Dr. Ron Ehrlich: Hello and welcome to “Unstress”. I'm Dr. Ron Ehrlich. Now the purpose of this podcast is to explore stress. That is to understand what actually stresses your body and your mind. What has the potential to compromise your health? That inevitably means you have to think holistically. Now that's another theme of this podcast and it's why we've done shows on regenerative agriculture for example because if you want healthy food you need healthy soils and the decisions that farmers make can actually impact on your health too.

Now my point is this podcast is about understanding stress and thinking holistically and most importantly empowering you with information to take control of your own health, five pillars. Go back and listen to episode 1 “The mission statement”. Now you've probably noticed that I also love talking to integrative health practitioners. They are generally people who have realised that the traditional medical training doesn't supply all the answers. And then as they move through their practices prescribing medications to manage the variety of conditions their patients present with, this is the traditionally trained doctors, these patients may be on two, three, four or more medication. A medication for reflux or heartburn for high cholesterol depression, anxiety, trouble sleeping. I think you get the picture. Does that sound familiar as a patient? And if you're a doctor listening is that your kind of practice?

And then if it is well then, the pharmaceutical reps come in with the latest journal articles many of which have been sponsored by drug companies and hold out a promise to manage these common conditions even better. I mean if you're running a busy practice dealing with all of those issues and keeping up with all the "latest", I just put that in inverted commas well, then you just don't have the time, right? Well, what about if you're a patient and you just want to go to the doctor for that prescription to manage the list of conditions? Well, this certainly is synergy there, isn't it? There are lots of doctors lots of patients just like that but if you now this is why I love an integrative approach because actually there are many things I like about it but firstly, the doctor has actually reached a point in their professional life where they say, “I don't know”. Where they say there must be more to this health career that I've bought into than just working out which drugs to prescribe or maybe there are some common themes running through Let’s say inflammation, reflux, depression, anxiety and other common themes. And if I find out what they are maybe I can solve all of those problems rather than just manage them. No need for drugs oh my god what a revelation that would be. And or also maybe I can educate my patient to be part of their own healing or health journey.

Well, my guest today is an integrative gynaecologist and fertility specialist Dr. Natasha Andreadis. Now we cover some interesting ground here that is relevant to every one of every age, male and female. We cover issues from 18 to 75 and beyond but what I love talking about to doctor Tash, Dr. Natasha… Oh, well, she is a gynaecologist and her attitude her philosophy integrative approach. I hope you enjoy this conversation I had with Dr. Natasha Andreadis.

Dr. Ron Ehrlich: Welcome to the show Natasha.

Dr. Natasha Andreadis: Thanks for having me on here Ron.

Dr. Ron Ehrlich: Natasha you are an integrative gynaecologist and a fertility specialist and, in your practice, you're seeing patients, women from the age, I think you were mentioning to me 18 to about 75 and that's quite a journey for women. I was hoping we could talk a little bit about some of the issues that women face on that journey and this integrative approach.

Dr. Natasha Andreadis: Yeah, I'm all ears to your questions.

Dr. Ron Ehrlich: Well, let's start with you know you mentioned fertility and fertility you know when we decide to have a baby it's kind of a whole "let's have a baby" but it's not always as simple as that. Can you just share with us some of the issues that the women are facing today?

Dr. Natasha Andreadis: Yeah, I think a lot of it's based on the fact that people think it's going to be really easy and they take it for granted you know, that all it takes is just one episode of intercourse and that's done. Women don't realise that it might take quite a long time to get pregnant and it doesn't necessarily mean there's anything wrong with you. So, I think what people they do is often compare themselves to other people I've got my friend only took two months to get pregnant or my mum fell pregnant really quickly with the three of us. So, there's too much of a comparison going on out there I think people should just really focus on themselves and what they're doing on a day to day basis. So, looking very much into their lifestyle so I think the main challenge women really is lifestyle you know little things not like not sleeping very well or not sleeping enough you know there is quite a lot of evidence on women who maybe sleep less than seven hours or more than say ten hours are more likely to have difficulties with conceiving. Same with their partners effects, semen analysis you know, stress, not only under exercising and obesity but there are lots of women that I see who are actually over exercising and that obviously switches off their periods and interrupts ovulation and when I see them and say you know you've got a stress less, meditate more, sleep more, do less HIIT training, they're quite surprised by that because they think, “Wait a minute doctor, doesn't everyone know that exercise is good for you?”

Dr. Ron Ehrlich: HIIT training being high-intensity interval training for our listener…

Dr. Natasha Andreadis: That’s right. So, yeah. I think there's a lot of misinformation out there and I think because of social media as well people think that this perception that everybody else's life is really perfect and easy and they're falling pregnant is easy but it's not. It's actually a miracle that it actually does happen.

