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The Many Manifestations of Hormone Imbalance

Hormone imbalance is the root of health concerns ranging from monthly migraines, bloating, mood swings, weight gain and under-active thyroid to osteoporosis, heart disease and both benign and malignant processes of the reproductive system. Men are also subject to hormonal imbalance issues including hair thinning and balding, loss of bone density and even prostate conditions. Women and men alike are now caught between their desire to avoid or minimize the impact of these seemingly inevitable problems versus their concern to avoid the risks and side effects of treating them with the synthetic solutions given to us so quickly by the mainstream medicopharmaceutical approach.

The recent release of the fourth edition of my book, "The Estrogen Alternative (A Guide to Natural Hormone Balance)," which is co-authored by Raquel Martin, examines the multitude of disorders that women deal with from puberty to PMS to post-menopause. For all too long, the physiological effect of estrogen has been misunderstood and the advocacy of estrogenic solutions—whether they’re synthetic, bioidentical or phyto-estrogens, such as soy—have been oversold to the public. A paradigm shift is sorely needed.

The book examines the multitude of factors involved, but focuses on the relative ratio between estrogen and progesterone in both men
and women. It explains the underlying causes, environmental as well as endogenous, that lead to estrogen dominance and its counterpart—progesterone deficiency. Based on extensive documentation, research reports and clinical results, I have found that progesterone deficiency, not estrogen deficiency, can underlie a myriad of disturbances. The amount of these hormones that the body produces can vary from day-to-day and month-to-month depending on a whole host of factors such as: stress, exercise, nutritional habits, spinal subluxations/misalignments and even the body's level of acidity. Many doctors, as well as the patients they treat, are unaware that bioidentical, botanical progesterone acts to oppose the many negative consequences of chronic estrogen dominance.

"The Estrogen Alternative, 4th Edition," details the latest research on natural hormone balancing, including alternatives to synthetic birth control. It gives a rationale for the dangers involved in menstrual suppression, be it via shots, pills or implants, and encourages women to look into natural contraceptive approaches rather than the more convenient, quick-fixes that are being promoted through expensive advertising campaigns. It also explains the profound impact of cumulative chemical saturation at the cellular level due to the molecular breakdown of pesticides, plastics, petrochemicals and the many synthetic compounds found in personal and household care products. In this article, I'll address the synthetic therapies versus natural hormone approaches regarding the many manifestations of hormonal imbalance.

**ENVIRONMENTAL ESTROGEN MIMICKER & XENO-ESTROGENS**
An estrogen mimicker is any molecule that can bind to an estrogen receptor site and create an estrogenic cellular response, thus acting as an endocrine disruptor. These molecules are found in a multitude of commonplace substances from pesticides to fertilizers and growth additives to all of the various plastic and petroleum products. One of the main physiological actions from such estrogenic stimulation (be it exogenous or endogenous) is cellular replication or proliferation, which can lead to unwanted cell overgrowth. Unfortunately, we are continually introducing more chemical estrogens (xeno-estrogens) into our environment—including our food supply—that's setting our bodies up for a multitude of disorders.

**ESTROGEN DOMINANCE AND/OR PROGESTERONE DEFICIENCY**
There is an alarming "epidemic" of estrogen dominance and/or progesterone deficiency among women (as well as children and men too) in industrialized nations that use petrochemicals and whose food supply has been subject to chemical fertilizers and growth hormones. Over the past 15 years of investigation in the area of hormone imbalance, we found women who experience the uncomfortable symptoms associated with PMS through post-menopause, may actually have a condition of estrogen dominance in combination with progesterone deficiency—not estrogen deficiency as they are most often told. It's easy to see how estrogen has the upper hand and is doing a lot of damage without its essential partner, progesterone, to balance and oppose it.

