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Dr. Taniqua Mil...: For the average person, they're going to live 30 years beyond this milestone. And so how do we then optimize this transition so that we can live healthy and fruitful, and like I like to say, boundless lives?

Mary Purdy: Welcome to the Good Clean Nutrition Podcast. I'm your host, Mary Purdy, integrative dietician and nutrition educator. Today we are talking about menopause and how to empower your clients, perhaps yourself, with strategies to support women and those assigned female at birth, who are preparing for or navigating this midlife health journey.

So when I was a teenager and even in my 20s, it felt like menopause was a joke or something that you whispered about or something bad that happened to you. And there was this impression that when you hit menopause, you were somehow less than or no longer really a woman or no longer feminine. And as I got older, then it became something that was associated with all of these health concerns and health issues. And in fact, it is still listed on the Mayo Clinic website under diseases and conditions instead of being considered a natural transition that anyone who has ovaries go through. And this is not to say that there aren't concerns for some people going through menopause and that some of the symptoms people experience aren't always fabulously fun. Although, as somebody who has run cold her entire life, I have enjoyed a good hot flash here and there. I will admit that.

But it is high time that we embrace and delight and honor this transition and also learn about ways that help to mitigate some of the challenges around it with diet, lifestyle, and a change in mindset. So today I am so delighted that we are joined by Dr. Taniqua Miller, a board certified OB/GYN and National Certified Menopause Practitioner. Dr. Miller trained in psychology at Yale University and then earned her medical degree from Harvard Medical School. Dr. Miller has spent her career empowering women over 40 to live a boundless midlife. She's based in Atlanta, Georgia and has been recognized for her exceptional care by Atlanta Magazine's Top Docs Recognition and Emory School of Medicine Educators Award.

Welcome, Dr. Miller. It's so fabulous to have you here.

Dr. Taniqua Mil...: Hi Mary. Thank you so much for having me. Like I said at the beginning, I love talking about menopause as much as I can. So hoping that I'll be able to give some great information for the audience.

Mary Purdy: I am really excited to talk about this topic as well, and thank you, can I say. Thank you for empowering women over 40 to live a boundless midlife? I love that. How did this become your calling?

Dr. Taniqua Mil...: Yeah. So interestingly, I received very little education about the menopausal transition and even menopausal healthcare as a trained resident. So believe it or not, only about 20% of physician training programs will have some sort of dedicated menopausal health rotation as part of the curriculum. So I did see menopausal patients, but if you asked me if I had a specific rotation where I was seeing these patients and really putting it all together, the answer would be no. So when I got into practice in my role within the first year or two, of course, I started seeing these patients. So what I noticed is that these patients were really siloed in terms of their care. At the time, there were only two people in my department that were considered certified in menopausal healthcare. And so those patients were exclusively being seen by them. But overall, the fellow OB/GYNs in my department really didn't have a good expertise.

And so one of those patients just landed in my clinic, and I will never forget, she was referred over to us by the heart health center. She had a heart attack and was taking off of her hormone therapy. And while she wasn't sent to me specifically for management of her hormonal symptoms, it was really more to reestablish care with a gynecologist. It was clear from the very beginning of our visit that that was something that was really on her mind. And I remember kind of picking in the recesses of my brain, what can I do to help this woman? Because obviously, there were legitimate concerns because of her heart history. And I remember trying to find something that could be compatible with her and her history. And I came up with a non-hormonal option for her symptoms, which were particularly night sweats, vasomotor symptoms, and some mood changes.

And I'll never forget, four weeks later, she came back and was a completely different person. She was bright eye, had lipstick on and felt finally seen for her holistic self. So much of what we do in medicine is really silo our organs. So you have a cardiologist for one thing, a neurologist for one thing, a gynecologist for something else. And no one was really seeing that she was being impacted by her menopausal symptoms. And so to really kind of see her as a full person was incredibly rewarding. And it was such a small intervention that was so effective that I really felt obligated to learn more. And so shortly after that, I took my first menopause 101 course, which was hosted by the American College of OBGYNs, and I was hooked. I then discovered the North American Menopause Society and started attending their conferences and then became a national certified menopause practitioner, I believe in May of 2015. And so since that time, I really tried to

focus my practice on women over the age of 40 living midlife, in that menopausal transition and then beyond.

