73 - Memory Loss, Dementia and Alzheimer's
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: Welcome to BioBalance Healthcast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. Today we're going to talk about memory loss, cognition issues, dementia, and Alzheimer's. We've done a couple of podcasts lately that touch on these topics and we've gotten some interest and people want to know more. So we thought we'd spend some time talking about it. Globally or generally that whole range of mental acuity breakdown is identified by a cluster of symptoms. So we thought we'd start by identifying what are the general symptoms that would make a physician start to say 'am I looking at some early dementia, am I looking at the onset of Alzheimer's'? And how do they diagnose it? I know that's a segue, but Alzheimer's compared to short term memory loss. Can you talk about the symptoms and the diagnostic categories?

KM: I can. You first have to talk about cognitive impairment.

BN: I forgot that.

KM: Cognitive impairment is when you just can't remember names and it gets ore frequent and more frequent and you can't remember names of people and names of places and names in general, you just get confused, you get lost, if someone else has to end your sentence. That's cognitive impairment, if you can't concentrate.

BN: I've been cognitively impairment and I thought it was called marriage.

KM: That is, marriage actually covers a lot of issues because couples often fill in the sentences for one another and so that make them not find this cognitive impairment to be a problem unless one of the partners is not there. So often times in marriage we don't see it early on.

BN: Because they mask it for each other.

KM: Right and they're trying to make each feel better and function. So a lot of time we see this at work. They say "I can't concentrate at work; I'm having trouble completing tasks." It sounds a lot like A.D.D. And sometimes it is, sometimes it's just that they were never treated for that and now it's worse. But most of the time it's about not remembering short term things. Not remember what they ate yesterday.

BN: What did I do this morning? Yeah, exactly.

KM: Or getting lost while they're driving. That's acognitive impairment.

BN: I love that because I watch these T.V. shows, lawyer shows and they have somebody interrogating a witness and they say at June the 5th in 1973 at 8 a.m. I the morning, where were you? And people can answer that question. I can't even tell you where I was at 8 a.m. yesterday.

KM: Well you aren't going to go to law school, that's what lawyers are for. They sit down in a room and they talk to you about that. My husband is a lawyer; he does that all the time. He talks to you about, recreate where you were on that day. You've got to go back and look at your calendar. You've got to go recreate it. So to really remember it you have to go recreate it. No one remembers that except the few people who have very unusual brains. No one can do that. So that's not what we're talking about. We're talking about normal life, you've always been able to function at a high level, you have a job that requires thought and organization and then all of a sudden, you can't do it.

BN: You're so scattered, you can't pull it together.

KM: And that's cognitive impairment, that's not Alzheimer's, that's not dementia. When that gets so bad that you can't function, then you have to be evaluated for Alzheimer's and dementia and that means you have to have an MRI of your brain to see if your brain is shrinking, Alzheimer's causes brain shrinkage.

BN: The incredible shrinking brain.

KM: And that is part of the Alzheimer's work-up. And then they look for plaques in your brain. Because plaques mean you're developing this goo on the neurons which is like taking an electrical wire and blocking it by putting too much insulation around it, blocking it's ability to communicate to the other side, so that's part of Alzheimer's. Then they also look at other factors and I'm not a radiologist so I can't tell you about that but I read the reports and they come back and say yeah this guy has Alzheimer's, or this woman has Alzheimer's and we're going to start them on medication. That's one thing. Now dementia can be from many things. Dementia can be vascular, you can have strokes, mini strokes all over your brain, that can shrink your brain. But usually it shows not an overall shrinkage but little areas that have shrunk. Or little areas that have white spots in your MRI.

BN: Like dead zones all over your brain?

KM: Dead zones.

BN: So the synapses that fire and connect to those files can't find those files.

KM: No, the files are gone. Because you've had mini strokes. And that's from high blood pressure hyper coagulation.

BN: So a mini stroke there's a tear in the blood vessels and blood leaks out into the brain.

KM: Nope, it's a blockage of the vessel, it's usually not a bleed, it could be a bleed, but it's a blockage of a vessel with plaque.

BN: So the brain cells around it die from the lack of nutrients and blood cells.

KM: Oxygen. And then there are some dementias that are caused by bleeds. They're less likely, and they're less likely to be silent because that hurts. That increases the pressure in your brain so it's less likely to be a silent change.

BN: Right, because your brain is a skull, creates a limited capacity and your brain floats in a fluid sack. And if blood starts to pour into that environment it has no way to expand to absorb the fluid so it compresses and kills brain cells.

