

65 - The Cascade of Aging

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

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Kathy Maupin: Welcome to the BioBalance health cast. I'm Dr. Kathy Maupin.

Brett Newcomb: And I'm Brett Newcomb. And today we're going to talk about dominoes. Kathy and I are writing a book about what she does and the treatments that she has. And one of the analogies that we use in the book constantly refers to the cascade of aging. And as you age there are a series of things, a sequence of things that happen that negatively impact your health. And we refer to those as the dominos that fall. And much of the time when we do these podcasts we talk about the first domino which is the loss of testosterone. And today we're going to be talking about the second domino that falls which is the domino of progesterone. Kathy, can you tell us a little bit about that?

KM: The sequence starts usually around the late 30's and early 40's. So we're talking about dominos that start falling at the stage. That in general no one speaks about in medicine.

BN: Yea, and today we're going to talk a little bit about anthropology.

KM: It is about medicine too.

BN: It is about medicine too. But conceptually you can think of these things like an old mid evil fortress or castle. There were walls of defense. And if the enemy would reach the first wall then there'd be second or third wall.

KM: The walls are hormones.

BN: These walls are the hormones that protect and defend you against the aging cascade. And so if they work appropriately to protect the castle then testosterone is out there as the first line of defense and the strongest wall. But if it is breached, if it weakens and our bodies make less and less over time.

KM: Which it does in everyone over 40.

BN: Then the second wall is not as strong, not as good, not as universal as the first wall, but the second wall is progesterone.

KM: That's right and that's the second thing that actually starts going away. But progesterone is a little different from testosterone. Testosterone takes a slow kind of decrease all the way up between 38 and sometimes 50. So it slowly comes down. You may feel it earlier than when it's all gone. But it's a slow decrease. Now if you are

talking about progesterone. Progesterone is an intermittent hormone anyway. Progesterone is secreted throughout our life from the time we start having periods until the times we stop having periods, in the second half of the cycle. So the second half of the cycle is when the body is preparing to implant an egg and progesterone is that hormone that prepares for pregnancy. It's only real use is for us to become pregnant. And then when it goes away at the end of the cycle for us to bleed. So progesterone is what you are familiar with causing your cycles to be normal regular. Causing you to have normal bleeding, giving you a nice even temperament.

BN: When you talk about regular, predictable, consistent, you're talking about the chemistry of the system that makes the 28 day cycle and there are things that happens in each of those weeks. And about half way through the progesterone kicks in?

KM: Right, on day 14 on a 28 day cycle. So if you are having a period you have very low levels of everything except testosterone. Testosterone's pretty consistent in a cycle. And then we're talking about young women. So the normal is testosterone stays even except a spike right before ovulation. Estrogen is very low during the time a woman is having a period. I'm talking to you. I don't want to say you. I'm talking to all the women out there.

BN: I don't know, I think men have regular cycles too, mood fluctuations.

KM: Well, we haven't figured that one out yet. The estrogen goes up and then kind of evens out during the second half of the cycle and then drops right before a period. So that's the cyclic nature of estrogen. And so that was meant for child bearing. And then progesterone starts being secreted from that very area from where the egg was ovulated from. And it's secreted until you get to the point where estrogen drops it drops as well and starts the period. So progesterone is basically a stabilizing hormone for the lining of the uterus, it's a preparatory hormone for pregnancy, and it keeps us even in terms of our mental state, and it keeps us calm, and when we're pregnant we have tons of it and in general when we have tons of it we're very calmed and chilled out.

BN: So you know where this is going to go and that is even, consistent, moderately tempered female who then becomes uneven, inconsistent, immoderate and they talk about PMS syndrome.

KM: Right, putting up with men's stuff.

BN: Yea, putting up with men's stuff.

KM: But it's really, PMS is a loss of that progesterone cycle or no ovulation which means all you go that month was estrogen and testosterone. Or it is a low level, you're not producing as much. OK, so when you don't produce as much progesterone, the ovulation wasn't good, it probably wouldn't sustain a pregnancy.

BN: The balance is not right.

KM: The balance is not right. So when the progesterone is too low and the estrogen is normal or high, that balance makes you unable to carry a pregnancy and it makes you also unstable, irritable, unhappy, swollen, and hungry.

BN: So the irritability and all those are symptoms that tell you there's a progesterone imbalance?

KM: Yes

BN: So it's not about diet, or mood, or exercise, or hard work, or attitude control.

KM: Well if you're not under stress and you are eating properly, you have less likelihood of having PMS when you're young. Ok so you can have PMS when you're young and when you're old. It's two different reasons to have it. When you're younger and we go into a stress mode or we exercise too much or we don't exercise at all or we don't have a balanced healthy life then our bodies aren't getting ready to have a pregnancy. So it's not good for us to get pregnant if we're too stressed out. Or if we're running all the time, you'll talk about the anthropology of this, but if we're running all the time we're running too much our body fat drops too low it's not safe for us to have a pregnancy. So this system was designed to allow us to ovulate, get pregnant and carry a pregnancy when we were healthy, when we were well enough to take care of a baby. And it's gets dysfunctional when we're not healthy.

