**SEXUAL ENERGY SERIES-5: New Options for Women's Sex Lives – Dr. Somi Javaid – #791**

Announcer:

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Dave Asprey:

You're listening to Bulletproof Radio with Dave Asprey. Today's episode is going to be a lot of fun, sometimes anyway, because we're talking about women, sex, and sexual wellness with Dr. Somi Javaid, who's a leading women's healthcare provider, a board certified OB/GYN with 15 years of experience, who's worked for all those 15 years on saying we've got to pay attention to women's sexual health.

I wanted to have someone on to talk about menopause, to talk about perimenopause, and all the stuff that is a part of biohacking for women. And it really matters even if you're not a woman in this episode because I promise you that when the women around you have their sexual health in order, they're probably going to be happier, higher performing, more present, and other stuff like that. So this is something that is very important.

Somi, welcome to the show.

Dr. Somi Javaid:

Thank you for having me. I'm very, very excited.

Dave:

How did you decide that you wanted this to be your focus when you went into medicine? I mean you could've looked at any part of the either sex's anatomy and specialize. Why OB/GYN?

Somi:

Yeah, why do I look at vaginas all day? I've been asked that numerous times.

Dave:

Yeah, pretty much. I wasn't going to quite go there like that. But yeah, okay, what's in the vajayjay?

Somi:

Lots of stuff, the key to the world. No, the reason I went into it is actually a very personal story.

I'm 45 years young this year. My mother nearly lost her life when she was 45 years old due to repeated dismissals at the hands of her healers. She had chest pain, left arm pain, shortness of breath. And if you Google those symptoms, or anyone who's not a doctor, will say it was cardiovascular disease. She had lost a mother and a sister in their 50s to cardiovascular disease, and her doctors patted her on the back and said, "Too much caffeine, your kids are stressing you out."

She ended up six weeks later coding, and nearly lost her life at the hands of her healers. And I remember looking at the physician who had challenged me and thinking, "I'm never going to be like you. Thank you for giving me the antithesis example of the way I'm going to be." I was premed at the time, and I decided that I was going to be an advocate for women, and not let another woman become an invisible patient and be dismissed and lose her life because someone can't take her seriously, or the science and data at hand can't explain why a 45 year old thin woman would have cardiovascular disease and nearly die from her quadruple vessel disease.

Dave:

Because she was a woman, and typically they see heart attacks as more of a male thing, they just didn't consider the obvious things?

Somi:

Correct. And women are left out of three out of every four major research studies, and the studies at that point couldn't explain why my mother ... She was thin, Middle Eastern, nonsmoker, didn't drink. Why this woman would have four vessel disease? Surely it was something else, and didn't take her seriously, and it nearly cost her her life.

And there's data even now to this day that women are more likely to die at the hands of their providers when they present with cardiovascular disease. They studied 580,000 women, and that data is true to this day. It's still happening to us.

Dave:

It's interesting too with Alzheimer's, where two thirds of cases are in women, but they look for it more in men. I've been pretty heavily involved and donated to Maria Shriver's Women's Alzheimer's Movement because these are things where we don't even have the race thing down where different races, different genetic backgrounds, can have different risk profiles and different genders. And I just figured this out the other day, but apparently women aren't just little men. Is that true?

Somi:

That's absolutely true. Yeah, we're not little men.

Dave:

Who would've thought right?

Somi:

We have different body parts, right. But these repeated dismissals, this lack of funding and science, has led to in certain conditions up to an eight and a half year delay in diagnosis for women. Women have to go to the doctor three times for every one time a male patient has to go. And I'm certainly not man-bashing by any means. Men deserve all the healthcare they have and more. It's just women have to work three times as hard to get a diagnosis. And it's not because women aren't making the effort and aren't starting the discussion. It's because providers are dismissing them.

Dave:

It's kind of funny. Since the very beginning of biohacking, the followers on the podcast and blogs and all that, it's always been very close, 50/50 men and women, and my experience has been that on average, women are better biohackers than men, if I was to just pick two random people off the street. There's some degree of self-awareness that I think women development because you tend to notice changes every month, and guys don't notice them because the changes we have are much more subtle so we can just ignore them.

So this, "Some days I'm off my game," is more like, "I drank too much last night," or, "I worked out too hard," but it's not just the cyclical stuff. So it's surprising. You go to the doctor and, "I feel that something is wrong," and then the doctor blows you off. I can all say fat people get the same thing. When I was obese, I'd go to the doctor and say, "I've been working out 18 months straight, six days a

week, and eating nothing." And he looked at me and goes, "No you haven't." Like literally just don't believe it because of that.

So there's a certain arrogance that I think was taught maybe two generations ago in medical school. And there's still some, but do you feel like it's getting better?

Somi:

I do feel like it's getting better-

Dave:

I do too.

Somi:

-For sure. I have peers that are like me. I have women and men providers that are changing things and changing the narrative and saying, "Okay, this was our history, and we're going to change things, and it's going to be different going forward." And even I'm involved in teaching and educating, and the biggest thing is changing the next generation of healers so that we are truly healers and we're listening.

And part of the other problem is our medical care system, it's broken. I mean 15 minutes. So I have my mom's story, I go into OB/GYN residency, get my first job and I'm thinking, "I'm going to change the world." And then the reality of medicine smacked me in my face. It's like you're going to see 51 patients. I didn't have time to take care of myself. How was I going to advocate for my patients? I'm running eight patients behind continually all day long because the healthcare system and insurance companies don't value extra time in room with patients, and so you're forced to see too many patients in one day and not be able to advocate for them or truly practice sound, safe medicine.