True, estrogen does decline with biological aging; however, in most cases, progesterone is lower than estrogen when a woman becomes symptomatic. This then creates a functional hormone imbalance and can manifest as hot flashes, night sweats, menstrual or menopausal migraines, anxiety, depression, excessive uterine bleeding—the list goes on. Unfortunately, instead of recommending a bioidal progesterone to correct these imbalances, doctors typically prescribe synthetic hormones such as an oral contraceptive or Premarin (Pregnant Mares Urine, containing powerful estrogens), with or without a progestin (synthetic progesterone). The body cannot properly utilize these synthetic hormonal substances. These factors may account for uncomfortable symptoms such as bloating, weight gain, the risk of blood clots, and the possibility of future benign or malignant cell proliferation in the breast, uterus, ovaries and/or cervix.

**BIOIDENTICAL & BOTANICAL PROGESTERONE THERAPIES**
Surprisingly enough, the wild yam is the original source material for hormonal therapies. Dr. Russell Marker, a pharmaceutical chemist, discovered it in 1938. He went to Mexico to find the plant that was rumored to be a possible ingredient source for a synthetic birth control preparation. Since natural food substances cannot be patented, and because of the extraordinary health benefits of the wild yam plant, the pharmaceutical industry wanted to be able to make it a prescriptive medicine. Unfortunately, during this pharmacological processing, it is denatured and in its synthetic form gives rise to the potential for many risks and side effects. However, in its natural state, the Mexican wild yam is remarkable for its progesterone-like effect when extracted, concentrated and hydrolyzed. It took several decades for the natural health care industry to come into its own and to develop an effective delivery system for the active hormonal form of the molecule as is now found in bioidentical progesterone. Today we have the benefit of many such pure and/or organic transdermal or sublingual formulations.
SYNTHETIC PROGESTINS VS. NATURAL PROGESTERONE

Provera, (medroxyprogesterone acetate) a synthetic progestin, is often erroneously called progesterone by some doctors, and prescribed mainly for its ability to induce shedding of the lining of the uterus when its dose is halted (as on day 26 of birth control pill use). Although this chemically-induced menses results in uterine bleeding, it should not be considered the equivalent of a biologically-induced menses that comes as a result of a woman’s own hormonal biorhythms. These cyclic patterns, synthetic versus natural, are extremely different and should not be equated. Unfortunately, Provera, and other synthetic progestins, are prescribed when women complain about the side effects of estrogen dominance such as bloating, weight gain, breast tenderness, anxiety, mood swings and sleepless nights. However, the addition of progestins to estrogen is like adding fuel to an already hot fire.

Such was the evidence of the 2002 World Health Initiative study which resulted in Prem-Prol (the combination of synthetic estrogens with synthetic progestins) being pulled off the market after only three years into what was supposed to be a 10 year longitudinal study, which would be the largest investigational study of HRT to date. It can’t be stated often enough that Provera, or other progestins, are dangerous and have grave risk factors as the body cannot properly utilize these artificial substances. Unfortunately such use often results in side effects far worse than the original complaints. The 2002 study was halted due to cases of stroke, heart disease and breast cancer occurring far earlier than is considered appropriate. On the other hand, natural progesterone has a broad spectrum of physiological benefits in the restoration of hormonal balance with no such risk factors to worry about.

CHOOSING A BIOIDENTICAL HORMONAL THERAPY

I think it is very important to point out that during any/all our life stages and ages, we can feel the effects of an imbalance between estrogen and progesterone. In almost all cases, we are estrogen dominant, rather than estrogen deficient, in combination with a deficiency in our levels of ovarian progesterone. Bioidentical progesterone use has been found to alleviate symptoms ranging from puberty to PMS to peri- and post-menopause. It has many physiological roles and is welcome for its ability to normalize thyroid functioning and thus to help the body burn fat for energy; to act as a natural diuretic and thus reduce the symptoms of premenstrual bloating; to provide an anti-spasmodic effect and thus help in the treatment of fibromyalgia; and for its role as a calming agent, thus helping to relieve anxiety and depression. It has been found useful in dealing with the following:

- irregular menstrual flow, severe cramping, endometriosis
- hypoglycemia, chronic fatigue syndrome, yeast infections
- bloating, irritability, mood swings and other PMS symptoms including menstrual migraines
- infertility issues, first-trimester miscarriages, premature labor and delivery
- hot flashes, night sweats, insomnia, vaginal dryness
- osteopenia and subsequent osteoporosis
- heart palpitations, high blood pressure and other cardiovascular disorders
- cellular overgrowth and proliferation in the breast, uterus, ovaries and/or cervix.

