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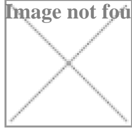
Clinical Pearls for Testing and Prescribing Hormones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Liz Sutherland, ND (LS) had the pleasure of speaking with Amy Day, ND (AD). Dr. Day will be presenting at the 2019 Restorative Medicine Conference in San Diego in September.

LS: Dr. Day, tell us about your background and your journey to becoming a naturopathic physician.

AD: I grew up in Florida, in Miami where we didn't have naturopathic doctors or much natural medicine at all at the time. When I learned about naturopathic medicine it was just fascinating to me because I had been interested in nutrition and herbal medicine. I was also a science, engineering and math kind of person. I really like understanding how things work and the logic behind things, but I recognized that in medicine, and when it comes to health and healing, there's so much more to the body and to what healing really means beyond what we really understood in science. Naturopathic medicine seemed like a beautiful connection of the science and the art of medicine.

LS: What is the focus of your clinical practice?

AD: I'm exclusively a women's health practitioner. My practice is only women, or people with women's parts, whatever gender they identify as. I've been specializing in hormonal aspects of women's health for the last eight years or so.

LS: What kinds of health issues do you mostly treat?

AD: PMS, menstrual issues, PCOS, endometriosis, and perimenopausal/menopausal health issues.

LS: Talk us through how you typically assess and treat a patient.

AD: I do a really comprehensive initial intake. I think it's really important to get to know the whole person and be able to connect. I have an annual membership practice, so I work with people over time to establish rapport and help them see how health fits into their overall life. Take for example a patient with PCOS. I take a very thorough history because a lot of women with PCOS don't know that they have it. With some women it's pretty obvious, and their other doctors have noticed it and diagnosed it. But there are subtle versions of PCOS-like presentations where women are falling through the cracks with their other doctors. They think, "Something's wrong with me and no one knows what it is."

LS: What will alert you that this might be a PCOS patient that their doctors haven't diagnosed?

AD: The kinds of things I look for are acne and facial hair growth, irregular periods, and weight gain. When you take the totality of those things it starts being obviously PCOS, but if there's only one piece of that and other signs and symptoms are normal, that's when other doctors can write it off and say, "That couldn't be

PCOS." A patient may or may not have cysts on the ovaries. That's confusing from the patient point of view because the condition is named polycystic ovarian syndrome, but you actually don't have to have ovarian cysts to be diagnosed with PCOS.

LS: Do you have a typical treatment plan for somebody with PCOS? I know you will tailor it to the individual, but are there certain therapeutic approaches that are foundational for any patient with PCOS?

AD: It's very tailored. I really work with what's going to work for that patient and help them figure out the next step from wherever they are. But, to give an overview, one of the really important underlying factors with PCOS is insulin resistance. I treat almost every PCOS patient as having insulin resistance, even if their blood levels are normal and they're not showing up as being pre-diabetic. There is still subtle insulin resistance going on for most cases, so it's really important to work more aggressively than you might with someone else on blood sugar regulation through diet, exercise and herbal and supplemental support.

I look at the hormone balance aspect as well. There's the metabolic side and the endocrine side to PCOS. I look to optimize adrenal and thyroid function, and then at the balance of the sex hormones to see if they're high in androgens, so that I can support them through diet, herbs and nutrients. Oftentimes there can be an estrogen and progesterone imbalance as well, especially if they have irregular cycles. You need to watch for estrogen dominance because very often the PCOS patient is not ovulating or having delayed ovulation. That can lead to a lack of progesterone, and that's an estrogen-dominant situation that you want to work with balancing as well.

LS: Do you prescribe bioidentical hormones?

AD: I do when it's appropriate. I think of our interventions as a pyramid, where the base is lifestyle and we work with nutrition, fitness, sleep, stress management. All the things people can do in their choices every day. Then, moving up, when lifestyle changes are not enough, to herbs and supplements to address particular imbalances. Then, if that's still not quite managing things sufficiently, going up the pyramid further to bioidentical hormones.

LS: What kind of hormone testing would you do to make your decision about whether to prescribe hormones?

AD: I do a combination of testing between blood, urine, and saliva. So, it's complicated.

LS: Do you mean for different hormones you might use a different test or for different patients?