And so I left my job, bought a building, and opened a practice. Yeah, scary. Cliff dive.

Dave:

I've found that for me to get well and then to get the levels where I am now, I had to go to doctors who actually hated insurance companies. Some of the people who've done the best work for me literally will say, "I will not give you a code to give your insurance company because I don't want to talk to insurance company. I'm a healer, I'm not an administrator, and I just won't do it." And they've opted out of taking insurance, which sucks because if you're someone who relies on insurance to get care, that's a problem.

And so I'm always appreciative if I can bill something to insurance, but I also know that it's going to take two hours of time because the insurance company's going to back me up with paperwork and all that, and they'll back up my care provider because they know that then they won't have to pay it a lot. And that's a systemic problem, especially in the U.S., and it's different in different countries. I live in Canada now, where the problems are different, but honestly probably I would say it's a better system overall, as long as you still have the right to go say, "I need to buy something that the system doesn't think that I need because I am no better than a system."

That's a harder problem than solving let's raise awareness on women's issues, but you did something pretty cool, in fact the reason I wanted to have you on the podcast, is you opened Her MD in Cincinnati. And you said we're going to have sexual healthcare, normal OB/GYN stuff, adding in hormones which oftentimes is separate from OB/GYN and hormones are so important for anti-aging, I've been writing about that for years. But you also added vaginal laser therapy, which is life-changing, every woman I know who's gotten it, and you're doing pelvic floor PT and tying it in even with counseling on sexual health.

So you kind of hit it from every angle, a lot like the recovery angle that I'm looking at from Upgrade Labs. I don't know of any other full circle comprehensive clinic with that area of focus. Was this your brainchild? Did you stay up at night kind of figuring out what are all the angles we can hit this from? Or how did you come up with that, because I've not seen it.

Somi:

It's very rare. And what's even more rare is most of the sexual health mentors that I had, they told me, "Good luck, you'll never be able to do this with an insurance model." And I'm the kind of person when you tell me I can't do it, I'm like, "Watch me." And so I was like how can I bring a cash system into an insurance model?

So we also have a surgical center, we also do phlebotomy, so women don't have to go to another place to have their blood drawn. They have their surgery. We do imaging. Everything is done in the office. I wanted it as easy as possible, and I was not going to yet another barrier for women. I was not going to have what happened to my mother happen to my patients.

And so the fastest growing model in medicine is aesthetics, and you don't have do a residency, you don't have to be a plastic surgeon. I mean I'm not doing facelifts or anything that I shouldn't be doing. But we brought in a full-blown medical spa, which is cash, but women can choose to spend their dollars there. They don't have to pay to become a part of my practice. There's no concierge fees. And the med spa supports the medical side of the practice, allowing the providers to spend a long time with our patients and not to sweat the bottom line.

So I can practice good, good medicine. And women love it. They come in, they get their Botox, they get their Pap smear, they get their fillers, they get their ultrasound, all in one place.

Dave:

You're giving me hope. My Upgrade Labs Recovery Center for Men and Women, the one under my office here in Victoria, we're opening a small clinic. And that's exactly the model I'm looking for, which is I want the things that all of us want to be able to support the clinic so that we can help people get hormones and all the things they need, and hiring the right medical specialists to do that. Whereas if it was just a medical office, maybe it wouldn't work. But I think all of it together is going to provide a different way to do it where people are saying, "Some stuff that you go to the doctors office for, I needed wellness. I didn't need sick care."

But you stuck them together, and them you said specifically for women let's do this. Let's talk about the vaginal lasers because I just like lasers. Lasers are awesome. So sneeze peeing, vaginal dryness, these are serious problems, and I have lots of friends, and I don't know why people tell me all their medical stuff even though I'm not a doctor, and I've had some conversations like, "Seriously, you can't go on a trampoline? What's going on?"

So guys, if you don't know this, lots of women just kind of pee on themselves a little bit all day long after they have kids. What's up with that, and what do lasers do for it?

Somi:

So lasers are very, very fascinating, and you guys have gotten a lot further in Canada than we have. But I am a key opinion leader for a few devices. So we use CO2RE Intima in our office, and it is a CO2 laser which has been used for decades in gynecology in surgery, but basically you cause controlled injury. So it's just like create a very pretty pixelated pattern in the vagina. It's actually pretty painless, takes just a few minutes. And basically the brain says, "Oh, I've been injured. I need to repair myself." Lays down

new collagen elastin blood flow because as we age and even after babies, our vaginas if you break it down very simply are like accordions. They have these big, thick folds called [inaudible 00:13:05] so we can stretch and accommodate our partners.

And as we age, that tissue thins, and it flattens and becomes more like a tube sock. Tube socks don't stretch. It hurts. Angles change. The pressure in the bladder exceeds the pressure in the urethra. And so when you cough or try to jump with your children on a trampoline, you can pee on yourself. And this collective syndrome is called genitourinary syndrome of menopause.

And traditionally it's been treated with surgery or hormones, and we do all that in our office. But if there's a minimally invasive procedure that takes just a few minutes ... And it's been proven. Actually Health Canada gave the CO2RE Intima two indications this past year that the FDA has still yet to do. Both for GSM and for stress urinary incontinence. Now would you rather have a two minute procedure, or would you rather go to surgery?

So I teach other physicians how to do this in the United States. Our biggest battle is that despite the literature and despite the data, I've done clinical research trials with it, helping with a very painful condition called[inaudible 00:14:13], it's still not FDA-approved for all those other indications. It's just in the United States FDA-cleared for tissue regeneration.