Mary Purdy: Wow. And it's amazing to think that for so many decades we have not acknowledged the fact that different organ systems in our body are actually communicating with one another. Like fancy enough, the brain is actually connected to the heart, which is connected to the liver, which is connected to the microbiome, which is connected to our hormonal system. It's amazing that you are helping to bring all of that to light and work with those who are going through this transition. And let's actually talk about some definitions just for those out there who may not be totally clear on perimenopause versus menopause. Can you just quickly define those for us?

Dr. Taniqua Mil...: Sure. So when we clear the term menopause, it is actually a clinical diagnosis. It is literally the day that you've had absence of menstrual bleeding. And so 12 months, no more menstrual bleeding, then you officially reached menopause. Now the perimenopause usually refers to that transition leading up to the menopause. That transition is on average about four years, but can be as long as 10 years. So when you consider the average age of someone going through menopause is about 51 and a half to 52, you can imagine 10 years ahead, that's someone in their late 30s, early 40s. And so these symptoms of the transition can appear pretty early.

Mary Purdy: And let's actually talk about some of those symptoms. You mentioned vasomotor symptoms, hot flashes. Talk a little bit more about what might be some of the things that come up for those going through that transition or starting to go through that transition. What might they experience?

Dr. Taniqua Mil...: Sure. And so one of the first symptoms that some people will experience are changes to their menstrual cycle. And this can vary. Sometimes we call it abnormal uterine bleeding because the timing of it is off or there's extra bleeding or excessive bleeding. But what can typically happen is that you can have cycles that start to get closer together as the brain is sending signaling to the ovaries, which house all of the eggs that you'll have when you're born. As those eggs start to age, they don't really respond to that brain signaling in the same way, and as a result are not producing estrogen in the same way. And so sometimes there are extra signals sent to those ovaries and that speeds up the actual cycling each month. So you might notice that your menstrual cycles are typically 28 days and then all of a sudden over the course of several months, you might notice that they're 24 days, 22 days or even 18 days apart.

Sometimes that can be one of the first signs. For others, it can be a spacing of the cycle. So you're starting to skip cycles as you're going through the change. That's usually one of

the first signs of recognition. But there's lots, including the vasomotor symptoms. I would say 75% of women will report some sort of vasomotor event, whether that is hot flushes, that kind of rising up, starting in the central of the chest, causing kind of like a heat wave if you will, into the face. And then your body's mechanism to cool is sweating. And so sometimes bursting out in beads of sweat to cool the response or that happening at night in the form of night sweats. And so that can be really, really disruptive to sleep, to kind of overall quality of life, your day-to-day, and that can be a big symptom.

For others, they may notice a change in their mood or their ability to exhibit patience. And so sometimes this may show up as increased irritability, increased rage or anger, increased sadness. And what I try to tell my patients as well as colleagues, trust your patients, they will know if they are experiencing something different about their mood. Some have already preexisting mood changes, whether that's anxiety or depression. But if it's something that's outside of the realm of their baseline, then that may in fact be related to some of these hormonal changes that we're seeing.

Also, brain fog and the idea that you're kind of like finding words or having more difficulty really committing to some of those complex tasks throughout the day. Forgetting, forgetting what your thought was or searching for that word. These are all things that can come up along the way that especially with someone with the appropriate age should be investigated whether or not this is part of that menopausal transition.

Mary Purdy: So a shorter fuse, a bit of a brain fog. There's the hot flashes, those vasomotor symptoms or the night sweats. There's also of course vaginal dryness or atrophy or libido issues. And then of course, we know that estrogen is incredibly important for those who are assigned female up birth or those who are women. So there are even issues that are perhaps beyond the hot flashes and discomfort, but potential health risk. You talked about the woman who had had a heart attack. So talk a little bit about some of the issues that may arise as a result of lowered estrogen in the body.