BN: Ok so you're talking about the medicine of it and you're giving good medical descriptions of the process. I deal with psychological spectrum and in 30 years of practice I can't tell you how many women I've had come in or families I've had come in where there are concerns there is fertility in the relationship that's attributed to PMS and the moodiness and the volatility and the unpredictability and so on and historically to my knowledge, not being a physician, so I'm going to ask you, my interpretation of that, my understanding of that has been that it was thought of as a mood disorder or an emotional disorder not as a medical disorder. Does that agree with your training, does that agree with what you were taught?

KM: It does, yes. I mean I investigated this early on in my training in the 80's and into the 90's in fact now OBGYN's are taught that it is not a progesterone problem. They are taught that doesn't have anything to do with it.

BN: It being PMS.

KM: PMS is not progesterone; it's about women getting crazy because their neurotransmitters are off. Well their neurotransmitters are off because their progesterone is too low or non-existent. So yea it ends up being a philological issue because we're unbalanced 2 weeks out of the month. The rest of the time we're normal. Which makes it very hard to deal with, well kind of normal.

BN: Or you're normal those 2 weeks and the rest of the time you're not. Whichever works?

KM: Yea, but in general it's the second two weeks. That's kind of how we differentiate PMS from mania, and depression, and anxiety syndromes. Is that PMS is only that two weeks before your cycle, or one week before your cycle, but only the second half of the cycle. And generally we don't consider PMS if you're menopausal. I mean OB's know this. You don't have PMS when you don't have M. You don't have menstrual, you don't have pre menstrual syndrome. But they still deal with it like we're crazy. This is one of my favorite complaints about being an OBGYN and having been an OBGYN in the 70, 80's and 90's is that women were always considered to the medical society as kind of crazy, they just do that stuff. Just give them something and they'll get better, give them something to stop there.

BN: It's the nature of the beast.

KM: Yea, that we are just naturally like that and when we get overwhelmingly out of whack in terms of being psychologically stable. Just give her a pill and it will be ok.

BN: Like Richard Harris, how do you handle a woman? Just love her.

KM: Yea, just give her a pill. And so they really, I'm not sure what the reason is, maybe it's control, I don't know. But it was and is largely at the top a male run organization. Medicine is a male run organization. For some way it keeps us in our place. We're in our place if we're crazy all the time of course. So why should we look at this and try to fix it. We know they're crazy so just give them an anti depressant.

BN: So feminist that know what you know become enraged and outraged at the wrongness and unfairness of this.

KM: Right and I had the ability to fix it in my patients. Because in the 80's when I started practice I saw all these people with PMS, no one was doing anything about it, they didn't even have anti depressants then to do anything about it. They were giving them vitamins. Vitamins are well and good but it didn't fix it. So I went to a compounding pharmacist, who's still a friend of mine, and said what can we do, I know it's a progesterone problem. And he said "oh I have progesterone rectal suppositories, you have to be really bad if you're going to have to do that all the time". He said "you use them day 14 through 28 give them to your patients. They'll use them because they're desperate."

BN: Daily dose?

KM: Daily dose at night and FYI don't take progesterone during the morning because it makes you very tired. You should always take pure progesterone at night. And so I gave it to them day 14 through 28 and lo and behold I gave them back what they were missing, they were normal again. Everyday of their month

BN: There was no PMS.

KM: There was not PMS, they weren't bingeing, they weren't swollen, they weren't hungry, and they weren't crazy.

BN: OK, so you know this. You saw this in your practice, you know other OBGYN's, you talk, some of them are doing same things. But it's still not being talked about in medical school.

KM: Right, and in the guidelines for OBGYN's that we are tested on, I've gone through boards twice, once when I was first in practice and then you have to re-board at 10 years. So I re-boarded. And so they still have this because I still get stuff.

BN: Re-board means she took the board exams so she could be board certified.

KM: Right, so I took the written test the second round, because the first one is both written and oral. And on that test it said is "PMS due to progesterone, black, or is it due to a psychiatric disease?" And the proper answer was "it's a psychiatric disease". That was in the 90's.

BN: Your answer was wrong.

KM: Right, it was in the 90's. What were they thinking? And there's a lot about medicine that is so delayed, and I'm not griping because it was wrong. I'm griping because they're testing every OBGYN in the country on this and the people that know it are being tested by ancient information. There are studies on this, they know this.

BN: Any bureaucratic system is slow to evolve and it takes momentum and time to get changed through the system. You were telling me that when you were doing surgeries and you started removing ovaries laparoscopically.

KM: Yea, I did that in the 80's.

BN: Was there a reprimand; was there a challenge to your doing it? Even though it worked that way, it was less invasive, there was less scaring, it was more satisfying, all that.

KM: And now everybody does it that way.

BN: Everybody does it that way.

KM: Now everybody, so I knew how to use a laparoscope and I was good at it and I didn't want patients to be off work for 6 weeks.