Dr. Ron Ehrlich: You've mentioned two things there of course straightaway sleep and stress which is a recurring theme on this podcast and so interesting to hear it in terms of fertility, what's the average time that it takes that person you know, moving away from the social media, moving away from your mate that just got pregnant what's the average time that it takes people to get pregnant?

Dr. Natasha Andreadis: Probably around a year. It depends on their age as well. So, we say if you're over 35 and it's taking you longer than six months you should seek assistance.

Really if I'm seeing a young couple that is less than the age of 35 and there's nothing obvious in their history I say go away and try you know, having sex regularly for a year. So, it's really a year and it obviously depends on the age cut-off and it depends on comorbidities you know, or in both the male and the female. So, it's not just about the female, it's very much about the male as well.

Dr. Ron Ehrlich: What do what do you mean by comorbidities?

Dr. Natasha Andreadis: Things like if someone, for example, has cystic fibrosis. A woman who has Cystic fibrosis can still get pregnant but the fact that she has a lot of thick and mucous also affects the cervical mucus and it will take her longer to get pregnant. So, we overcome that by doing things like our IUI for example.

Dr. Ron Ehrlich: Hang on a second, IUI?

Dr. Natasha Andreadis: Yeah, intrauterine insemination.

Dr. Ron Ehrlich: Okay.

Dr. Natasha Andreadis: So, that so, that's an extreme form of about comorbidity but a more common thing would be you know, being very overweight and having type 2 diabetes. A lot of women with autoimmune conditions you know, thyroid Hashimoto's thyroiditis is very common. So, I saw a woman yesterday with her partner 42, regular periods and she was told you've got irregular periods because you're 42 when in fact she has some clinical hypothyroidism that hasn't been treated. So, that's a clear example of a very common comorbidity.

Dr. Ron Ehrlich: Yeah, and thyroid, I mean just from taking a medical history in a dental practice it's amazing how common that is.

Dr. Natasha Andreadis: Well, you know I'm super impressed that you actually take a history like that I've never had any dentist asked me about my general health,

Dr. Ron Ehrlich: Okay.

Dr. Natasha Andreadis: Yeah, well, pretty good too.

Dr. Ron Ehrlich: Okay, no but does it does surprise me in and you know their whole story of autoimmune I mean that's that underlying issue alone given how common it's becoming, it must be a huge impediment to that fertility process. I mean where we haven't even touched on some of the digestive issues as well and yeah, neurological you know, it's a… it's a big one, isn't it? That autoimmune issue.

Dr. Natasha Andreadis: Yeah. And you know, it can affect so many organs and you know, we don't even know but one of the common gynaecological issues that we see that impacts upon fertility and falling pregnant is polycystic ovarian syndrome. You think that there might be an autoimmune component to that but yeah, you know, from celiac disease to Hashimoto's

to rheumatoid, yeah, you know, an autoimmune disease has every other organ covered pretty much.

Dr. Ron Ehrlich: Yeah, yeah, I mean I've even heard that a while it's not strictly speaking an autoimmune condition PCOS, polycystic ovarian syndrome. We had one guest who mentioned that it's actually going to be should be renamed to be a reproductive metabolic syndrome. So, about insulin resistance and that whole story around well, not diabetes but almost.

Dr. Natasha Andreadis: Yeah, it's a complex condition, I think it's multifactorial, to be honest, there are many things that impact upon it. It's not one of those easy to tease out conditions and managing that I get a lot of satisfaction out of managing patients with PCOS because there are lots you can do for them.

Dr. Ron Ehrlich: Yeah, like?

Dr. Natasha Andreadis: One educating them. You know, I always make sure I encourage patients to go and read books on a condition so for if they have a diagnosis of something I say you know don't just go onto Google and skim articles, don't just go onto Facebook pages. Educate yourself you know, go and read a few books on the condition, go deep into it so you that you then become more of an expert than say me. I think that's really important that's so empowering patients and saying to them look, you know, go in and have a good read come back with any questions. I think that's really, really important and even go in and have a read and if you find a good article what you've seen in a PubMed Journal then come back and we'll discuss it.

So, I think education and reminding them of that, sending them links to good books that if I if I have a good book I like to recommend I will email that book to them and say go away and have a read of this. A lifestyle is a huge factor for PCOS. You know, diet. You know, I like to recommend a low carb, low refined added sugar diet and I think that works really well for people. Regardless whether they're overweight or not exercise so you know strength and resistance training for the insulin resistance and sleep, meditation and you'll find that just with those very simple recommendations menstrual cycles change, they feel better and then from that you can build on that so if you know, if people they may not regularly ovulate despite those changes but there are still positive changes.