Dave:

It used to be you could just hop in a car and drive to Canada and get all the care you couldn't get in the U.S. By the way, Canadians are all laughing at me right now because they typically have been absent. But right now, you can't really cross the border without a lot of quarantine issues, so we'll see what happens.

It seems like the FDA when it comes to vaginal stuff might be extra slow. As a matter of fact my wife, we talked about this at one of the biohacking conferences that I do. She had her own stem cells injected vaginally, and I mean it was a massive change, like losing 20 years kind of change, or gaining 20 years, getting 20 years younger. So that's also one of those things where I would say there's almost hostility towards it that I don't quite understand. How do you keep pushing the edges there when people are saying, "Well you're not allowed to do that," but that's what women need? How do you do that dance?

Somi:

I'm not shy, and I've been invited to the FDA, and I share my experiences with technologies and just clinically what's happening. And it's the FDA, but it's also ACOG that's really far behind. The American College of Obstetrics and Gynecology have put statements out warning against lasers, and I think we have to be careful with the claims that we make. You can't promise a 70 year old she's going to have a 19 year old vagina, it's not going to happen. But if you give people clear, concise expectations, education, education, education, and empowering women to let them know that they have these choices. I'm not going away, the technology's not going away, and these problems are not going away. So we have to address it and change things and make this a more palatable conversation.

Women have to have more choices than just going under the knife, or taking hormones if they don't want them. And frankly, some of my patients aren't candidates because of cancers or strokes or heart attacks, so we have to do better by women.

So I just repeatedly talk about it. I go to the FDA any chance I get. And then any time they tell me there's no data, we're like, "Okay, let's do a trial. I have 8,000 patients in Cincinnati. We're opening another center. You want research? You want data? I'll give it to you. I'll provide it."

Dave:

I love the data-driven approach. And it's really clear. The FDA, their desire is to protect people from predation, and there's always this delicate balance between if we have 15 studies, can we say it's true now? And they're like, "I don't really know." It's not just the FDA. Like I said, it's all the different medical boards and things like that.

And one of the problems that a lot of people listening might not know happens, by the time you get to be sitting on the board, you've probably been in practice for 25, 30 years, which means you went to medical school like 40 years ago. And now I'm going to be really blunt. If you look at the membership of ACOG, how many of them are old white dudes?

Somi:

A lot.

Dave:

Now as a not old and not planning on getting old anytime soon white dude, I really like vaginas, but I didn't study them with my life's work. But even so, it feels to me like there's a bit of kind of patriarchal vibe there that's always been there. And it's hard to create shift there, but it feels like it's happening.

Somi:

It is happening. There's people like me that aren't going away. But I can't tell you how many times when I have been considered for a key opinion leader position or have been asked to sit on an advisory panel, and they see my CV and they're like, "Great, we want you." And then they'll send in someone to meet me, interview me, and train me, and they're like, "We're looking for Dr. Javaid." I'm like, "All five foot two of her is right here." And they're looking at me, and I know what they're thinking. And I'm like, "What, just say it?"

And they're like, "Well you don't look like a typical speaker." And I'm like, "Lots of Botox," or I'll make a joke. And I'm like, "I took all the same tests. I did the training. I've been in practice a long time. I have a very successful practice. I see thousands of patients. I can do the work. But-"

Dave:

Do you ever think about adding some gray streaks maybe, just to-

Somi:

Dave, they're there, it's just colored over.

Yeah, so it is frustrating, but there are ... I mean I have some colleagues, and they're just as strong as I am, and we're not shy and we're not going away and we're going to change the movement, and we're going to allow women to come forward and say, "Hey, this is a problem and we're not going to take this anymore." And it means research and FDA, but you're right, it has to be evidence-based. We have to produce the data.

Dave:

It does.

Somi:

Yes.

Dave:

I've been interviewing a lot of people lately around women and fasting because only about a third of the studies on fasting account for differences between men and women. And I pulled them together and put a chapter in my new book Fast This Way about that specifically. And then it gets very interested because the rules, although they're broad category ways of thinking about it, they're very different nutritionally for women in their fertile years. And then you go through the roller coaster of perimenopause, and then there's a different set of things that generally work for menopause.

And what I'm seeing over the last 15, 20 years of working with people as sharing information, first on the nonprofit side then just on the Bulletproof side, is that women are way more willing to talk about perimenopause and menopause than they did before. You go back a while, it was almost something you didn't talk about, like an unkept secret. And now they're saying, "I'm having issues with perimenopause. What do I do?" I'm noticing these shifts, and they're just super open about it, which is awesome. And guys are getting that way a little bit more with erectile dysfunction too, although no one likes to talk about that. I've done episodes on all those things, having not experienced either menopause or erectile dysfunction. But hey, maybe some of what I'm doing kind of works.

But what I want to do now is ask you specific perimenopause questions, and then I want to ask you menopause questions.

Somi:

Okay.

Dave:

So when a woman says, "Okay, I'm about at that age where I'm probably going to start getting menopause or getting into menopause, and all the sudden what worked last year nutritionally, exercise, sleep, whatever, and it just stops working," what's the first thing they should do?

Somi:

Well, go see their provider.

Dave:

But you go see a provider and you're like, "I don't know, I don't sleep very well." "Here's some Ambien." Like, what do you ask your provider? Because you see your provider, you're talking about this whole universe of stuff, half of which you don't even recognize is tied to perimenopause.

Somi:

So I talk to them about weight gain being very, very common as part of the perimenopausal and menopausal years, and I'm a big believer in fasting. We talk about intermittent fasting. It's helped me on my own journey. But I do explain to them hormonally what's happening.