Dr. Taniqua Mil...: Right. And so as we consider aging and estrogen levels declining, we see a concurrent increase in the risk of cardiovascular and cerebrovascular disease. So we're talking heart attacks and strokes, especially in those who have that family history risk. We also see an increased risk of bone loss and loss of bone density, which potentially can lead to osteoporosis. Osteoporosis can be very concerning because if someone was to sustain a hip fracture, there's a 3 to 5% mortality in that episode, but then also up to 80% chance that they won't be able to live independently. And so we know that if you're at risk for cardiovascular disease,

cerebrovascular disease or osteoporosis, the time of menopause can then compound your risk.

Mary Purdy: Interesting. Yeah, and I know you like to talk about this a lot as well, which is different women experience menopause differently. So how do you feel like women of color might experience menopausal symptoms or risk factors differently? And even a bigger question, how do they get treated differently in the healthcare system?

Dr. Taniqua Mil...: Yeah. So we have several studies that have looked at this. I think one of the more famous studies would be the SWAN study. It was this perspective cohort study of thousands of women, and a really good proportion of them were women of color, compared to some of our earlier studies. And what they found is that these women tended to have more severe symptoms, earlier onset of symptoms, and the intensity of their symptoms were rated higher. But what they also found is despite having a higher presence of symptomatology in that group, they were only 50% as likely to actually be treated, whether that was hormone therapy or otherwise. And it's really unknown and we can kind kind of conjecture why that was. But part of it may be bias as it relates to offering care. So if there is a bias of whether or not someone, for example could afford it, will that clinician or that provider actually offer the treatment?

If there is a bias, for example, of weight. So we know that for those who identify as black and African American, the CDC reports 80% will qualify for overweight or obesity. If you are and you're seeing this patient and they fit that criteria, will you bring a weight bias and kind of blame the patient for their symptomatology? So again, going to bias. What about trust in the system? If you are offered as a patient, a treatment, how much do you trust that care provider relationship? Would you take that advice or is there some hesitation because of past negative experiences with the healthcare system? And so yes, we know that for certain groups they will experience symptoms longer, more intensely and at a earlier age, yet they're not getting the treatment. And again, those are some of the reasons that we conjecture why.

Mary Purdy: Yeah, and thank you for shedding more light on that. And we know obviously that bias extends to many other conditions and health issues beyond menopause, but it's really interesting to understand from that SWAN study, which I'm familiar with as well. And I would recommend anyone who's interested in this topic to take a look at it. I'm curious too, in terms of what puts people at higher risk for these symptoms. And you mentioned having some of these issues in your family perhaps. But are there other things in our diet and our lifestyle that may put us or those who are going through menopause at a

higher susceptibility to some of these less than pleasant symptoms and other health risk issues?

Dr. Taniqua Mil...: Absolutely. And so we know for example, those who use tobacco, so smokers who have active tobacco use, they will tend to have menopausal symptoms much earlier and much more severe than non-smokers. We also know that if you are starting out with other medical comorbidities, let's say hypertension, diabetes, and then maybe carrying a little extra weight, you too will have an exacerbation of your symptoms, especially those vasomotor symptoms. Maybe also those heart palpitations that people will experience. You might have a worsening of those.

And when I was training, I was told that if you have a patient that is classified as obese that they don't need hormone therapy because believe it or not, our fat cells can actually produce estrogen, an enzyme rather called aromatase that can actually create estrogen. But that's actually false. And so you do have people who have some excess weight who will have a worsening of the symptoms because at that point, it actually is creating an insulation effect.

And so when we think of what can you do to optimize going into menopause, one, it's really hard to predict because everyone's so different. But the things that we do know that can help is to make sure that you're not smoking, limiting the amount of alcohol intake that you have, keeping a fairly healthy diet, things that we know are what we would expect for just generalized health, making sure that you have appropriate fiber, vegetables and lean proteins as part of your diet. Keeping a healthier weight because we know that excess weight at the time of perimenopause can actually worsen symptoms of those vasomotor symptoms that we talked about.