Dr. Ron Ehrlich: And comorbidities for men? Because we kind of always think fertility is a theme at well we don't always we'd but it's often put at the feet of the women but males play a pretty big part in this problem.

Dr. Natasha Andreadis: They do. I mean forty percent of the time if a couple can't get pregnant it's because of the male. And we know that the male fertility is declining, sperm quality is declining and that's why the WHO changed as guidelines for semen analysis interpretation back in 2010. So, you know, we're used to be 20 million per mil of sperm in a semen sample now it's down to 15 million per mil. I think a lot of it's environmental more than anything.

Dr. Ron Ehrlich: So, they've set this as the norm?

Dr. Natasha Andreadis: That's right. So a good quality fertility andrology lab should be using those guidelines. So, whenever I see, and it doesn't happen so much anymore but when the guidelines changed, two years after the guidelines were changed you would still see people who went to labs and had their semen analyses done at a lab using the old sample, the old guidelines and I'd say look you need an up-to-date semen analysis. So, I think it's important to inform patients about where they're getting their tests done and what that test means.

So, you know, a lot of the time I'm spending a fair bit of time explaining to patients you've had this ultrasound but I'm not happy with the quality of this scan because it doesn't give me this information and I need this information to make a diagnosis. You know, going back to PCOS you need a scan where if someone's had their antral follicle count measured so someone's actually counted the number of follicles to give you a diagnosis of polycystic ovaries which is what one in five women have but doesn't give them the diagnosis necessarily a PCOS because that to have a diagnosis of PCOS you need two out of three criteria according to something called a Rotterdam criteria after you've excluded for thyroid and prolactin issues.

So, when you explain to patients this is why I'm diagnosing you with this condition they'll say oh I get it now and this is why I need you to have that repeat scan because without that I can't be confident that you've got this condition.

Dr. Ron Ehrlich: How does so people say… okay, oh, I'm getting ahead of myself here I'm still on the male comorbidity because I got another question about but go on I mean that's not the only issue, is it? Well, there's sperm quality, quantity.

Dr. Natasha Andreadis: Yes. And their lifestyles. You know what they eat. Men don't I don't think men look after themselves as well as women I really don't although men are very I have to say men are very receptive to the advice I really again enjoy looking after men because you'll give them some advice and they usually go okay yeah sure.

Dr. Ron Ehrlich: Very compliant men tend to be you know very compliant.

Dr. Natasha Andreadis: Yeah. It's a nice balanced, women are way more complex.

Dr. Ron Ehrlich: God that could be the whole subject of another podcast really, couldn't it? I've learned that in my own house as I've grown up with two daughters who are now 31 and 28. You know I'm just I'm very simple in comparison to them of the far more complex.

Dr. Natasha Andreadis: On the topic of male what I find interesting is the effect of technology on sperm health. So, you know, men really shouldn't keep their mobile phones in their front pockets next to their testicles. You know, I've seen so many guys that do that and we… I said I'm going get it to go get yourself a nice little bag Versace man bag put them my

phone away from your front pocket because it does it heats up the testicle. Now and as you know Nicole Bijlsma who you know very well has written a little bit on that.

Dr. Ron Ehrlich: Lyn McLean we did a whole program on wireless people, wireless wise people and then you know you just have to I'm often surprised if I ever put my laptop in my lap, oh my goodness does that warm up.

Dr. Natasha Andreadis: Yeah, it does and especially when you put it to your ear you know, and I try not do that anymore, but Lyn's book was great on "Wireless family" so I went to an event that she was at met her so…

Dr. Ron Ehrlich: Yeah. No, no, it's a really, it's a well, you watch it you look you got onto any transport system, any public place and you just see people on their technology that this is a huge issue actually in terms of its effect, its potential effect on a whole range of things but in this particular case on our reproductive organs.

Dr. Natasha Andreadis: And look when you in my rooms when I say to people look this is what you're exposing yourself to and I'll wreck them recommend them to Lyn's book they find it quite interesting oh wow okay, we'll look at making changes but it's very different if I'm talking to say someone at a dinner that I've met or someone random and bring the topic of Wi-Fi up. They all automatically will say where's the evidence. People get it's interesting they get very…

Dr. Ron Ehrlich: Very defensive.

Dr. Natasha Andreadis: Very defensive. And it's almost again it's about mindset because when I'm seeing a couple with infertility and I'm trying to give them advice on ways to improve sperm counts etc. so they're very receptive to that and they'll go yeah sure go away and have a read, but other people when they're not ready for that information will automatically go what wait a minute, you know.

Dr. Ron Ehrlich: Yes, where's the evidence? I love that, that statement because you know often you hear people often who are critical so-called experts who are critical of an integrative approach. Some will say there's no evidence to support X Y or Z and really what they should be saying is they haven't read I haven't read the evidence and that's a very different statement, isn't it?