And so, FSH levels are increasing, which is slowing down their metabolic rate and causing them to deposit fat in areas they have never done, i.e. the middle aged spread. And we talk a lot about intermittent fasting in our office. We talk about weight loss medications. We talk about checking your hormone levels, and then making sure that they don't have thyroid dysfunction. The thing that-

Dave:

Thank you for saying that part. It's rampant, especially in women more than in men, right?

Somi:

And it's one of the biggest mimickers of menopause because it can cause temperature problems, sleep problems, and people go undiagnosed, especially women. And then changes with hair and everything else. So we look at all of those levels. And then if they're complaining about fatigue or anything else, we talk a lot about like I said fasting. I like to shift the blame away. So many women come in and they've been basically told to push away from the table, or they're lazy, or they're not exercising enough-

Dave:

It makes me so mad.

Somi:

And polycystic ovarian syndrome, that causes so many problems with insulin resistance. But basically I tell them about the study, and you're probably very familiar with this, but they took, and I'm not comparing this to mice, but they took two subsets of mice. They injected one half with FSH, making them menopausal, and the other half not, and then they got the same grain, same exercise. All, not most, all the FSH mice became obese. And so those are the changes that are happening.

And so I tell them, "It's not going to work anymore, not because you're to be blamed. And so we have to fix this, and there are things that we can do to change your metabolic rate and to keep you at a weight that you are confident at, that you want to be at." We also talk about goals and getting away from social media and what they perceive as perfection, and what a 50 year old needs to look like versus what they actually want to look like. And so, it's managing expectations and giving them real goals, and talking to them about their options.

Dave:

You said something that made me happy around changing metabolic rate.

Somi:

Yes?

Dave:

That is pretty much a function of how your mitochondria work. What are the tools you use for perimenopausal women to increase their metabolic rate so that their bodies do what they want them to do?

Somi:

Well No. 1, if there are any deficiencies in hormones, specifically testosterone, I will make sure that they're on testosterone so they have the appropriate muscle mass. I encourage exercise, and then obviously, like I said, rule out anything else. But I tell them to fast, and get their insulin levels to come down. And so those are the things that I recommend to them.

Dave:

Fasting for women is controversial because you have definitely eating disorders and they're a thing, and they're a thing for men and women, although a lot of guys with eating disorders become bodybuilders. Seriously, this is a thing. Not all bodybuilders by a long shot, but it can be like, "I'm just not happy, so I'm going to go for it."

But if you take that out of it, the fasting regimen that works for a guy oftentimes in my experience working 10 years of hundreds of thousands of people on the Bulletproof diet, is that it's a little bit too aggressive for women. Is there a schedule of intermittent fasting that you find works best?

Actually, let me ask you three questions in one. Give me the fasting schedule you like for women in their fertile years, women in perimenopause, and women in menopause. How does it change? Can't wait to hear this answer.

Somi:

Oh God. So this is not based on data, this is just based on what I'm doing in my office with my patients.

Dave:

Well clinical experience is data, it's precious data. It's actually the most useful data. It's just not like double blind placebo controlled blah blah blah.

Somi:

Okay, okay. So 14 hours for my younger patients, 16 to 18 for as you're getting into perimenopause and menopause. And personally, I'm finding that 14 no longer works for me anymore. I have to push it to 16 and 18. And depending on whether they're trying to maintain or whether they're trying to lose weight. And so when they've lost the weight or gotten to their goal weight, then we back down again and let them go back to 16 hours or 14 hours, whatever was working for them.

Dave:

Do you do this every day?

Somi:

Do I fast every day? Yes.

Dave:

Or do you recommend it for patients? You're seven days a week?

Somi:

I'm seven days a week right now, but-

Dave:

Wow, and that works for most of your patients?

Somi:

Yes, although I will tell you I'm seven days right now. You didn't ask the question because COVID was not kind to me, so I'm not at my baseline right now. So I-

Dave:

Oh, so you're losing some weight, so you're pushing it, okay.

Somi:

Yes, I'm pushing it. Yeah, there was too much wine and pasta in 2020.

Dave:

It happens sometimes, especially if it's really good wine right?

Somi:

Yes.

Dave:

The studies that I've seen. There's one from Dr. [inaudible 00:26:29] out of Australia who was just on the show. She was finding that even three days a week of 12 plus, ideally 14 or 16 hours for women, was having very meaningful effects on their metabolic rate, and it wasn't suppressing their immunity. But a lot of women I've seen go into this 14 hours a day is amazing and I feel really good, so I'm going to go to 16, and then I'm going to go to one meal a day.

And at a certain point, and this is almost like really predictable, I wake up and I don't feel good. I feel like I didn't sleep enough. And then even if they did sleep enough or they wake up in the middle of the night. And then they say, "Well now my cycle is not what it used to be, like things are getting irregular," and then they're getting thin hair. And it feels like they're getting too much cortisol, they're not eating often enough.

Seven days a week is pretty aggressive for a lot of women. How do you recommend they start fasting versus once you're used to it? Is there a gentler approach, or do you just go for it?

Somi:

No. It also depends on I have the ability ... So I have their labs in front of them, so I have their CMP, I know their insulin levels, I know their hemoglobin A1C. I also have their objective data with their weights and everything else.

Dave:

That helps.

Somi:

Yes. So if they're pre-diabetic or heading down a disastrous route, or if they're very resistant or they're scared, I'll tell them to start at 12. Just stop snacking after dinner. Stick to water, and in the morning have coffee with no cream in it. So small steps, baby steps, right, because I treat women with eating disorders. I don't want them to develop that because they're so fixated on this.