BN: But you were ahead of the curve.

KM: But I did that, I was ahead of the curve and I learned to do it, I was trained by other physicians and going to conferences, so they're teaching it. But I go to my oral

boards early on in my training and I had this on my case list, and they just castigated me for that. They told me that that was just dangerous and the most horrible thing to do. So if you wait long enough then it's standard of care. So 10 years later it was standard of care. Everything is delayed. So what you hear on the news today if it's from the AMA or the American College of OBGYN or the American College Family Physicians or Endocrinologists it's 10 years behind.

BN: Actually I was watching a news show yesterday morning and there was a newsline going underneath that said there are now studies that challenge the 2003 study that linked hormone replacement to cancer. And we've been talking about that for a year now on these podcasts. And you've been doing this work and talking about it much longer than that. And yet it's so demonstrably inaccurate, that 2003 study, the science was bad and yet so many doctors out there have been trained that it was accurate and.

KM: Well the American college of OBGYN said "look here it's accurate" and then three years later they retracted their statement. So for three years they were telling everyone in OB that this is right and you should take everyone off of hormones and estrogen and progesterone and then they come back and it's retracted but no one hears about that.

BN: Because it might cause cancer.

KM: Might. But the whole study actually showed that estrogen did not cause cancer. But they reported it wrong. Doctors have to read the study. When doctors get, this is what they should do, what we should do, is if you get a study on the news or from the American College of OBGYN that says something that's opposite of what you've seen your whole life, if you've been in practice a long time, you know that estrogen in any form doesn't cause breast cancer. That you have the same risk of breast cancer in estrogenized patients as in people who have never had estrogen in their whole lives. So you know that and so when you get the study and you look at it and you know that it's wrong then you have to read the study and see where it went wrong. And this study didn't even say that, that's how it was reported. All the OB's believed it. The American College, I don't even know if they read it.

BN: And lots of doctors are still saying it.

KM: They're still saying it. They haven't listened to the retraction; they listen to what they want to listen to.

BN: Let's come back a minute or two to progesterone. Because what fascinates me as a former teacher. When I was teaching high school and college we used to, professors, teachers, would talk about the lack of transition of knowledge. I taught history and I required my students to write in correct English sentences. And they would say "but this isn't English class". And I would say "if you can learn to write a sentence in English class, you should be able to write a sentence in history". And they would be frustrated by that. And one of the social studies classes I used to teach was anthropology and

when you started talking to me about progesterone and the way that it works and the timing of the cycle and all of that. In service of the capacity to have a pregnancy and to maintain a healthy pregnancy what I remembered was that when I used to teach anthropology we read about and talked about primitive nomadic tribes who were basically hunters and gatherers that's how they obtained their food. When they would go through periods of times when food was not available, the women in the tribe would stop the menstrual cycle. And the only modern corollary to that that I have seen is when girls become anorexic to the point that they have amenria and they don't have a menstrual cycle.

KM: Or excessive runners or athletes.

BN: Who border on anorexia, for the same reasons. So you start to get the transitions and carryover of knowledge. But in these cultures because the society couldn't afford women to be pregnant and to produce babies that would make a demand on the resources of the tribe that wasn't there. Those babies wouldn't survive. They quit being able to have babies. And then when the food supply returned itself they'd all get pregnant. So you'd have these clusters of children all born in the same age cohort because that was the year that we had a good supply food. And so I was talking to you about that and you said that the science and medicine behind that, not the anthropology, is progesterone.

KM: And what you're talking about has estrogen involved too. So when we're starving we don't make estrogen or progesterone. So when we get down to such a low body fat both are missing. But when we are stressed by something and I mean of you don't have enough to eat, that is stress. So the first thing if you were watching this society would have been they'd stop getting pregnant or miscarry a lot because they didn't have progesterone. The second thing you would see would be no menses. In our society we have constant stress and our stress is different. It's not like we're running from a tiger and our cortisol goes up and down. Cortisol is the stress hormone. It's like we're always up here because we're stressed every minute of the day. And it's mental stress not physical stress, in the U.S. and in Canada.

BN: Well some of it is starvation and food issues in the United States. We're going to talk about stress in the next podcast.

KM: We're talking about stress and progesterone and how it effects PMS. How it brings it out. How chronically stressed women get PMS and then it makes it worse because our mental state isn't so hot and it's hard for us to actually live our lives.

BN: And one of things that we really want to explore and we will do so in the next podcast is the linkage that's there between the physical issues and the emotional stress issues, because PMS has always been characterized as a mood disorder not as a physical science medical issue. And giving medicines for mood disorders is a real issue in the country. The thought is that it's a characterological deficit of some kind if you

don't just muscle up and get through it. So we're going to talk more about that next time. So if you have questions about this or input that you would like to share with us directly you can reach us directly, Kathy how can they reach you?

KM: You can look at my website at Biobalancehealth.com. You can email us at podcast@bioblanceheath.com or you can call my office at 314-993-0963.

BN: And you can reach me at my blog which is Brettnewcomb.com.

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