Dr. Natasha Andreadis: So true. And in fact, I hate it when people say that it really sets a Bunsen burner up my bottom it really does and I almost find it insulting when people say that to me because I think well you know what? I'm not going to sit here and forward you articles you should go and do your own PubMed search. You know going in it yourself.

Dr. Ron Ehrlich: But it raises another interesting issue on a much and that is when you know something you can't unknown it. So, it's almost – it's very tempting not to know it. You know that whole story ignorance is bliss?

Dr. Natasha Andreadis: Yeah.

Dr. Ron Ehrlich: You know if I don't know it, I don't know it but as soon as I do know it you can't unknow it.

Dr. Natasha Andreadis: Yeah, and it causes a bit of discomfort in some people and depending on how they put up with that they might morph and change and look into it further, other people were just pushing into the background until suddenly something comes up that affects them directly you know.

Dr. Ron Ehrlich: But you're obviously in your practice because you are an integrative gynaecologist. I mean it might be worthwhile to define that for people because you know. I mean I've we've had Ross Walker on here who describes himself as an integrative cardiologist and so just let's take a step back from it as we are looking at these co morbidities but lets I should have asked you this at the beginning… What is an integrative gynaecologist? How do you define that?

Dr. Natasha Andreadis: I suppose what that means to me is that I integrate options into a patient's treatment or management plan so for example if a woman has irregular periods I will say hey you know, let's look at acupuncture and Chinese medicine. So, I will give her the option of seeing a complementary medicine doctor or alternative medicine doctor whatever you want to call it and I work really well with acupuncturist see some really positive changes.

So, for me it's about bringing in other things apart from say conventional treatments that I was trained when I was trained as an ONG to use because really I actually think it was that wasn't until I went into private practice and had a lot of freedom to practice as the doctor I wanted to be, did I realise that my training was really quite deficient and I really don't think it helps people in the best sense possible. You know, I don't remember getting taught during my ONG training, you know when you do a ward round ask a patient how they slept overnight, you know?

Dr. Ron Ehrlich: Yeah.

Dr. Natasha Andreadis: It wasn't until the patient says I just can't sleep can you give me a sleeping tablet?

Dr. Ron Ehrlich: Yes, yes.

Dr. Natasha Andreadis: So, it wasn't until then I moved into my private little world that I realised wow you know all these other people I can kind of knock on their doors to ask for help but for managing patients and you know, naturopath I work a lot with naturopath so I've got a group of naturopaths that I referred to you know, dieticians, Sports physiologist, pelvic floor physiotherapists. And so, I like to bring in a lot of help.

Dr. Ron Ehrlich: Yeah, yes. It's quite a liberating way to approach things too, isn't it? I mean if you think well I think this is one of the weaknesses of the traditional medical approaches is often that if the practitioner doesn't know the answer then the patient doesn't have a problem. You know, oh, yeah, so, it's all in your head all the tests show you find this there's really there's no reason why you shouldn't be pregnant.

Dr. Natasha Andreadis: Yeah.

Dr. Ron Ehrlich: Well, are you sleeping?

Dr. Natasha Andreadis: Well, talking about saying I don't know…

Dr. Ron Ehrlich: Yes, very liberating.

Dr. Natasha Andreadis: And I like to ask patients "Why do you think it's not happening"?

Dr. Ron Ehrlich: Yep.

Dr. Natasha Andreadis: And then they look at me and go I think it's this and it's usually they're usually right you know.

Dr. Ron Ehrlich: Yeah. I was on a course year and years ago in America and the woman we spent six days with this practitioner and it was like Zen in the art of medicine and what I learned from it was if you ask your patients the questions they'll often tell you the answer and if you ask them the right questions they'll often tell you how to fix it.

Dr. Natasha Andreadis: Yeah. And a lot of consultations that run like that. I love it because it means I have to do less work.

Dr. Ron Ehrlich: But it also involves the patient in that whole journey which is great but back on to infertility because we've got the female comorbidities and the male comorbidities we've talked about technology and lifestyle and sperm quality and quantity. Once we've got those away I mean people and you also mentioned, this a pretty important point too, "Go away and have sex". How often should people be having sex? You know, I mean I think that's something that probably is open to people's imagination as well and often isn't explained. I mean you know there's a… there's a cycle go on and tell us about how often people should be having sex because that's a pretty important part of fertility, isn't it?