And then I tell them as it becomes palatable and they're feeling okay to increase. I also like you said, we have this multidisciplinary approach. I have providers who specialize in weight loss, and I also work with nutritionists to make sure that we're not seeing hair loss or we're not seeing vitamin deficiency. So because we have all of that available in our office, we're able to make sure that they don't fall into a negative pattern or end up causing more damage by trying to fix the underlying issue.

But the feedback I get is the cravings are better, like they actually feel better. They don't feel like they're in carb comas anymore. They're not craving [inaudible 00:28:47] foods. They have more energy. So for sure.

And with my polycystic ovarian patients, the PCOS plan is a book that I recommend that they've read, and so then they know that even during their eating hours what choices are better for food. And same way for calorie counting or points. I feel like that puts too much pressure on patients. And sour, hours seem to be a little bit easier.

But yeah, during weight loss, I will recommend seven days, and then maintenance obviously back down, and then obviously weekends let them have fun, let them relax, but absolutely.

Dave:

I recommend in the book that Saturday morning or Sunday morning, have breakfast. You don't have to fast every single day, and it doesn't have to be the same every day. Some days it's 14, some days it's 16 depending on how well you slept, depending on your readiness. And there's something I think is kind of magic about saying, "I'm going to have the pancakes. Maybe they're gluten free hopefully." But I'm going to do that every now and then because there's a ritual and a nourishing thing that happens there that's important for men and women. But the kind of militant fasting, unless you're doing it for a limited amount of time to try and lose weight, seems to be sustainable.

Somi:

Right.

Dave:

And what you said about energy, that's why I wrote a book fasting. The typical book on fasting is step one, don't eat for a while, step two it's good for you. But most people won't do that for a long period of time, or they over-fast after a while, and then you end up with all the stuff that you've seen in labs. So the idea that you're working with data is cool.

Do you ever use continuous glucose monitoring with patients?

Somi:

No, I don't do that. If I need something like that, then I will send them on to someone who specializes in that, either endocrine or we have a lot of functional medicine specialists in Cincinnati who will help me with that kind of stuff.

Dave:

Okay, cool. I've been doing that. I have one on right now, this is the Levels one.

Somi:

Nice.

Dave:

You're supposed to have the Levels thing, but I don't need the sticker. And for guys and women listening, Levels.link/dave puts you to the head of the line. There's a long waiting list to get them. But it's one of these things, it's about 199 bucks a month to get the sensors mailed to your house. And then, if

you're trying to get not insulin resistant, and you can see what every meal did to tell you maybe that glass of wine and that pasta, maybe I should've put some more butter on that pasta? Or whatever the thing is, but you get to play with it and see. It's been revolutionary for me just to be able to have knowledge of whether did what I thought would work actually work today versus tomorrow.

Somi:

And then insulin levels, we know, go beyond just the weight. We know that insulin resistance can lead to cardiovascular disease and certain types of cancers, and they were looking at metformin to reduce insulin resistance to decrease our risk of breast cancer. So it's very interesting to me about making sure people don't have insulin resistance to develop secondary conditions that were preventable.

Dave:

Well I'm hopeful that we all realize that fasting is a normal and healthy thing to do, and that no one's going to die if they skip a meal, and that's ... It sure feels like you're going to die if you skip some meals if you're into cravings, but for me to have no cravings, more energy, it sounds too good to be true. Like you mean I didn't have to make breakfast and I felt better? But that is really the experience of your patients it sounds like. It's your personal experience. So I want everyone listening this is possible, really it's okay.

Somi:

Yeah, no, for sure.

Dave:

There's some other things that happen if you over-fast, or if you just are going through aging in women. Low libido, talk to me about why that happens.

Somi:

So many reasons. So low libido is multifactorial. I tell people imagine walking into a cockpit of a plane and looking at all those buttons and dials. So it can be relationship, if you don't like your partner or you're not attracted to your partner, that has a lot to do with it. Neurochemistry, if we have too many inhibitory signals in our brain and not enough excitatory signals. Hormones, as we age our ovaries produce less and less testosterone. There was a consensus statement two years ago that testosterone is key and vital for women in all the domains of sexuality.

Our lifestyle. You're working third shift, he's working second shift. You have young babies in the bed. Medications, illness, stress. You're stressed about money. You're stressed about the pandemic. There are so many things that can interfere with sexuality, and the truth is that one out of every 10 women struggle with something called HSDD. We changed impotence to erectile dysfunction. We call low libido, which I feel like blames women, hypoactive sexual desire disorder. And one out of every 10 women suffer from it at some point in their lifetime. And we have to decide when they need treatment.

And as of 2015, there were zero treatments on the market. None for women. And now we have two that are FDA-approved, and then we have a few that are off-label treatments, meaning they're indicated for something else, but there's FSFI data, Female Sexual Function Index data, proving that libido does increase if you prescribe these medications.

Dave:

And these are ... They've stopped naming medications that you can pronounce. Addyi, A-D-D-Y-I, and Vyleesi. Who names these things?

Somi:

I don't know.

Dave:

Addyi, what is that?

Somi:

Addyi.

Dave:

Addyi, is that how you say it? All right.

Somi:

Yeah, Addyi.

Dave:

So I have never experienced the effects of these drugs because Lana doesn't use them. What are they? How do they work?