SUPPLEMENTING WITH PROGESTERONE OUTSIDE OF MENOPAUSE

Progestosterone deficiency usually begins in the early to mid-40s. However, in some women, progesterone levels begin to decline in the mid-20s to early 30s. This is often the case due to stress from accidents, surgery or other traumas (from fetal chemical exposures to environmental toxins), which can hasten the decline of this essential hormone. Another huge factor in accelerating the decline of ovarian progesterone is the widespread use of synthetic contraceptives. Young women are not informed that to protect them from unwanted pregnancies, the synthetic form of progestin is used to trick the ovary into thinking that conception has already occurred and that you are, in fact, pregnant. Thus, it does not release an egg due to the high levels of circulating synthetic progestins. In this manner, ovulation is prevented—which may very well be the desired effect. Unfortunately, and because it is dependent on the release of the egg, no ovarian progesterone is then released during the second two weeks of the cycle and consequently estrogen dominance is assured.

Should this continue month after month (and now year after year) as in the case of shots of “DepoProvera”, the use of the oral contraceptives “Seasonal” or “Lybrel,” or the surgical insertion of the chemical-filled rod “Implanon,” this important and vital event in the natural cycle is suppressed. These latest devices in the marketing of birth control create a chemically induced suppression of ovulation for anywhere from three months to three years. Given that the definition of menopause is one year without ovulation, all of these unsuspecting young women are entering into a condition that I have termed as “chemical” menopause. In a very short time such use gives our 20- and 30-year-old females the same hot flashes, night sweats, and bone loss issues faced by their mothers. This is an extremely dangerous trend. My hope is that this message is shared and women everywhere begin to question this type of physical, emotional and energetic suppression. It has gone on for all too long.

PROGESTERONE DEFICIENCY, CHRONIC ACIDOSIS & BONE DENSITY

Osteoporosis is a debilitating consequence of chronic acidosis in combination with lack of adequate hormonal stimulation (via bioidentical progesterone) along with long-term deficiencies in the micro and macro minerals. It is a major public health problem in the world today affecting both women and men and is the result of the progressive loss of bone mineral density. A surprising, and generally unknown fact, is that the greatest loss of bone density in women occurs the five years before and the five years after the onset of menopause. This comes as quite a revelation as most of us feel that osteoporosis is an “old person’s disease” as opposed to one that hits us, in what could be, the prime of life. Unfor-
Unfortunately, it is during this transition period that the bone loss is insidious and all too often goes undetected. It is not until several decades later, when our bone density falls close to or below the fracture threshold, that we begin to experience the deep bone pain that marks the onset of the microfractures that precede the inevitable gross fractures to come.

It’s very likely that what appears to be preservation and protection is just a false promise—one that is limited and temporary in nature.

An often overlooked ratio in bone health is one’s pH, or one’s acid/base balance. The current body of evidence suggests that with the standard American “fast food” diet and our high, chronic stress levels, we live in a condition that is more skewed to the acidic end of this scale. As such, we are setting ourselves up to be host to many degenerative conditions. With respect to our bone density, a chronically acidic metabolic state is one that cannot be tolerated for too long. When this is the case, the body searches for a way to buffer this situation in order to quickly neutralize the pH of the blood. It does so by stimulating the osteoclasts to break down the stored alkalizing minerals (especially calcium) and releases them back into the bloodstream. As this is the predominant process relative to chronic acidosis, this sets the stage for the unfortunate onset of osteoporosis with all of its consequences.

