

Fatigue and Low Testosterone Part 1

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

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Dr. Kathy Mapuin: This is episode 31 of BioBalance Healthcast and I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb and today we're talking about fatigue.

KM: Fatigue is the most common thing I hear about all day. It was more common when I was in my GYN practice. But now, I still hear it as my second most common problem for menopausal women and premenopausal women.

BN: I think it's a chronic problem in the United States. People are always stressed out, they're always tired, they're always exhausted. In my practice I hear constantly from people about how tired they are and how much they don't have the energy to do the things that they are supposed to do. And there are lot of reasons for that.

KM: They're over booked.

BN: They're over booked, they're over scheduled, they're over connected, constantly checking their emails.

KM: That's a pervasive problem.

BN: And people argue about it. I mean even in sessions, husband and wife will be sitting there arguing about something and one of them will check their messages. Somebody just got a text from the kid, or somebody just got an email. And you need to separate this out. You need some time when you turn that stuff off and pay attention to each other. And you won't be as stressed or as tired. So I come at it from a perspective that involves stress and overbooking and over commitment. You come at it with other information that I don't necessarily have.

KM: That's true. And if you look at the medical information, the medical journals, the medical books, fatigue is the biggest differential diagnosis. Now differential diagnosis means what are the many things that can cause this one symptom? And that's how doctors look at it. Now let me see this list. Well the list is like 25 things that can cause fatigue and there are some big diseases that can cause fatigue. Before I address it, I usually send people to their internist to make sure there are no medical illnesses. If I think there is a psychological issue I have them go to counseling. Or I suggest that they learn to say no, which is much cheaper than counseling. When they get called by church to do yet one more thing, learn how to say no, I don't have time, I'm tired.

BN: People need counseling to learn how to say no. It's a big issue. And not give too much information. Say no and shut up. Don't say no because or no maybe. Just say no and shut up.

KM: That's your best advice. Just say no and shut up.

BN: "No" and shut up. And that's what I tell people. You need to learn how to say no and then don't give any more information.

KM: Absolutely cause that's the lead in.

BN: We have the same issue in my business because we talk about cluster symptoms and there're are so many overlapping symptomologies that you have to differentiate or distinguish among to say is this more OCD, is this more anxiety, is this more depression?

KM: Even ADD in your business. People who have ADD, that haven't been treated and they get to 40 and they've always worked really hard at managing their ADD and they're starting to lose their hormones, they're getting tired.

BN: Yes, and then they're reluctant to take medicine or they're reluctant to allow their child who has ADD to take medicine because they say 'well I survived and I didn't take medicine' like the old guy that says 'well I didn't go to school and look at me'.

KM: Well if they had diabetes would you keep them from taking insulin? That's exactly the same thing.

BN: That's the question I always ask every time. Or if they had cancer would you avoid treatments for that just because it's a medicine?

KM: Most children want to be good at school. And want to be able to sit still. And since I can't sit still I totally understand that theory. And you need to have something to help you sit still and pay attention.

BN: A lot of boys in particular. School teachers like quite quiet orderly in row children that are attending and focused and boys have trouble with that especially in grade school.

KM: And most doctors are ADD. And obsessive compulsive. It makes a good surgeon.

BN: That's good to know. Those are good combinations.

KM: But the things that cause fatigue and the things that I think about the minute somebody comes in and says that and I've already ruled out medical problems because they've usually been to 10 doctors before they show up in my office, I ask them about their sleep. Insomnia is one of the reasons that you can have fatigue during the day. Because daytime sleepiness is what happens if you don't sleep well at night. That's one

of the things that can be related to testosterone but isn't always. Then hypothyroidism is another hormonal problem. I check their thyroid, if you have a low thyroid you're tired all the time. So that's another thing. The stress we discuss. Hypoglycemia is one that people don't think about. I go over their diet and they have a completely carbohydrate diet and then they wonder why they're exhausted at three o'clock.

BN: Or they're diabetic already and they're fatigued as a result of the mood swings that come with the insulin in sugar.

KM: High sugar, low sugar, all day long, make you exhausted. That kind of fatigue sounds like 'at 3:00 I have to eat something really sugary just to make it through the rest of the day. And then when I get home I pass out. You know 6:00, 8:00 I'm gone.' That's diabetes or hypoglycemia until proven otherwise.

BN: It's a major consideration. That has to be evaluated for and tests run to see. I have clients come in and say well, I think I have Chronic Fatigue Syndrome because that's a term that they interpret to be a global expression of really tired. Like the old Madelyn Kahn, "I'm so tired".

KM: Right, I'm so tired, that's from Blazing Saddles. I hear that in my head every time. The song that she sings about "I'm so tired." And she sings this song. And she has good reason to be tired.

BN: I could actually quote that song.

KM: I don't think you should.

BN: I probably shouldn't. So they come in and they say I must have Chronic Fatigue Syndrome. What good will counseling do for that? And I say well you need to learn to say no.

KM: Chronic Fatigue [Syndrome] doesn't mean chronically fatigued. It's a name for a different kind of process. And chronic fatigue can mean low cortisol, an adrenal failure from too much stress. Or it can mean a chronic infection and generally it's that. Usually mono virus. Mono virus can become a chronic infection that plagues you. After you've had mono you think you're over it but you never get back to normal. And there's a test for that, it's called the EBNA test and we test it all the time and find people who I treat with hormones, they're fatigued. They should be completely better after getting their hormones balanced and their thyroid replaced. And then they end up being still tired. So I check the EBNA. That's kinda the last diagnosis. When it's positive then we have chronic fatigue. That requires a medication that's not even out yet. It's called Valsite it's an IV medication that actually does kill the mono virus. And in my way now I just treat people with optimal hormones and that improves their immune system so they can kill that virus. So most of my patients in the end feel so much better because I've given them all the hormones they need and with time their immune system starts

killing this virus and they get over it. But that's not what we're talking about today. Because that's a whole different kind of diagnosis.