Somi:

So they work on different neurotransmitters in the brain, and basically they increase excitatory signals and decrease inhibitory signals. And they did a fascinating study where they took women who were struggling with HSDD, women who weren't, showed them erotica, i.e. porn, and then put them in MRI machines and watched the neurochemistry. And what they saw with women who were struggling with HSDD is the parts of their brain that's saying, "Yes, I want to have sex," or, "Yes, I'm going to eat that cake," were very quiet. And the parts of their brain that told them no were very active. And the opposite pattern women who weren't struggling with their libido.

Dave:

Okay.

Somi:

Yeah, so these medications work on neurochemistry, and they're non-hormonal, which is really nice for patients who can't have hormones. Addyi is every night regardless of whether or not you want to have sex, so it is not the female Viagra. It's not on demand. Vyleesi is an injection given at least 45 minutes before you want to want to have sex, and it is on demand. So they both work differently.

Dave:

Can you take them together?

Somi:

No, that's-

Dave:

Okay, it's one or the other?

Somi:

Yeah, it's one or the other, and then I oftentimes will add testosterone depending. But the side effects are both different. Some are contraindicated for certain patients. But basically, Addyi met clinical endpoints as far as increased number of sexually satisfying events, so no more checking a box X or keeping the [inaudible 00:36:22] in the marriage, decreased distress about your sexuality, and increased desire. So that's really, really nice, and some of my patients who are like, "Dr. Javaid, you have to fix this now," Addyi can take six to eight weeks to work.

No, I'm serious. They'll come in and be like, "Listen, I'm having a save the marriage weekend." And we're like, "Okay, well then I can't give you this medication because it'll take too long. And so I'll prescribe Vyleesi because that works immediately." Both drugs have side effects, both drugs have non-responders. So it's just setting expectations for patients, but it's a travesty because Addyi took six years to get FDA-approved, Viagra took six months. Men have 26 options, women have two.

And so, it's been an interesting journey with the FDA, and to even get solutions out there that you can prescribe for patients.

Dave:

It definitely changes the quality of your energy when you have good sex, and there's so many evolutionary biology reasons for that. There's these kind of three things. You need to not be afraid, to not be hungry. You need to have some sex in your life because when you have those three things, that's what unlocks then your ability to support your community and your family and all the other things like that. But if some of those are missing, it creates background anxiety that you won't even be aware of.

And I feel like hunger is the easiest one to hack because fasting isn't that hard to do, and if you eat the right stuff you're just not hungry, that unlocks some energy. But if you're not getting nourished in the bedroom, whether you're a man or a woman, over time everything in your life gets flat. And that's why this is important.

Also, there's a lot of people that seem to say, "I don't want to do pharmaceuticals." I'm not of that mindset. I'm like I'll do whatever works as long as the risk reward is best. I don't believe being dogmatic for or against them is a good thing. Do you find most people with lifestyle things can get their desire where they want it to be, or do you have a meaningful number of hard cases where nothing works except these drugs?

Somi:

75% of my practice is sexual healthcare, and I have women traveling all over the United States to come see us, so my numbers are skewed compared to the traditional gynecologists. So I see most women when they're at their wits end and are like, "You have to help me." If there is an offending agent, birth control, antidepressants, and we just remove that from the equation, a lot of times they get their sex drive back and they're like, "Dr. Javaid, why did it take eight gynecologists to tell me that I just needed to stop that medication?" I'm like, "Because we're not trained." Less than 30% of OB/GYNs are trained in sexual health. My training all came afterwards.

So a lot of times I can get rid of the offending agent. Of if it's a relationship issue, we get them into counseling. If it's a pain issue, nobody wants to do something that hurts, so obviously we address the pain first. So we can fix a lot of things organically. I just don't throw medications at people unless they really need them. And they have to want them. If a woman says, "I'm not having sex and I'm okay with that," she's not distressed by it, so she doesn't meet the markers for treatment, so she doesn't need it.

But I have a lot of patients on medication, and they tend to do really, really well. But Dave, I stay on top of my patients. Like I don't write the medicine and say goodbye. They're in counseling. They're seeing me at eight weeks and then three months and then six months. I'm checking in on them. We're making sure that they're seeing their counselor. Yeah, because otherwise if you set up unrealistic expectations and just leave them, they're not going to get the results that they want.

Dave:

That makes so much sense. And you said something in there that we have to talk about. I am of the opinion, I'm the author of a pretty heavy duty book on fertility along with my wife who's a medical doctor, that hormonal birth control for women is not of service to women. Birth control is a necessary thing for women, but hormonal birth control, I'll use a technical word here, it fucks women up. Is that true.

Somi:

Oh God, you are making me walk into fire. So here's the deal, and this is the approach I take. Do I use birth control in my office to treat conditions like endometriosis or acne or uncontrollable bleeding for a woman who doesn't want surgery or can't afford an IUD? Yes, but here's the key difference. Every single one of my patients who gets on birth control knows what happens to her testosterone level. She understands what may happen to her libido or frankly her vagina or her vestibule, where there are testosterone receptors. They understand, so it is about informed consent. And if those changes start to happen, we can supplement with testosterone.

So do I think there are conditions where I do need to use birth control? Yes. Are there adverse effects with birth control? Absolutely. But sometimes it's necessary, either because of finances, insurance, or medical conditions.

Dave:

Some of the guests I've had on, I'm talking about birth control specifically, in fact one of them said 85% of women are on the pill at some point or another. And that's a really big number given what you just said about side effects. So sure, if there's a medical necessity, great. But it's one of those things where I feel like it's disrespectful to women to just kind of hand these out all over the place without talking about the real serious downsides in what it does cognitively and physically and for desire, and even for some femininity when there are other forms of birth control that will stop you from getting pregnant, which is the whole goal there.

