first began to do this with a rectal suppository.

KM: Yes.

BN: And that you don't use that as the preferred method anymore. But the science has evolved through rectal, to oral, to pellets, I'm assuming.

KM: Well, not oral. That's why I chose rectal or anything besides oral in the beginning because you can take bio identical progesterone and if you take it orally it becomes estrogen in the liver before it ever gets into your body. So it's doing the wrong thing. It's doing the opposite of what progesterone does.

BN: Because progesterone balances the estrogen in uterus. And if it just turns into estrogen, there's not balance, you've accelerated the problem.

KM: And in the brain. You've just got more of the same problem. It makes it worse. So if your doctor gives you "oh it's bio identical, here take this pill", that's not going to work. So bio identical doesn't mean anything if it's oral. But if you take a progestin, which is a synthesized progesterone that also makes you worse because it makes a lot of estrogens; estrone, estradiol, all kinds of estrogens that make you feel worse. So, progestin's like povera and agestin, don't work.

BN: So if you feel bad now take this and you'll feel really bad.

KM: That's right. You will, It may put you over the edge. So that's not the way to do it. You have to do something that is not oral. So now we have, we've graduated to, vaginal suppositories, then we went to vaginal tabs, like little ready tabs that dissolve, they dissolve quickly. So we use them in the vagina or you can use those same tabs that are flavored under the tongue and they dissolve. And that goes directly into your blood stream instead of into your liver. So that's why we use the things we do. We even use progesterone cream, but cream you have to apply 6 times a day to get a really good blood dose. They don't last very long.

BN: I'm hesitating because I'm not sure I understand what you just said. You said it goes directly into the blood stream and not to the liver.

KM: It goes to the liver after it's been working. It does eventually go to the liver. But you get it delivered to your body, it works, it gets transformed a little bit then it goes to your liver and it doesn't cause the estrogen.

BN: OK.

KM: So it's already been broken down somewhat by being used. So that's how that works. But when you look at different types of progesterone have to think about how it's delivered. Because delivery matter, the absorption matters, but it also matters how many times you take it. If you use a vaginal tab, you can take it once a day. If you take a sublingual tab, if it's compounded properly, you can take it once a day. If you use anything else like a cream or a gel, you're going to have to apply it all day long. So as I said progesterone makes you tired so you don't want to take it all day long. You want to take it once at night. So the goal is non oral, bioidentical and a delivery system that you just take once a night to keep your system even. Otherwise you're going up and down all day. So that's not good for our brains either. So having an even delivery system's good. Pellets are available in progesterone and I like that using those because you don't have to think about it but every 4 months. And that's in menopausal women. But in premenopausal women we don't really use those because we want to cycle you.

BN: So if you do this and you restore the balance for women who are fertile and who have cycles and that solves a lot of those mood issues.

KM: It also makes them fertile.

BN: It increases their fertility. So what happens then when they go through menopause, do you continue to give them progesterone?

KM: Well when they go through menopause and I'm replacing their estrogen, if they have a uterus I give them progesterone.

BN: Why?

KM: Because estrogen stimulates the uterus to make a very thick lining. And it will just grow thicker and thicker and thicker unless you have progesterone. So we give low dose estrogen so it doesn't get too thick and then we give progesterone with it so that the lining is stable and it doesn't grow very high. If it grows high it becomes cancerous.

BN: That's what I was going to ask. Why would it matter if you weren't having pregnancies if your lining is thicker and thicker?

KM: Well if it's thicker and thicker it can become cancer. But if it's thicker and thicker eventually it's going to be so thick it's just going to bleed and heavy. So when you don't have progesterone, balancing out that lining, you'd have to see a pathology to book, it makes it go from real fluffy and thick to real compact and sturdy. You know you can see it just by looking at the pictures. And it keeps it from being destabilized and bleeding. It doesn't turn into cancer if you have progesterone. Progesterone is not necessarily necessary to keep you from getting breast cancer, but it is to for uterine cancer. So if you don't have a uterus I don't give progesterone to patients that are menopausal. They don't need it because they're getting estrogen and in general the small population that does need it I give them that but I only know that after I've given them estrogen, testosterone, made them normal there. And they just still feel a little irritable, they can't sleep, or they don't feel like themselves.

BN: So it still has to be fine tuned. It's not once size fits all medicine, this is not a panacea medicine. Take this pill or don't' take this pill.

KM: No this is the most difficult thing I've ever done. It's individualizing treatment for every person that sits in front of me. And you should know all these things but you have to know someone to interpret it for you. Because, I also look at blood work and I also look at history and what you tell me. So I have to put all that together into a treatment plan then we try it, just like it's a practice of medicine. We have to try it and your metabolism might be a little different and so then we have to tweak it. But once we get your dose after menopause, it's your dose.

BN: Well you know I'm sitting here listening to all that you're saying and I'm thinking about the years of practice in counseling and psychotherapy that I did and when I was in school I was taught that women get depressed 6 times more often or diagnosed with depression 6 times more often than men.

KM: They go to the doctor to get diagnosed.

BN: Well no, the way that it was explained to us was that men become drunks. They self medicate with alcohol in ways that women didn't.

KM: Or they put their hand through the wall.

BN: But they developed all of these pills for depression and mood disorders. And in working with men, men in my experience are chronically resistant to that because there's this cultural myth that you have to sort of tough it out, John Wayne wouldn't take medicine, sort of thing, so that it's characterological. That if I have strong character and I discipline myself, then I don't need pills and I'll just fight through this. And frequently they would give the same messages to their daughters and to their wives and yet loop back around to the myth that says women are emotionally unstable, what are you doing to do? They're always going to be depressed or hyper or volatile. And what you're explaining is that there is medicine.

KM: For women there's a reason.

BN: And there's a medicine or treatment that doesn't involve mood disorder medicines. I mean that's a "the skies are opening" kind of message for me. I'm not aware that in my field that message is out there.

KM: Probably isn't. Because it's not in mainstream medicine yet. We have to wait 10 more years.

BN: It's not in mainstream medicine; it's not in mainstream psychology.

KM: But women know because we have kind of like an underground. Which is what we are supplying the underground with information today because we know that there are people that understand this and we know that they're not going to be at the lecture studies by the medical societies because they're not accepted because they're so far ahead of their time.

BN: So spread the word.

KM: Spread the word.

BN: You spread the word in these podcasts and you spread the word in the book that you're writing. And the emphasis for this conversation is actually a chapter in the book that you're writing.

KM: Yea, I Want What She's Having. That's what it's titled.

BN: Look for it in book stores everywhere. But not yet.

KM: Not quite.

BN: So if you have questions or comments or feedback that you'd like to share with us regarding this topic or any of the topics on our website, you can reach us directly.

KM: At my website at [www.Biobalancehealth.com](http://www.Biobalancehealth.com) or you can email us at [podcast@biobalancehealth.com](mailto:podcast@biobalancehealth.com) or you can call my office at 314-993-0963

BN: Or you can reach me at my blog which is [www.brettnewcomb.com](http://www.brettnewcomb.com).

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