Mary Purdy: Yeah, thank you for all of those fantastic insights there. And as a dietician nutritionist, when I've worked with those going through menopause, I have found too that reduction in alcohol has been huge, in terms of helping those vasomotor symptoms, but so has reducing things like caffeine, sugar or highly processed foods and fats as well as spices. Really spicy foods sometimes will bring on a hot flash. I know that's happened for me as well. But not that we shouldn't discourage spicy foods because spice is the key to life, but it can be interesting to take note of the foods that cause or exacerbate some of those symptoms. And you hit on something really key, which is fiber, right? So there's that wonderful connection between estrogen and our microbiome, and we have this estrobolome, we've got these hormones as well in our gut microbiome. And there's a whole relationship between the gut and how we metabolize estrogen

as well. And have you found any interesting insights as it relates to digestion and digestive issues with those going through menopause?

Dr. Taniqua Mil...: One thing that does come up is increased stress and the impact that stress itself has on the microbiome and gut motility. We also know that there is a redistribution of fat, for example, as it relates to the menopausal transition. Believe it or not, the female body form tends to take on what we call an andromorph form, which is essentially male like form. And so we start seeing fat redistribution in the belly, which is also accompanied by bloating. So if you compound some of these changes that we see and add stress onto that, stress either from symptomatology, poor sleep, or kind of some of the psychosocial changes that are also happening around this time, we do start to see really poor gut health. And for those patients, I highly recommend working with a nutritionist or a dietician so that they can kind of reset that because I think that that will be really important going past menopause.

Mary Purdy: I'm Mary Purdy and you're listening to the Good Clean Nutrition Podcast. We're on with Dr. Taniqua Miller. Next we'll dive into strategies to support women navigating menopause as well as what you can do as a healthcare practitioner to help women ease into this transition. But first, a word from the sponsor of this podcast, Orgain.

Announcer: Thanks, Mary. Send your kids back to school with Orgain's kids shakes. Growing bodies and minds deserve the best nutrition that's not only good for them, but delicious too. Each shake contains 8 grams of grass-fed protein, 22 vitamins and minerals, and an organic fruit and vegetable blend. Now available in four flavors including chocolate, vanilla, strawberry, and fruity cereal. For a fun powder alternative, be sure to check out our new kids' protein nutrition shake mix for some extra playground fuel. Learn more at Orgain.com. Now, back to you, Mary.

Mary Purdy: I feel like there has been so much stigma around this conversation, so much discomfort. It's whispered around the dining room table like, "Mom's going through the change." We don't even call it what it is. We call it the change or the curse or whatever it is. So how do we change that? How do we shift the mindset around making this a topic of discussion that we can actually talk about maybe around the dinner table?

Dr. Taniqua Mil...: Absolutely. And that's where it starts, actually talking about it. When we talk about the menopausal transition and normalize it as a normal physiologic change that will happen if you live long enough, everyone will at some point go through it, that's when we start changing that narrative. And I would even say that it's not just enough to have the conversation amongst those who are actually going through the menopausal transition. But more broadly, how do we

get family members and partners and children to really understand the significant clinical implications that go along with it? Understanding that it's not just for comedic relief, ripping over the refrigerator and trying to stand in front of the cool refrigerator, but really that there are physiologic changes that not only are kind of disruptive potentially when we think of vasomotor symptoms and we think of bleeding issues, brain fog and sleep disturbances, but some long-term health challenges.

I was on a panel yesterday for the Women's Bureau Department of Labor, and we talked about the impact that it has on employment. So we know that this isn't just comedic relief, that this is not something that's taboo when we have one in 10 leaving the workforce because of menopause, and you have one in four who are considering it. Why? Because they may not feel like they have the appropriate accommodations at work. When you consider your late 40s, early 50s, it being a time in your career where you're really kind of bringing your all. But now you're suffering from brain fog or having really disruptive symptoms and not really seen for that. We have right talented people leaving the workforce because of this and not really feeling like they have a lot in the way of accommodation. And it's really, really a sad day if you don't really kind of bring some normal conversation about this.