Somi:

No, absolutely. Yep.

Dave:

Do you find that one of them is better if someone's not going to be on the pill, if they're going to go off pill? What's your favorite kind of birth control to recommend?

Somi:

Right now, I'm a big fan of Phexxi, which is a non-hormonal contraceptive on demand gel. So I really like the idea of a woman only using it when she has to. It's safe for our cancer patients. It's safe for people who've had strokes. And it does not effect their hormones at all, and frankly the texture of it is not off-putting. It feels like a lubricant. So I am a big proponent of Phexxi these days, but it's brand new to the market. And it's efficacy is a little bit lower than a birth control or an IUD. Rather than 99%, it's 93%, which is still much better than a condom, and patients are only using it when they need it, so they're not having adverse effects other days when they don't have to have it. And my patients are loving it. So that's been a really, really nice option for my patients.

Dave:

And how do you spell Phexxi?

Somi:

P-H-E-X-X-I.

Dave:

See, these drug marketing people. Guys, come on, you can do better.

Somi:

Dave, you know what Phexxi is a play on. Come on. Phexxi is-

Dave:

I can't imagine.

Somi:

Phexxi is sexy. You know someone sat in a room and said, "Okay, how can we play on the word sexy?" Come on. I mean they all-

Dave:

Someone got paid $100,000 to come up with that name at least. These naming consultants drive me nuts. By the way, one of my all-time life/business fantasies is to be hired to create the name for a line of condoms because my inner seventh grader would have the time of his life just making all of these ridiculous names up, none of which would be appropriate, but still.

So all right, Phexxi, I got it. That's cool.

Somi:

Yeah.

Dave:

And the other thing is women can become aware of when am I ovulating? How much of your practice is teaching women to just know, "Oh look, there's a reason that every man in the room is looking at me today, and my secretions have changed, and I'm really horny."? That's because you could get pregnant. It feels like that knowledge is lacking for a good number of women. Do you teach that or do some of your providers teach that in your clinic?

Somi:

Yeah, they do. And a lot of the apps have made it a lot easier for women to track. Their fertile days, whether they're trying to do it to avoid pregnancy or to conceive, or to understand. And because we deal with things like sexual pain and dryness and libido, so many women will say to me, "Hey Dr. Javaid, I'm only good for a week, and it's that week that I'm ovulating. And the rest of the time I have a dry vagina, sex hurts, and if he touches me I want to punch him."

And so, we talk about why they're experiencing those changes, so absolutely that's a very natural conversation that happens in our office. But there's a lot of apps that help, especially because you have to think about it. We deal with women who have all types of cycle lengths, so I'd love to tell them day 12 to 14, but in real life that's not clinical medicine.

Dave:

Especially around perimenopause, it's going to shift around a bit.

Somi:

Right, all over the place. Yeah.

Dave:

I've oftentimes for a few of the women I know, maybe you should date a guy who likes being punched and then it would be [inaudible 00:45:43]. Okay, maybe not.

Somi:

No, no.

Dave:

One of the conditions that I know that you treat is one that isn't talked about very much. It's vulvodynia. Can you talk about what that is and how common it is?

Somi:

Yeah. So there are millions of women that are struggling with vestibulodynia, so the vestibule is the area around the vaginal opening or the introitus, but inside of the labia minora, like the vestibule of a building. And that's where we have a lot of estrogen and testosterone receptors. And then vulvodynia is the whole vulva or the outside. That's not your vagina. So many women still think that's your vagina.

And so, there are neurologic reasons, hormones that lack thereof that can cause pain, and so there are things that we do in our office called [inaudible 00:46:34]. And we do screen mirroring. This is so easy. I got a Chromecast in my office. We have a microscope, and we show women their anatomy. And we're like, "This is why you're hurting." We do a very simple Q-tip test. We do anesthesia testing, so basically I inject certain areas. And if I numb it and they're like, "My pain is gone," I understand where their pain is coming from.

And they're so grateful. They're like, "Thank you for showing that to me. Thank you for letting me know it's not all in my head." But we're also looking for dermatologic changes, anatomic changes. Women can get adhesions or skin changes leading to very thin tissue, or tears in the skin. So part of it figuring out why they're having pain, and then we can offer treatment options, whether it's laser or whether it's hormones or whether it's pain medication, but helping them become pain free.

And then we do a lot of vaginismus treatment as well in my office. Sometimes I'm someone's eighth or ninth gynecologist, and it's pretty easy to treat when you have the recipe. And basically, it's an involuntary contraction of the muscles around the vaginal opening, and we're one of the few centers in the country that treat that with Botox because just like women can paralyze those muscles in the face, we can kind of retrain those muscles so they don't fire when there's touch or pressure around the vaginal opening.

And I've had women who've come to me who have been married eight years and have never been able to have sex, and now they can. And it's so satisfying to treat those patients because like you said, sexual health, it gives people their confidence back, their relationships back. It's such a barometer of the rest of their healthcare. Women who are having sex have lower resting blood pressure, lower resting heart rate. Their stress levels are reduced. They are more confident. Their pelvic floor is healthier. I mean it sounds like you already know all this.

And 43% of women struggle with sexual dysfunction, and it's like why is there such a stigma? Why do we have two medications? Why are we continually ignoring and dismissing these women? It's a travesty. Imagine if there was any other condition that affected 43% of women or men. Would we ignore it the way we do this?

Dave:

We might not ignore, but we might continue to do incredibly ineffective stupid things. I'm talking about Alzheimer's, diabetes, cancer, heart disease, you know.

Somi:

Right, yes.