BN: Right, and that leads into another causative factor which is different medications people might be on. And as you were sitting here explaining all that stuff it strikes me because doctors have to be so aware of so much chemistry. And it's important for the doctor and the pharmacist to have information about what you're being treated for and by whom. And what you're being given as a medicine by whom. Because all of these overlapping mixes cause problems in and of themselves. And you can be fatigued as a consequence of taking beta blockers and blood pressure medicines, diabetes issues that you may have medicine for to treat that but then a side bar consequence of that is you are fatigued.

KM: The medications that do cause fatigue are beta blockers that we use for lowering blood pressure or treating an arrhythmia. And arrhythmias are big as we get older, so that's often a medication we can't change. We just have to deal with the fatigue. But for blood pressure there are so many things out there that we can often lower blood pressure with something besides a beta blocker.

BN: So all of these things are possible and they're not the focus of your practice but they're things that your practice has to be conscious of. So if I come to you as a new patient and I may have some of these histories. I may be complaining of fatigue or I may be complaining of low libido. I may have diabetes I may have hypo or hyper thyroidism one way or another, and I present myself to you, and say can you help me, what do you do?

KM: First thing we do is ask you do get some blood work and see if you really have anything I can help you with.

BN: That's a lab test that I go to my lab.

KM: It's a panel, it's a bunch of lab tests where you feel like I've just taken all your blood, it's a lot of lab tests.

BN: So I go to your website, I schedule an appointment, I download your forms.

KM: And we send you a form for the labs, to go to the lab. You get the lab, and I look at it before I ever agree to be your doctor. Because I need to be able to help you. I'm not having someone come in that I can't help. That's just a waste of your time.

BN: If you can tell from those results that it's not a good fit for you.

KM: I can usually tell. And I look at their history. The next thing is their history that they fill out and send it me. So I look at both things together. So that's necessary. Then we sit down and go over the history which is huge. Knowing what started first. How it

started Was there a trauma, was there a head trauma was there a divorce, was there some other emotional problem that started this, or was it turning 40?

BN: What about like sleep apnea or a history of sleep problems?

KM: If I get fatigue and insomnia that does not sound like a hormonal insomnia then I send people to a sleep study to see if they need a C-pap machine. See if they have narcolepsy, which is sleepiness during the day, falling asleep at work. I had a mother who had that and it was very hard to convince her to be treated because she thought she was fine, except she would fall asleep at dinner or in a conversation. So that kind of thing needs to be treated.

BN: Or driving a car with kids in the back.

KM: Or driving the car. And of course that happened, and that often happens and it's my responsibility to find that out and make sure that it is treated.

BN: And suddenly they discover they need to be treated.

KM: When I'm looking at this I do those things. If I think it's cardiac as we're talking, hormonal and cardiac, then I send them to a cardiologist. And for women I ask for an ultrasound of their heart, an echo, which is what that is, while they're on a treadmill. That's the test women need to see if their heart has an arrhythmia. If they have some kind of compromise of their vessels.

BN: As opposed to men? Men don't need that?

KM: Usually, a treadmill test is usually good enough for men. But women need this other test and generally the cardiologists all know that. So I send them for good referrals because good referrals are the key to making sure that everything gets treated. So I do that. I go over the history of their symptoms and their labs. Their labs tell me whether their adrenals working right, if their pituitary is working right, if they have testosterone, if their ovaries are failing, and then one by one.

BN: So you have a really good diagnostic picture before you make the decision to use hormone replacement pellets. If you then decide together with the patient this is a protocol they want to have.

KM: Yes, it's a decision.

BN: Then how do you decide how much of which pellet you want to give them, because you do multiple hormone replacements. So the next decision is the chemistry set balance. Do you have standard rules of thumb for men vs. women on what you start with or how much you start with first?

KM: Let's address women first. Women have their pellets replaced every four months. So I have to determine a dose that will both make them better and replace their

hormones for four months and last long. So I figure out an estrodial dose. Usually an average dose would be 25 milligrams of a pellet. I increase it for someone who has a lot more hot flashes. I then usually look at the symptoms for testosterone. If they have more testosterone symptoms, I then go to testosterone and I increase it. If they exercise everyday I have to increase the testosterone. I look at every aspect of their life and determine what dose of testosterone and estrodial will make them back to normal. Then I go back and I try the dose that I've prescribed. It's not always perfect. Because everybody's metabolism is so different. I bring that patient back at 3 and half months right before their next dose and I ask them, "what's better, what's not better?" And by the symptoms that are not better, I can tell.

BN: So you make those adjustments.

KM: And I've also, at that point, I've drawn another lab and I look at that.

BN: Good, so you can see a visual comparison and you get an anecdotal or self report comparison of how they are feeling

KM: And that is very important because often times certain people need more testosterone than others. And that's how we decide. It's an art and a science.

BN: We are obviously not finished with our conversation about fatigue so we're going to have another podcast which addresses more of this. If you have questions about what we've done already, you can reach us at podcast@biobalancehealth.com or you can read my blog at brettnewcomb.com.

KM: And if you'd like to know more about BioBalance health or bioidentical hormones visit our website at biobalancehealth.com or call my office at 314-993-0963.