Dr. Natasha Andreadis: Well, yeah. I said to people there's nothing wrong with having sex every single day if you want to do that, no problem you know, but if your people have very busy lives a lot of couples one partner travels a lot for work etc. timing is difficult so then I'll explain to them the menstrual cycle and I'll explain around the time of ovulation is when they should be having sex every day or every second day possible and then I say to couples look if you don't really want to time it because you find it too stressful to kind of go ok I'm evaluating tomorrow or today, I've got to do it now, just cover yourself and do three or four times a week. You know, have sex three or four times a week.

So, I do then look at patient's lifestyles again to try and make that recommendation.

Dr. Ron Ehrlich: So, in terms of say a woman was having a 28-day cycle and she would be ovulating on what day range would they're typically ovulation occur?

Dr. Natasha Andreadis: Typically, around day 14.

Dr. Ron Ehrlich: Yeah. Give or take two or three days on either end of that.

Dr. Natasha Andreadis: That's right. And I mean the menstrual cycle is very kind of sensitive to environment stress etc. So, I often ask patients do you want to do ovulation tracking to know when exactly it is that you are you ovulate or when there about. And they do ovulation tracking which involves blood tests and sometimes ultrasounds to look at the follicle count and hormone levels and they'll say oh, well, I didn't realise I actually ovulate a couple of days before I thought I did. And you know I'll use the trackers the ovulation predictor kits that they'll buy over-the-counter. So, it can change with every month and I see so many women that if they don't ovulate on day 14 every single month most women don't, you know.

Dr. Ron Ehrlich: Yep, yeah, but there be a there'd be a three or four-day range on either side of that probably.

Dr. Natasha Andreadis: Yes.

Dr. Ron Ehrlich: Yeah. And then and then during that time that would be obviously the time to be having sex you know, every night or second night. How long the sperm is how long his sperm vital or fertile?

Dr. Natasha Andreadis: Oh, yeah. Sperm can live in the in the genital tract for five to seven days but the ovulated egg only has 24 hours to be fertilized so the sperm has to really be in the general track before the egg actually ovulates.

Dr. Ron Ehrlich: Okay. So, that I thought that was important to get you to know some basics there as well as the comorbidities but people then often you mention you also part of your clinic is dealing with people that have IVF and that's really… the IVF clinics is a bit of a something that concerns me about them is that there's a bit of a business model problem there because the more goes that people have the better the business is but then there would be a conflict of interest about preparing the person for the best chance to get the first go.

Dr. Natasha Andreadis: That's right. So, when I first moved into the world of reproductive medicine and you know, I was exposed to corporate medicine. I was wow this is interesting but all I know is as I know, I practice with Genea group of fertility doctors based in Sydney, obviously, all-around Australia and they export their technology elsewhere. All I know is that doctors are really, really wanting to get patients pregnant within the first cycle, so the ideal IVF cycle is you create a number of embryos, ideally you put back one fresh they get pregnant and then they've got a small bank of embryos that then they can use later on.

So, now certainly my ethos, my aim is to get someone just pregnant and have a few kids in the fridge with just one cycle.

Dr. Ron Ehrlich: Yep and that's part of preparing them for it which is exactly what we've been talking about.

Dr. Natasha Andreadis: Yeah and I know the first cycle was always kind of tricky because it is a test run you don't know how someone's going to respond to a drug. When you give them an IVF drug when you're stimulating someone's ovaries you don't have that much control over what those ovaries are going to do. So, I say to patients often the first IVF cycle is a test run and then if things don't go well with that first cycle you don't get pregnant then we have an opportunity then to then improve on that with hopefully the second cycle. And the majority of patients will at Genea get pregnant within the first three to four stimuli and I have not really had any patients go beyond that you know, because the technology in the laboratory for freezing embryos is improving and certainly pregnancy rates are higher when we use frozen embryos. So, because and the great thing about that is patients don't have to keep coming back to have the more involved invasive you know, ovarian stimulation and collection cycles which are more expensive too

Dr. Ron Ehrlich: Because it takes I mean it's quite a hormonal roller coaster the whole procedure, isn't it? I mean it's not just simple IVF you know there's a whole lot more involved there in terms of harvesting and ovulation.

Dr. Natasha Andreadis: That's right. Yeah, so it's daily injections. You know, we have different protocols but generally there's daily injections, monitoring, ultrasounds blood tests and then you do the egg collection and sometimes that can be disappointing for patients because you retrieve eggs and none of them may fertilise or you may not get any eggs or the eggs may be of poor quality or you may get embryos developing on the first day you get fertilisation and then by the fifth day of development they've all deteriorated, which in a way is also informative for patients and could explain why they're not getting pregnant naturally. So, when we look at embryo quality you know it tells us a lot about that couple.

Dr. Ron Ehrlich: And then, of course, the sperm quality's another side to that whole thing which we've already discussed and that must affect outcomes there as well.