KM: Right, it also causes pressure, so it hurts. So that would be something that you would probably know that you'd undergone. But a lot of these changes are very silent. And then there are the changes of Parkinson's. Parkinson's can cause dementia. Parkinson's is the lack of dopamine. Dopamine is a neurotransmitter. One of those little chemicals that runs around your brain and has lots of functions. So Parkinson's is one of the dementias. It's more than that.

BN: It's more than that.

KM: But it's a loss of dopamine.

BN: But there are motor neuron issues with that.

KM: Right, there are, so it's not just inability to remember, inability to react normally to stimuli.

BN: Well the main medicine for Parkinson's is eldopa, which is dopamine.

KM: Dopamine. And there are new medications that cause eldopa to go up. So it's more of a stimulatory kind of medication. But still they have side effects. One of the other things that happens with Parkinson's is that you lose your balance. You lose your ability to walk. You can tell by how they walk it's a little different. Can't play sports. So anyways.

BN: Yeah, I heard this morning that George Bush the elder has Parkinson's.

KM: And that's something that I hope to never have.

BN: Yes.

KM: But all of these things that have to do with dementia, memory loss, except for the stroke part, anything that has to do with stroke is out of this group. But all of those are sensitive to hormones in women, estrogen and testosterone, and in men, testosterone. So they've found many studies that support what I'm saying. They're in the endocrine literature, not in the neurologic literature. So often times neurologists have to go

outside their specialty to find them. But I have some neurologists here that do and they understand this. But when brains deteriorate, they don't' deteriorate if you feed them the right hormones. It supports them. So, if you give a woman her estrogen back during the 10 years after she goes through menopause, then she delays the onset of dementias, except for stroke dementias, by another 10 years. So she's got the 10 year window and then another 10 years until she would get it normally by her genetics and her lifestyle. If you give her testosterone when the testosterone stops then you've delayed it another 10 years. So a woman can get 20 year extension on her onset of dementia, by giving her testosterone when that stops and estrogen when that stops. And I see this every day. People come in and on their questionnaires they have 'I can't think anymore, I can't do my job, I can't recall things, people are finishing sentences, I feel like I've lost my mind. I can't remember what I was going for at the store.'

BN: It goes from being frustrating to frightening.

KM: it's scary.

BN: Yes because it's frustrating when you can't remember what was on the grocery list because you didn't write it down. And that's a simple every day irritant. But then when you were at work and there is critical data that you're supposed to have access to because you know and you can't get it, you're jeopardized.

KM: It's terribly scary. Part of what I experienced after my ovaries were removed, that was the scariest thing. I mean for me.

BN: Well and for you who had that life and death responsibility for your patients if you suddenly had a[n inability to recall].

KM: Yes. I was delivering babies and doing surgery. It was scary. It was very scary. And I had to use all of my energy just to perform well at work which I did. But then I had no energy at home or anywhere else.

BN: At home or a social life.

KM: Yes. I would just pass out. You have to use so many brain cells just to get through the day. And that's what I see my patients struggling with.

BN: They're exhausted, they're tired, they have no energy, their social relationships diminish, they get in trouble with their sexual life because they don't have any energy or desire left for that, with the testosterone loss. But all of that just starts to cascade into a zone of frustration and anxiety.

KM: And they're afraid to tell their doctor about it. Because they're afraid their doctor's going to say you have Alzheimer's.

BN: We're going to put you into a home.

KM: Yea, you need to be hospitalized forever. But once I've asked them about it in relationship to testosterone, then they fess up and say "yea I've had that and it scares me to death to talk about it." But interestingly enough, and gratifyingly enough I love giving testosterone and three weeks later having somebody call me and say " I can remember everything, my brain's back."

BN: I just called you because I remembered your phone number.

KM: That's true, yes. And they can generally, and I'm talking 90-95% of my patients who have this issue actually say, " I have my brain back."

BN: So not only that, but then all the energy that was being consumed and trying to track the mental processes now becomes available for the living of life.

KM: And they're productive at work, they don't lose their jobs.

BN: And because you replaced their testosterone they have a libido and now they have the energy to act on the libido.

KM: As usual Brett is talking about sex again.

BN: Harmony remains on the home front. It's important and you laugh and you make jokes about it, but you know how important it is.

KM: I know how important it is. I'm not diminishing that, I think it's very important.

BN: The question is are you increasing it? And the answer is, you are.

KM: That's right, we are and that benefits the neurotransmitters as well because all of the neurotransmitters are activated when you have sex. So having said that.