I always recommend to my patients to find community. Sometimes we suffer in silence. But when we start talking about it, then we feel like we're not alone, that we're not so isolated in our menopausal experiences. And there are studies that actually have supported that when you come together in community and talk about your symptoms, your experience of your symptoms, the intensity of your symptoms actually goes down.

And so that's a really good way to bring communities together. And I will say within the last, I don't know, five years, there's been an explosion of conversation around the menopausal transition and really how to navigate this as one, a physiologic change and have the appropriate support for that in the same way that we would support someone who has thyroid disease or who have gastrointestinal disease or some other ailment that is really disruptive and keeping them from living their best lives. But how do you then look at this period and realize that for the average the person, they're going to live 30 years beyond this milestone, and so how do we then optimize this transition so that we can live healthy and fruitful, and I like to say boundless lives?

Mary Purdy: Right. Absolutely. And so I'm hearing this idea of connecting with patients on who they are, what they're going through, having a conversation, whether it's around the table with friends, with family, with whomever, and then this idea of

community, of having a support network. These are all fantastic strategies. Let's also talk about some other strategies, because I have a feeling people out there want to know, "Okay, community conversation, I'm doing that. I've got it, but I am still really struggling." So let's talk about whether it's diet, it's lifestyle, and then let's talk about medication and HRT, or hormone replacement therapy. So kick us off with that, with perhaps some dietary strategies, and I'm happy to chime in here too.

Dr. Taniqua Mil...: So the things that I would tell you for good cardiovascular health, for good bone health, it also speaks the same language when it comes to menopausal diets, so menopausal health. We know that as we age, but then also precipitated a little bit by the menopausal transition, that our bodies overall are becoming more insulin resistant. And we know that protein becomes more important than ever as we age. And so when we start seeing a little bit more fat redistribution into the midsection, which is going to further compound that insulin resistance, there needs to be some shifts in change in how we're dieting. So for example, I have so many patients that come and they say, "I've changed absolutely nothing. I'm still exercising three times a week. My diet is absolutely the same and I'm gaining weight." And to that, I say, "You are absolutely right." Because as we get older, our bodies are not processing, for example, carbohydrates in the same way as it did.

I always make a joke that I have noise-canceling headphones and I have three little children at home and they're always, "Mommy, mommy, mommy, mommy." And I call my children insulin tapping on the door, tapping on me while I'm listening to my headphones, and they're like, "Mommy, mommy." And that's insulin tapping on the cells of your body saying, "Please take up the sugar that we just had in our meal." But the cells, they're not really responding in the same way. Our muscles, none of it is responding in the same way. And so what happens, insulin's responsibility is to make sure that our blood sugars are appropriately regulated and we'll store that excess sugar as fat. So if we don't make changes, especially to how we take in specifically carbohydrates as we get older, we will gain weight. There is this startling length statistic that even additional 10 calories per day, that's nothing.

That's me stealing a french fry from my child when we go out. That could yield two pounds of weight gain a year. And if you did absolutely nothing to intervene, that's 20 pounds of weight gain over 10 years. And so being a little bit more vigilant in terms of making sure that we're maintaining a healthy diet can be really important, especially as we're thinking of some of these longer term consequences.

And then obviously exercise. Exercise, this is nothing new. The American Heart Association recommends at least 30 minutes of moderate intensity exercise a week. That is still what I would recommend. That helps with weight maintenance, that helps with bone health, that helps with muscle development. When we add in that strength training, bit of muscle, that resistance training to help maintain our muscles. And as a consequence, we need to then also increase our protein.

The other thing that I recommend for my patients in this time is making sure they're getting adequate vitamin D. We tend to get pretty great on micronutrient support from our diets or from a multivitamin if that's something that we choose. I'm always a fan of trying to get it from the diet as much as possible because we just absorb it a little bit better. But vitamin D is that tricky one. And it's tricky because we get vitamin D activation from the sun, but we tend to wear sunblock or we tend to [inaudible 00:25:45], and all of these things. So making sure we're getting appropriate vitamin D is not just important for overall energy levels, but it's also important for bone health as we're looking forward through living through the menopausal transition and beyond.