Dr. Natasha Andreadis: Absolutely, does, yep.

Dr. Ron Ehrlich: Now this you know I guess this preoccupation with fertility and female problems is a reflection of my own family with my 31-year-old daughter and 28-year-old daughter and all that but women get older and there are other issues that you see in your practice and can you as we go as we've moved through the fertility stages you know, as women are approaching, let's talk about menopause a bit because I don't think we've covered that very much and that offers some significant challenges. When does menopause start typically for women? I know there's a big range but what is that range?

Dr. Natasha Andreadis: All those definitions I mean I say some women in their 30s who've gone through premature ovarian insufficiency, we don't call it failure anymore we used to call it premature ovarian failure, but we call it now insufficiency because we know that maybe a couple of these women will spontaneously ovulate and sometimes get pregnant that way. So, women can give to the menopause before the age of 40 and then you'll have a group that will get pregnant… oh, sorry go through the menopause after the age of 40 but before the age of 50 and then the average age of menopause is around 51.

So, when I described to people the menopause I draw a bell curve and I will say you know the majority of people will fall into this you know 51 age brackets but there are people on either side of this that will go longer with their periods or whose periods stop really early.

So, I think it's important to say the average and that it's and avoid words like normal or abnormal. And of course, depending on age and what age they go through it. It will have a different impact on their health and long-term health you know it is pretty devastating for a woman who is less than 40 to go through the menopause especially when she hasn't had any kids and she's wanted them quite badly. Luckily, we have we been able to offer patients egg donation, it's not for everyone but it is definitely an option for them. And women live a third of their life in the reproductive menopausal phase so you know, we once didn't outlive our ovaries and now we do.

Dr. Ron Ehrlich: Yeah.

Dr. Natasha Andreadis: It breaks my heart when I see patients who've been putting up with hot sweats, hot flashes night sweats for years because they were terrified of hormone replacement therapy thanks to you know, that big WHI paper that came out at the beginning in 2002. And so, how many more years on, I as a reproductive specialist and still trying to tell patients these are the pros and cons of treatment. And at the end of the day quality of life is so important you know.

Dr. Ron Ehrlich: Yeah. What I mean so… so, yes, the age range is wide. What are some of these problems associated? This is you know, I think it's important for us all to hear what some of the problems are. You mentioned night sweats and you know, poor sleep and all that but what are some of the other issues that faced with as women approached menopause?

Dr. Natasha Andreadis: Yes. So, menstrual disorders, heavy bleeding, heavy periods, a really quite common in the lead up to the menopause. So, when a woman goes to the menopause it's a bit like you know a light switch is not a flick on and off it's actually a dial down and in dialing down you will get a variety of different symptoms like irregular periods, heavier periods and the vasomotor symptoms you know. So, the hot flashes the night sweats are really the most common symptom that women complain of weight gain, depression, issues with sleep, pain with intercourse because they get more of a dry vagina. So, these are the quite common things that you see.

Dr. Ron Ehrlich: Yeah. And what I mean you've mentioned hormone replacement. I want to ask you a bit about that but from an integrative perspective what are some of the things that I guess it's all of these things, isn't it? It's one thing to focus on sleep but if you can't sleep what should we be doing? What are some of the measures that women can be following to help them through this period?

Dr. Natasha Andreadis: Yeah, just informing them of sleep hygiene as well. These are the reasons why you may be hot flashing at night, but it could be because of other reasons. So, I talk to them about you know Wi-Fi in the bedroom and getting a good kind of night-night shade so that they're not exposed to a night light. I think it's important to do that and yeah, I

like to prescribe kind of not kind of herbal sleeping remedies to help them. I think invariably though estrogen is really quite a powerful thing in managing most of the symptoms from the menopause.

So, I have a low threshold for prescribing when menopausal hormone therapy but often use it in conjunction with say the non-menopausal hormone therapies like herbal treatments you know, exercise all that. You've got to bring it all together and also ask the patient what are you comfortable with? You know do you want to trial the non-menopausal hormone therapies first? I mean a few weeks ago I had a woman who came in and she'd been having hot flashes night sweats for three years really hadn't had any good sleep broke down in my rooms and I said look really, I think the best thing for you is going to be oestrogen because you could just see she was at wit's end and the quickest way to for her to actually feel better was to give her that and I explained that to her and she said just give it to me you know.

Dr. Ron Ehrlich: Can you just run us through hormone therapy, hormone replacement therapy 101? I mean you know it's a word I've heard a lot of but I'm not sure I totally understand the range of options.

Dr. Natasha Andreadis: Well, there are many options and essentially, it's about understanding what happens when a woman goes through the menopause. Essentially, she's making less estrogen and progesterone which causes her to have a variety of symptoms as we talked earlier.