BN: There's a card store in St. Louis, or there used to be a card store in St. Louis called Huffleups and you could get all these outrageous cards there and I remember seeing one one time and it was like the cartoon figure of the 1940's woman and household and she's slapping her forehead and she's looks at her husband and say's "Oh my God, we forgot to have children." So that's what I think of when you talk about the recovery of the mental acuity, the alertness, the energy, and the libido that is possible to have for people who have lost it. The loss of it is so incremental and slow that you may not know until it's fairly advanced. Partly because. . .

KM: You're in denial. You don't want to have this.

BN: You're in denial but also as you were saying earlier in this podcast, your partner helps compensate for that because they're so used to you and the ways that you think, and the things that you talk about or do or want that they can say "oh honey" and you can say "oh here's your soda".

KM: You've told us before, but they say when you have a couple that has been married for a very long time, you have divided up your information. One person in the couple remembers these things and the other person remembers those things. And nobody actually remembers everything. So if someone passes away or is divorced, they will have half a brain.

BN: People at church or people will call and ask me something and I'll say "I'm not required to track that information; you'll have to speak to my wife." And then I get this long silence like "is he kidding me".

KM: Okay, well that's how most of us act. That's not my job. He does insurance or whatever, I'm not doing that. And that's okay, it's just that that's not dementia. That's just couples.

BN: Not it's division of labor.

KM: It's division of labor. But when that person in the couple forgets everything then the other partner notices it more than other person in the couple. Because she still has your half of brain.

BN: Right so as long as my half is working. But if I have dementia and I forget to tell her that I spent the house payment at the gambling boat, she's going to be really disturbed when they foreclose.

KM: Absolutely. I can't even imagine that. I don't even what to go there in this podcast.

BN: Yeah, I forgot to pay the bills.

KM: That would be awful. I haven't had to deal with that. Interesting is that when I was trained in hormone replacement, (I've learned so much in 10 years), when I trained I was not trained that it had anything to do with our memory. But it had something to do with my memory, because my memory came back right away. I mean I was like two days out from pellets, testosterone, and estrogen, and I was completely back in my brain. My body took a long time but my brain came back. I was shocked and then I thought, well maybe that's just me, and then I started asking on my questionnaire about it and so many wrote that down and so many people said they got better that I then did the research on it and said "what is this" and I found the research but it's not in the neurologic literature, neurologists who take care of Alzheimer's who take care of dementia, who take care of stroke patients.

BN: And it's not in the gynecological literature.

KM: No it's not, it's in the endocrinology. Endocrinologists don't deal with dementia.

BN: I have to tell you.

KM: It just kills me. I love the research that they do but why don't they send it somewhere?

BN: Why isn't it more easily accessible and more pervasive in the literature?

KM: There are fellows doing research on brains and it's not getting to the neuro-literature. Why is that? I don't know and I don't get it.

BN: I have to tell you, when we first started doing these podcasts over a year ago I sort of had the impression that you were a one trick pony. The only thing you could ever say was testosterone, testosterone, testosterone.

KM: Really?

BN: Well, let me tell you. As I have learned though the association with you on doing this thing with you, the things that we read, the research we look at, the studies we look at, it truly is a miracle rejuvenation process to get your testosterone back if you've lost it. Because it leads to the reduction of all of these other symptoms and all of these other medicines and all of these other problems that if you didn't replace your testosterone you would have.

KM: So you are calling me a one trick pony.

BN: But you're a champion.

KM: But I have to know about all of these other illnesses.

BN: You do, you do.

KM: I have to have investigated them. A lifetime in primary care helps.

BN: 25 years in the trenches.

KM: A lifetime in primary care really does give me the background for knowing how things are managed by specialists, how things are managed by interests. How we all take care of patients, how we should take care of patients, and the outcome. So I've had that in the background. I did a lot of primary care anyway because people didn't have to time to go to their internist or their family doctor. People were in my office for a pelvic and so I tried to solve their problems, you know sleep apnea, things like that. In general, back to memory, dementia and Alzheimer's, there are studies that say that women's brains shrink if they do not take estrogen. During the 10, (now stop, I'm going to make you be the other half of my brain for awhile), if they don't take estrogen for the 10 years after menopause then their brains shrink. That was done in 2002. It was a headline and everybody laughed at it.

BN: I remember as ac child my grandmother used to say there's something rattling around in my head. It was her brain.

KM: Because she didn't take estrogen.

BN: Well nobody did back then but when you said that I had a flash of my poor old grandma walking around her house saying there's something rattling around in my head. It was her shrunken brain.