AD: I'll always do blood testing for thyroid, but in terms of the sex hormones I test the urine for hormone metabolites and look at how the body is processing everything. Blood tests are good if you want to get test results back really quickly if you're trying to adjust a treatment plan quickly. I think progesterone levels are really hard to measure in any kind of test, but I probably utilize urine and blood testing the most often.

LS: What about testing for adrenal hormones?

AD: I think the gold standard for adrenal hormones is the four-point salivary test, but more and more I'm using urine panels that include diurnal cortisol patterns.

LS: In the instances when you prescribe progesterone do you prefer an oral or topical form?

AD: It depends on what we're trying to accomplish. If I want to have some of the mood and calming effects, like for insomnia and anxiety, I find the oral form to be more effective. If we're trying to regulate local pelvic health, like heavy periods, fibroids, or endometriosis, I use vaginal progesterone either a suppository or a mini

insert that is inserted vaginally in the second half of a cycle. That works wonders for local effect because of the first-pass uterine effect.

Topical progesterone cream I find is a little harder to monitor because there are so many variables with how well it's absorbing and how much is really getting in, but it can be a nice easy entry point for some people because it's available over the counter and can be a mild support to start with. When I really want to make sure that I am treating someone with progesterone in a way that I can monitor and follow more accurately I'll use either oral or vaginal forms.

If a patient is on bioidentical hormones that include estrogen they must take progesterone if they have a uterus. There's more evidence to support oral dosing of progesterone at least 100 milligrams a day, or 200 milligrams two weeks on and two weeks off if they're still cycling. That's what's required to balance estrogen and protect the uterus from hyperplasia and endometrial cancer. So with postmenopausal women I'm much more likely to use oral progesterone for that reason, just to make sure.

LS: Also, women have receptors for progesterone throughout the body, not just in the uterus.

AD: Absolutely. I think it's ridiculous to not give progesterone because someone doesn't have a uterus. Progesterone does so many good things throughout the body, and it really needs to be there to balance estrogen in almost all cases.

LS: Are many of the patients that you see on synthetic hormone replacement therapy? If so, does that have an impact on how you approach your treatments with them?

AD: I often switch patients to bioidentical hormones. But even in conventional medicine now, they frequently use bioidenticals of some kind, like the patch or oral prometrium. Sometimes it's a matter of fine tuning the delivery method or getting the balance better: Instead of only E_2 I'll use bi-est to get the protective benefits of E_3; or, the patient is on estrogen only because she doesn't have a uterus, so I go ahead and add progesterone.

LS: What's your professional opinion about using hormones such as pregnenolone or DHEA that don't have receptor sites but are used by the body to synthesize other hormones down the line?

AD: I don't use pregnenolone in my practice. I know it's a common approach because of its upstream support, but I want to provide what I know the patient needs and be able to monitor its effects and levels. I'm more likely to give estrogen, progesterone and testosterone and fine tune them based on the patient's symptoms and follow-up labs. I do use DHEA. I do a lot of work with adrenal health, which involves regulating cortisol and DHEA. Also for androgen support, some women don't want to use testosterone, although I do prescribe that when appropriate, but DHEA can be a nice support instead.

LS: When you prescribe testosterone for women what form do you prescribe it in?

AD: Almost every time as a vaginal insert or a concentrated cream that gets applied to the labia. Sometimes I'll prescribe it as a cream to be applied to the inner thigh or wrist, but it's much more reliably absorbed when applied to labial or vaginal mucus membranes. It reflects well on blood tests, and we can really fine tune the dose accurately.

LS: Do you generally find that to treat a thyroid health issue you have to provide support for the adrenals?

AD: Yes. The thyroid is often impacted by adrenal health. The thyroid and the adrenals are at the foundation for sex hormones as well.

LS: Is there anything else you would like to add before we finish up?

AD: I talked about PCOS, but I want to emphasize that patients with endometriosis can also be misdiagnosed or fall through the cracks. In the case of endometriosis, the patient will say she's having painful periods, or bleeding issues – something's going on that the doctors just aren't taking seriously. There's a lot of shame in our society and a lot of normalization of period problems and pain. When a woman is experiencing a lot of pain with her period it can take a lot for her to bring it up with her doctor and really be honest about how bad it is. I want to encourage clinicians to be on the lookout in our intakes, to really listen for when endometriosis may be a part of the picture.

LS: Thank you so much. That is really a great reminder to clinicians everywhere.

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