Mary Purdy: What about some other lifestyle factors or lifestyle strategies that you have found to be helpful?

Dr. Taniqua Mil...: This is going to sound really obvious. Are you ready?

Mary Purdy: Yes.

Dr. Taniqua Mil...: Stress mitigation.

Mary Purdy: Oh, hello. Yep.

Dr. Taniqua Mil...: And so really, how do you manage such a challenging time in life at this point? When we think about the psychosocial things that come up in midlife, we cannot divorce those from the actual hormonal milieu that women are in during this time. So we call this the sandwich generation that we may have some people who are caring for children, teenage children, young children, if they've had, children older in life, and they're also caring for aging parents. And so having to be a caretaker and kind of sandwiched in the middle of that can be really challenging, especially given some limited support that we have. This is where we start seeing changes in just overall life purpose and how we see ourselves and our families, how we see ourselves in our careers. It's really kind of that pivotal transition of what are we going to do?

We see changes to relationships. We start experiencing some health challenges. So we know that breast cancer is a very common cancer, and we start seeing that as we start our screening in our 40s where we're seeing folks who are our age or even ourselves

having some of these health challenges. For some, it can be tricky because this is really the decline of reproductive potential. And so if there was even a thought that you wanted to have a pregnancy, the reality that actually probably won't happen for you and for your legacy, then that could be really trying.

And then obviously, the increase that we see around mood disturbances like anxiety and depression in this age cohort. And so there's lots going on. And it's hard to know where to start, but I always encourage patients to have some mindfulness practice that they have in place that can help mitigate some of that stress, whether that is a cognitive behavioral therapy technique, which has been shown actually to also mitigate the vasomotor symptoms in the menopausal transition, meditative practice, something that could really, really help with some of that stress mitigation in addition to making sure you're getting appropriate sleep, eating a healthy diet and getting appropriate exercise.

Mary Purdy: So stress obviously a huge factor for so many issues. But in particular, for those going through this transition, it sounds like it's exceptionally important because of all of other these things that are happening during this time of life. And life's purpose, very often we talk about things from the negative point of view, like reduce the stress, don't smoke, get more sleep, get more exercise. You also have this incredibly positive way of embracing. You mentioned this boundlessness of this time of life. What about this mindset switch? What about how you're coaching individuals now around how to look at this differently? Tell us about that.

Dr. Taniqua Mil...: So much, and I'm guilty of it as well, and so are a lot of my colleagues, we think of menopause in terms of the pain points, the 32 plus 45 plus depending on what website you look at, symptoms of menopause. And we see it at this very negative transition because how disruptive it can be. But in fact, when we see that now this is the end of reproductive potential, but for most of us, we have 30, 40 plus years ahead of us. How do we make the most of that? Not only are you coming to the menopause with tons of experience, tons of just intellectual curiosity, the ability to really kind of remake and transform yourself into someone new.

How can we do the work around that? Not seeing it as the end, but really the beginning. It can be challenging because unfortunately, we live in a society that really favors youth. So when you see menopause as the end as opposed to the beginning or the loss of youth because it is the end of reproductive potential, it's really hard to see the other side. But I love the movement now that we see so many incredible Gen X people out there talking about menopause and really having empowerment in menopause, not just through symptom relief, but really

putting a flag in the sand and saying, "Listen, this is menopause and it is amazing," and going forward, we're going to really embrace it.

Mary Purdy: Excellent. And I think there is, as you mentioned, there's a true wisdom. Once we reach a certain decade of our life, things are different, in this area, and I am pointing to my head, and in this area, I'm pointing to my heart. Not just in down here in this area of our ovaries.

What about HRT? I know a lot of individuals, you mentioned breast cancer as well, and I know there's concern around that. Are perhaps what people think are myths around HRT. Can you talk us through when, why and how HRT may be beneficial for certain individuals? And HRT is, I'm sorry, hormone replacement therapy.