So, you've got estrogen-only therapy and that you would give someone who doesn't have a uterus. When a woman has a uterus, you have to keep give her sample one for gesture or progestin because if you give someone just estrogen who has a uterus then that you're risking build-up of the lining of the uterus which we call endometrial hyperplasia which would then lead to endometrial cancer.

So, that's pretty much the most important point there in terms of what do we have up our sleeves. You know you can give women patches you can give them tablets, there are different strengths of patches, you can give them only you know vaginal therapy for example so if a woman's only symptom is dry vagina with intercourse then you can just give her estrogen-only vagina therapy. We have the Mirena IUD, so we have our IUDS that you can insert that kind of release a small amount of progesterone to protect the uterus. You have creams, you have gels. So, yeah, there are so many things that we can give women and that's one thing I like about managing the menopause because we have so many options.

Dr. Ron Ehrlich: And why has it, you know, what's been the bad publicity about why people have been concerned about this?

Dr. Natasha Andreadis: There's a big paper that was published in 2002 that said you know women who are on HRT significant risk of breast cancer and you know, there are that was such a really a very interesting time, it did mean that a lot of women were basically stopped off their hormone replacement therapy, a lot of women did suffer and then yeah there's been many people who've dissected that paper and the papers following that criticising this study is looking at the women who were recruited as part of that the hormone replacement therapy

that they were actually taking was probably not the best and it's really changed for that I think for the better what hormone therapy now we give women and you know, I think one thing women don't understand is if I drink more than two drinks of alcohol a day and if I lack regular exercise and I have morbid obesity my risk of dying is higher than if I say take HRT for five years.

So, it's about putting it into perspective as well. Putting risk into perspective is really important and when you do that for patients, so they've got oh, okay, you know, but at the end of the day the woman has to feel comfortable with what she's taking because if she is taking menopausal therapy and she's just not comfortable with it you know, that's going to nibble away at her and it's not going to be good. But I actually find when you put risk into perspective women are very receptive. But you know it's about really reviewing every year that a woman is in the menopause, how she's going and does she need to be on the therapy?

Dr. Ron Ehrlich: Yeah, yeah.

Dr. Natasha Andreadis: You know it's been someone away and go okay that's it for the rest of your life you're going to be taking this treatment, it's about let's review it regularly.

Dr. Ron Ehrlich: Is it just guiding or helping people through this part of their life? I mean do we you know, if you're if you're going through this change at some point say you are in your 50s and you've been on HRT through that five-year transition period, does that mean that most of those women are then on their HRT in their 70s and 80s?

Dr. Natasha Andreadis: Oh, yeah some of them are. Yeah, I'll never forget one lady that when I was doing a menopause clinic at Northshore during my training she was in I think 75 and she insisted on being on HRT, people were trying to get her off it, but she was like no, I got a much younger boyfriend you know, I need to be on an HRT. And I was like you go girl. l loved her and she is a very sprightly spirited woman and you know, wanted to live a quality life. Yeah, and at the end of the day she knew the risks of HRT and she was like nup I want it.

Dr. Ron Ehrlich: Yeah. So, from your perspective yes, this 2002 study raised some important issues which are important to keep questioning, we need to keep questioning what is considered normal treatment but there are so many options that people just need to be aware of them and monitor. There's not one simple answer.

Dr. Natasha Andreadis: There isn’t, and you know is not one simple patient that will just fit every you know and tick every box so that's where it's interesting as a practitioner to discuss you know, the current literature. Yeah, and to be informed of current and new developments in the area.

Dr. Ron Ehrlich: Now, Natasha, you mentioned they're just very quickly hysterectomy and I know that's something that does happen, and I wonder if you could tell me firstly why a common… what are the common reasons why women would have a hysterectomy?

Dr. Natasha Andreadis: I'd say fibroids and adenomyosis.

Dr. Ron Ehrlich: Hang on. Fibroids and…?

Dr. Natasha Andreadis: Adenomyosis. So, I don't do hysterectomies anymore being a very specialised type of gynaecologist but what I know is that fibroids are very common particularly as women get older and they can, they're basically collections of smooth muscle within the world the uterus that can significantly cause a bleeding and it's usually because of that women tend to have a hysterectomy for fibroids. I don't know meiosis which is kind of the cousin of endometriosis is when the lining the glans of the uterus, the lining of the uterus grow into the muscle, the wall which can cause quite severe pain for a lot of women. Prolapse is another reason why women may have a hysterectomy, but it's usually, usually related to bleeding.

Dr. Ron Ehrlich: Right. Yes, we did a whole program on endometriosis. Oh, my God I just never fully I knew it was a problem, but I didn't realise what a huge problem it was.