The other overlooked, but fundamental ingredient in the maintenance of bone density, is the proactive role that bioidentical progesterone plays with respect to bone health when compared to the more passive role of estrogen. Throughout our life, osseous breakdown (via osteoclasts) and buildup (via osteoblasts) is continually occurring and is known as bone remodeling. As long as these two processes are kept in balance, our bone density is maintained. Whenever the ovaries discontinue their production of progesterone and the osteoblasts are no longer directed to build new bone tissue, osseous breakdown is actively stimulated and we have the onset of osteopenia and eventually, osteoporosis.

A reduction in progesterone levels with its subsequent decrease in osteoblastic activity occurs during several conditions:
- during the transition from perimenopause to menopause
- with a surgically-induced menopause
- with exercise-induced bone loss
- with the long-term use of birth control
- OR, in men, with the age-related decrease in the testicular production of progesterone.

Yes, men do produce progesterone at the rate of 9-10 mgs per day whereas ovarian production is limited to the second two weeks of the female cycle and is produced at the rate of 18-24 mgs per day. Thus, both men and women produce approximately the same amount on a monthly basis. As such, progesterone is not a “female” hormone but one that has numerous physiological benefits for both men and women. For this reason, both sexes can support themselves with regular application of bioidentical progesterone.

ESTROGEN AND OSTEOPOROSIS

Estrogen was long advocated due to the fact that it keeps the existing bone in place by slowing down bone loss. This gives the appearance of holding off osteoporosis but, in fact, old bone is brittle bone and over time will eventually fracture. However, for many years estrogen was promoted as the gold standard in the treatment of osteoporosis as it was thought that it would be good enough just to slow down the rate of bone loss. But unless the osteoblasts are stimulated, there is no active new bone buildup as there was when the ovaries/testicles were producing adequate amounts of progesterone. This is exactly what supplying the body with transdermal progesterone can accomplish.

As of 1998, Fosamax was the only non-hormonal drug available for the treatment of osteoporosis and is still widely prescribed in spite of the risks associated with its use. It continues to be utilized in spite of the fact that its long-term studies were manipulated to make it appear that its use would prevent osteoporosis. The official studies were stopped just prior to the point (four to six years) at which fractures began for women taking similar medication (Didronel). Up to this point, bone density tests look positive as Fosamax slows down bone breakdown by the osteoclasts and thus keeps the old, more dense bone around. However, old bone is brittle bone and eventually, if this data were collected, it is probable that the fracture rate would increase sharply.

If Fosamax had no side effects or risks associated with its use, perhaps this delay in the onset of fractures would warrant its use. However, the story doesn’t stop here and unfortunately includes:
- the caustic and abrasive nature involved in the very swallowing of this toxic drug has been reported to cause severe, permanent damage to the esophagus and stomach especially if you lie down after taking it;
- the development of deficiencies of the very nutrients required in the prevention of osteoporosis (calcium, magnesium and vitamin D);
- the onset of multiple side effects such as “diarrhea, flatulence, rash, headache and muscular pain” plus possibility of damage to the kidneys, thyroid and adrenals;
- and, as of 2006, we have documentation that some women using Fosamax developed osteonecrosis of the jaw.

We must seriously begin to question the advisability of taking any drug that is prescribed under the guise of “protecting us from osteoporosis” and which, at the same time has, as a possible side effect, the destruction of the jaw. If Fosamax, or any of the other bisphosphate derivatives, carries such a risk, why is it prescribed to women to ostensibly preserve the bones of the skeleton? It’s very likely that what appears to be preservation and protection is just a false promise—one that is limited and temporary in nature; one that has far more consequences than most women bargain for when they are told to use such drugs to “protect” their bone density.

Dr. Judi Gerstung is a chiropractic consultant as well as a personal wellness coach and national speaker on hormonal and nutritional issues. To order copies of “The Estrogen Alternative, 4th Edition,” please visit at estrogenissues.com. You can contact her with further questions or to set up patient wellness consultations at: dr.judi.dc@gmail.com. For a more in-depth account and fully documented references, please refer to: “The Estrogen Alternative (A Guide to Natural Hormone Balancing), 4th edition, 2006” published by Inner Traditions International, Rochester, VT.