Dr. Taniqua Mil...: Actually, when we think of replacement, that's actually a little bit of a misnomer because we're actually not replacing back what your endogenous ovary like our hormone production was, what ovaries make. In fact, it's a fraction of that. When we think of menopausal hormone therapy, it's actually a fraction of what you would get in your very typical contraceptive pill that has estrogen and progesterone in it. And so there are very few people who would not qualify for hormone therapy. We know that if there is someone who has preexisting cardiovascular disease, someone who has estrogen receptor positive breast cancers, someone with abnormal bleeding that hasn't been evaluated, and some other medical conditions, yes, they would not be candidates for their hormonal aspect of therapy. But there are lots of non-hormonal aspects too, which I'll get to in a second.

So some of the earlier studies that looked at hormone therapy kind of scared people off of therapy, and I'm referring to the Women's Health Initiative, which was a study that was released in 2002 that showed with a very specific combination of estrogen, it was conjugated estrogen and a very specific progestin, which was medroxyprogesterone, one of the older synthetic progesterones, that there was this increased risk of stroke and this increased risk of breast cancer.

What was interesting is that for those without a uterus and were given the estrogen only arm of that study, there wasn't the same finding for breast cancer. In fact, there was a non-significant protective effect for estrogen. But what that study did is that it made people really fearful that hormone therapy potentially would cause breast cancer, or increase your risk by 20%. What we know for absolute risk is that it's probably one additional breast cancer for over a thousand breast cancers. And what's tricky about breast cancer is that is a very common cancer. About 12.5% of women will actually develop breast cancer in her lifetime, so that's one in eight. So because it's such a common cancer, it's hard to tease out what causes

what. But what we do know is that we have lots of different hormonal solutions today, if you will, compared to then.

And a lot of what we're seeing is a movement towards the transdermal options that are bioidentical or what we consider bioidentical, and FDA approved bioidentical medications. So when we think of something like a patch or gels, something that is absorbed through the skin, we're able to give lower doses and still be able to meet symptom management goals. We also know that with the transdermal options, you don't have the same risk associated with some of the oral options, especially around blood clots, heart attacks, stroke, and the like.

And so our goal, and this is what the North American Menopause Society would say, is to start someone on the lowest dose of hormone for the lowest duration of time, for the shortest duration of time. And that is really a trial and error. That is a partnership with you and your clinician to really find the good fit for you. I recommend that if someone does qualify and they want symptom relief, we think that especially earlier on, there may be some cardioprotective effects of hormone therapy, especially if you're using it within that first several years of the menopausal transition and menopause. And so that may be worthwhile for people to explore. But really the goal would be initiation of therapy before the age of 60 or within 10 years of the menopause.

Mary Purdy: And this is where it feels so key for practitioners to be able to ask individuals questions about what they're going through so that you can really create that relationship and understand how to individualize and tailor treatment and that, gosh, that there's really benefits not only to reducing some of these symptoms that people are having, but may actually have benefits to cardiovascular health and perhaps bone health as well.

Dr. Taniqua Mil...: Exactly. And I will say there will be some, like I mentioned earlier, that won't necessarily qualify for the hormonal treatments that we give. But there are lots of non-hormonal treatments that are very accessible and very effective. We have several that are on the market and that are FDA approved. Frankly, they come from our colleagues in psychiatry who use, for example, SSRIs. And we use them at lower doses to really help with some of not just mood symptoms, but also those vasomotor symptoms. And that could be really, really helpful. But again, having someone who has expertise in that area can be beneficial to really know what your breadth of options would be.

The other thing that I also want to mention because you mentioned it earlier about vaginal dryness, we know that the vagina, for example, has tons of estrogen receptors. And as our estrogen levels decline, sometimes the natural lubrication found in the vagina

can also decline. And that can also lead to increased risk of urinary tract infections and not just maybe painful penetrative intercourse.

And so we have vaginal estrogens that are exclusively used in the vagina that do not give you that systemic response. So there's some people who are fearful of having kind of systemic estrogen or cannot have systemic estrogen. It is something that has been used quite effectively. I have had patients that I've seen that have had estrogen risk sensitive breast cancers that are pretty far out from their diagnosis and working with their oncologists. Again, creating those collaborative relationships, not just treating that one part of that person's life, but looking at them holistically. We've been able to bring back some vaginal moisture using some of the vaginal estrogens. But again, I would encourage that you advocate for yourself and have your providers talk to each other to make sure that whatever you choose for your overall health is a safe choice.