Dr. Natasha Andreadis: Yeah, it is and I main issue I think with that is its diagnosis you know, diagnosis really does require a laparoscopy.

Dr. Ron Ehrlich: Yeah. And I and I heard that diagnosis on the average for women was seven to ten years. In fact, you know, we were talking to Kate Powe and she was she taken 14 years. 14 years to be diagnosed, wow.

Dr. Natasha Andreadis: Yeah. That's way too long.

Dr. Ron Ehrlich: That's incredible. And what are some of the challenges? I mean with the hysterectomy? Once a hysterectomy is undertaken you mentioned that progesterone was a must or is that right? Did I hear that correctly?

Dr. Natasha Andreadis: So, someone you mean when someone's had the uterus out?

Dr. Ron Ehrlich: Yeah, yeah. What were some of the challenges they're in or how do we compensate for this obviously important organ being removed?

Dr. Natasha Andreadis: Well, you know what? Some people don't miss it when it's gone because you know it was causing them so many problems when they had it. You know I know the French for a while were leaving the cervix behind because I put it in play an important role in intercourse and satisfaction and with intercourse but most people will remove the cervix now being part of the uterus and it does save women from having to have pap smears. Provided they had a normal cervix when the uterus was removed in the first place. So, yeah, women you can get scarring anytime you have any operation you can have internal scarring and then internal scarring like adhesions can then lead to other problems.

Dr. Ron Ehrlich: But a better hormonal replacement is not a must? It's not a kind of oh you've had your hysterectomy you must have…?

Dr. Natasha Andreadis: No, unless the ovaries are removed. If you remove the ovaries at the same time and depending on the woman's age, she will probably require oestrogen.

Dr. Ron Ehrlich: Okay, okay, okay because there are of course partial or full hysterectomy and a full hysterectomy would include the ovaries, the fallopian tubes, the uterus and the cervix?

Dr. Natasha Andreadis: Yes. So, we call that TAH-BSO. So, total abdominal hysterectomy bilateral salpingo-oophorectomy. So, “sal” means being the tubes and 'ooph' being the ovaries.

Dr. Ron Ehrlich: Wow. Well, people are going to have to read the transcript for that one. Say that again, come on, say that again.

Dr. Natasha Andreadis: Total abdominal hysterectomy and bilateral salpingo-oophorectomy. So, bilateral means both sides and salpingo is the Greek word for sopping seeds, the tube for being tubed in and uterus being the Greek word for ovary.

Dr. Ron Ehrlich: Yeah. Well, we've certainly covered some territory here Natasha. Well, just before we finish I just wanted to for you to take a step back from your roles as an integrative gynaecologist and fertility specialist and just if I was to ask you what do you think people's greatest challenge is for them on their health journey through life? Not just women, not just women.

Dr. Natasha Andreadis: Not enough downtime.

Dr. Ron Ehrlich: Okay.

Dr. Natasha Andreadis: Not enough you know looking up at the sky, you know, looking up at the sky through trees, lying under a tree. People are too connected to their mobile phones I think. So, too much too much external stuff going on not enough internal. So, I think people just need to chill out a bit more. Easier said than done.

Dr. Ron Ehrlich: Yes. Something we all aspire to, but I think that's a good message for us to finish on. Natasha thank you so much for joining us today. We've covered so much territory there we'll have links to your website and it's been great to talk to you.

Dr. Natasha Andreadis: Thank you, Ron, thanks for having me on.

Dr. Ron Ehrlich: Notice how irrespective of the topic we cover on this podcast there are some common themes. Sleep always keeps coming up. Without a doubt the most important part of the day for your physical mental and emotional health and sleep hygiene. Well, Tash referred to that and I just like to add as we get older the issue of snoring and disturbed sleep is not to be ignored. It's not a joke, it's not a throwaway line believe me I've been there. If you accept it's the most important thing for a person's overall health and assuming you truly love and care about the person you are lucky enough to share your bed

with then do something about it. Episode 7 with Dr. Anup Desai and episode 9 with the Sleep Whisperer himself Dr. Chris Winter. Go back and listen to that.

Diet, exercise informing encouraging our patients to be well even better in form than we are. Assessing risks getting them involved thinking holistically. Look we're gonna have links to Dr. Natasha's website it has got some great resources there so if there were any things in this episode you wanted to explore more visit the site. She's got her own TV station or YouTube station some great blog posts and response to questions. So, get on to that website.

Hope you've been enjoying the podcast it's hard to believe we're coming up for our first six months. So, they've been just so many great guests, so much great information. For me personally, it is such a treat to talk to these fabulous people of varying perspectives on what goes in to make us what we are individually and globally. So, until next week, this is Dr. Ron Ehrlich, be well.

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