KM: And we're trying to wipe out shrunken brain syndrome. I mean because if you take estrogen, you have to take estrogen at a high enough dose that actually helps your brain and the trend today, trends are always interesting, they always go down to one extreme and then back to another extreme and someday they'll hit the middle. But the trend today is to give as little as possible in terms of estrogen.

BN: It's all a minimalist approach, we don't want to intervene.

KM: Now do we do that with diabetes? I'm going to give you as little insulin as possible. I'm going to let you glucose go way up.

BN: Yea, you'll just be semi-comatose.

KM: I'm going to give you the smallest amount of cholesterol medicine so you can be half way between where you are now and good. No. We don't do that with anything but hormones and women's hormones. We don't do that with testosterone either, more's better for men, but not for women obviously. But we're going to swing back and this is going to help us swing back.

BN: Well I don't know if that's medicine or the general population because there is a movement I run into, and it's a different area, when I work in counseling with people with children that have ADD. And the question is should we give them medicine to help them compensate with those issues? And there's a cultural concern out there about medicating my child. You know, the school teachers don't want to deal with him, they just want to medicate him. And they have no understanding about what the medicine is or how it works or what it does but there's a cultural resistance. Do you find the same thing with estrogen replacement? Or is it medical, pharmacological, insurance concern?

KM: It's not insurance. It has to do with the WHI study which was wrong, and all of medicine embraced it without reading it and then read it.

BN: Because they read the headline.

KM: They read the headline just like everyone else. Took everybody off estrogen, then they never read the retraction, so they still have people off estrogen. Or I'm just going to give you a little tiny bit of estrogen, which doesn't do anything, I do their lab tests, it doesn't even look like they're on anything when they're taking low dose estrogen. It doesn't help them. So what's the good in giving you a pharmaceutical product that isn't high enough to do anything.

BN: So if you're not getting a clinically effective dose, it's a waste.

KM: Right, it happens with thyroid too. And since we're on the minimalist stuff, I had a patient recently who had a doctor give her 25 micrograms of thyroid. She's young and healthy; the only risk to thyroid is a high heart rate. Which she had a very low heart rate, and she's young. There's no risk to giving her a normal dose of thyroid. But he said let's give her a little dose of thyroid. She actually went through becoming so swollen, it's called mixedema, when you have no thyroid, she got so swollen; it got worse after she took thyroid. Thyroid usually gets rid of fluid in your tissues and makes you less swollen. That she actually had to have fasciotomies in her legs. That means that had to cut down the fascia of your legs to release the pressure so that your muscles in your feet don't die from compression you get so much fluid inside of you. So she had those things done.

BN: So you swell up like a watermelon? And the way to treat it is to cut the skin.

KM: And they cut the fascia, the connective tissue around the muscles. Usually they use it for sports injuries, like you get a blow and the blood fills in, and then your muscle starts dying and your foot starts dying and they cut a line through there with a scalpel. It's a very emergent thing and they did that to her to save her feet and her legs but truly what they had done was they gave her a tiny bit of thyroid. It was enough to shut her own thyroid down. Just enough to shut down her thyroid, not enough to replace her, it made her worse, she swelled up more. So I had to go through this thought process of here's how this fed back to your brain, shut your own stimulation down, but you didn't have any thyroid, so you swelled up. In any case, that's the problem with giving 'oh we're just going to give you a little bit'. That doesn't really work with hormones of any kind. You have to either replace it or not replace it, because it shuts down your own production.

BN: And do you know that you have a clinically effective dose because you can measure that with blood tests or is it an anecdotal reportage?

KM: It's both. I mean if I have a lab test that tells me that a patient has too much or too little thyroid but all of their symptoms are gone, their hair is growing, their nails are growing, they're not swollen, their energy is back, they're not constipated.

BN: So it comes back to you have to spend the time with the patient, the patient needs to spend time with the doctor and have a good clinical interview.

KM: The patient, to ask them the questions. Right. And unfortunately that's what the insurance companies are eliminating.

BN: Mass consumption, Wal-Mart medicine.

KM: One thing at a time, not looking at everything. But the problem still lies in, even after you do that some doctors still look at the labs tests instead. And so lab tests are

important but frankly for things like this you need to get enough estrogen that your brain doesn't shrink, you need enough testosterone that you get back to normal healthy levels. Estrogen should be back to 60-250, that's where we are when we are young, that's where you should be. Testosterone should be over 30.

BN: As you can tell, we are both very passionate about these topics and we are intrigued with presenting you with the information that you need so that you can become an intelligent and educated consumer of your own medical processes. So if you have questions about what we are talking about or if you have comments that you'd like to share with us, feedback you'd like to give us. you can reach us directly at

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