Mary Purdy: What about libido? I know that a lot of individuals feel a decrease in that part of their lives. What can be done about that?

Dr. Taniqua Mil...: Yeah, that's a great question. We also have to see what's happening. So if you imagine you're having poor sleep, you're having change in kind of body image in terms of weight gain, especially redistribution in the midsection, having desire for any sort of sexual intimacy can be really challenging. But there are some that really do have what we call female sexual arousal or sexual interest disorder. It was previously known as hyposexual desire disorder, where there's actually a diagnosis associated with that where you're having avoidance of intimacy, a loss of interest, decrease in the ability for arousal, decrease for the ability for orgasm, pain, avoidance, and that's going on for over six months, and not related to anything else. And so that is a clinical definition for that.

And there are medications that we have. So the FDA has approved two medications that are on the market. One is called Flibanserin, the little pink pill that's taken daily that can help increase some of the interests in sex seeking behaviors. And there's also bremelanotide, which is an injection that's available that would be taken prior to any sort of intimacy activity, 30 minutes or so, and that helps with that arousal response and that orgasm response.

And then in the right patient and with the appropriate clinician that feels comfortable doing this, there is an indication for testosterone treatment as it relates to that. I will say that there is no FDA approved testosterone medication indicated for women at this time. Most practitioners are using male formulations in certain doses or some compounded formulations. And so I would highly, if this is something that you're considering, I would highly talk to someone who has a lot of experience in being

able to not only dose these medications appropriately, but then also to follow you because they may require some laboratory testing and follow up.

Mary Purdy: Once again, this comes back to having open conversations with yourself, with your partner, with your doctor. So thank you for that information.

Dr. Miller, I feel like I could talk to you for about 16 more hours about all of this, but I know we need to wrap up. And I also really want to give you an opportunity to talk about the work that you are doing, the courses that you offer, the coaching that you give. How can people find out about you? And tell us a little bit about what your platform is right now.

Dr. Taniqua Mil...: Yeah, so thank you for that. So I am an empowerment coach. I help women in the midlife transition quit. I myself, after 14 years in my career, experienced professional burnout and really kind of had a pivotal turning point to understand how did I want to move forward. Sometimes when we're starting off early in the careers, we think we have to do all the things to be able to find value in our lives, develop our own idea of worth. And I realized as I entered my 40s, that wasn't the case, especially as I started seeing my role shift in my life as a parent, as a daughter, and being in that sandwich generation, if you will.

And so now I coach professional women, just like me, on this idea of quitting. What does it mean to let go? And what does it mean to then use those mental and physical energies doing all of that busy work that no longer serves you and pouring back into yourself and really finding purpose again. And so I found my purpose through entrepreneurship. And so I do help in terms of being an entrepreneurship coach for women as they need it. But I also really just want the recovery through burnout to be one that is holistic and validating about their experiences.

Mary Purdy: Well, I'm sure there are many individuals out there who are gaining so much from you. And just having this conversation with you, there's a real joy that's here and there's a sense of trust, and there's a sense of groundedness. So I really appreciate how deep we've gone in this conversation today. Thank you so much for everything you have shared with us. I so appreciate your expertise and your compassion as well. So thank you.

Dr. Taniqua Mil...: Thank you for having me.

Mary Purdy: And here's to New Beginnings.

Dr. Taniqua Mil...: Yes.

Mary Purdy: Thanks for tuning into this episode of the Good Clean Nutrition Podcast. Hey, if you like this podcast, we would really appreciate it if you would give it a five star

rating or review on your favorite podcast platform, like Apple Podcasts or Spotify, or give us a thumbs up on YouTube if you're watching. Hello. To stay up to date on the latest episodes of this podcast, be sure to subscribe. Thanks so much and see you next time.