Dave:

But at least we're not ignoring them. We're just doing stuff that isn't that effective compared to what could work.

Somi:

Right, right.

Dave:

When it comes to vulvodynia, it's an area where I have an interest because one of the substantial causes that isn't well known for it is a buildup of oxalic acid crystals in the vulva. And there are lots of women who have candida, yeast infections, and candida increases oxalic acid levels. And then because they're good kombucha moms, they go out and they have several kale salads and a bunch of raw spinach, which are just packed with oxalic acid, and it makes the condition much worse. And they don't know it. In fact because I'm in pain, I probably need more kale.

And one of the things you get when you fast is you're eating no oxalic acid or any of the other irritants that are common in food. So then they're like, "Well, my urethra isn't irritated. My pain levels

are going down." Or, "My feet don't hurt." And just highlighting that there's an interaction between your food and where you get pain is really meaningful. And I hope that doctors for lots of conditions, "Oh, so that happens. Do you ever keep a food journal. It's funny, every morning you have this condition, but every night before you had Italian food," or whatever the heck it is, because those links seem like they're really real. Do you guys help people sort out which foods are causing vaginal pain?

Somi:

We do, and we also help people when they're coming in with recurrent vaginal infections, and we talk about probiotics and if they're having particularly acidic foods and then they're coming to me with urethral symptoms and saying it burns and hurts when they pee, but then when we check their urine there's no infection but there's inflammation, right? So if they're having too much lemon juice or acidic things, then we'll tell them to cut that out of their diet.

But probably more attention needs to be paid to this for sure. And the nice thing is we do have nutritionists at our disposal to help women. But absolutely, I recommend that they keep track of what they're doing, and even detergents and things that they're exposed to or things that they may be putting on their vulva that may also be causing irritation. Women don't think about that, detergents or soaps that they're using, or even shaving creams and things like that. So yeah, we do talk about that in our office.

Dave:

Tell me about screen cream.

Somi:

Screen cream, I don't know anything about that.

Dave:

I thought it might be a name that you would know. I'm sure that you know the effect I'll talk about when I define it. This is small doses of topical testosterone on the vagina or the vulva.

Somi:

Yeah.

Dave:

What happens when women put very low doses of testosterone in the right places?

Somi:

So when you put it in the right places, number one we actually see skin changes. We see the skin become less red, less irritated, and actually we see a decreased interval to orgasm. So I will recommend that women use it on the clitoris or the vestibule to help with pain, but also to help with that orgasm lag time. And it's one of the things that's been proven to help with some types of orgasm dysfunction. So those are the changes we see.

Now obviously, I have seen disasters with women putting too much testosterone on, or-

Dave:

Yeah, don't do that.

Somi:

Yeah, yeah. Like if you don't want a little penis, then don't have someone inject testosterone directly in your clitoris thinking you're going to have amazing orgasms.

Dave:

Do people do that, inject it?

Somi:

Mm-hmm (affirmative), yes.

Dave:

Oh my God, that doesn't sound right.

Somi:

No, it's actually awful. Yeah.

Dave:

The changes in vasodilation though from very low doses when you use it before sex or during foreplay, it's kind of profound. So that's why some of the natural paths I know who get it compounded. They actually just nicknamed it screen cream because ... And sometimes they'll put other things like oxytocin in it. But that testosterone effect on orgasm that one time, I wonder if that be as effective as some of the pharmaceuticals for some patients because it's one of those things that seems to be quite safe to do as long as you aren't overdosing like you're talking about. But the changes in lubrication in just the amount of blood [inaudible 00:53:33] to regions, it's remarkable. Every woman I know who's tried it has been like, "Oh my God, I had no idea." So that's a little hack that's useful.

Somi:

Yeah, no, I don't call it screen cream, but it's one of the things that we use because there's no ... I just did a lecture on orgasm dysfunction. There's no FDA-approved treatment option, so we have to use either off label medications, [inaudible 00:53:55] is one of them. Addyi and Vyleesi both help with orgasm as well. Topical testosterone. There's a nice other over the counter arousal serum, because most of them have menthol and they're like Ben-Gay and tingling and-

Dave:

Ow.

Somi:

-That's not ... Yeah, no, I mean-

Dave:

A little capsaicin for fun.

Somi:

Yeah. Right? Try putting that on menopausal skin and see what happens. It's not a good kind of fire.

Dave:

Right, right.

Somi:

So wave arousal serum has got a proprietary blend of amino acids that also causes some pretty potent vasodilation just in the area. And they've done some clinical research. It's a newer product. I've had some patients love it, some patients say it's made no difference. It just depends on where the orgasm dysfunction is coming from. Is it a nerve issue? Is it a lack of partner skill issue? Is it a true vascular problem, or is it a hormonal problem? So there's so many reasons. Or is it a neurotransmitter problem? Dopamine, which is released after ... You talked about satiety. Released dopamine after a really good meal. We also do during and after orgasm, and that's why we feel satiated.

And it's very interesting. Addyi causes that satiety feeling, so not only are women more satisfied with food, they tend to lose up to 5% of their body weight because they're just more satisfied with sex and food. So it's very interesting how that neurochemistry effects the bedroom and our eating habits.

Dave:

Jade eggs, yay or nay?

Somi:

No.

Dave:

No? All right. Why not jade eggs?

Somi:

You're talking about Gwenyth Paltrow right? Putting jade eggs in there to-

Dave:

Not her specifically. I mean there are many people who talk about them. She's probably the best known person that talked about them. But I've had a few people on who talk about these are strengthening pelvic muscles and it's basically an advanced Kegel exercise and that there's value to them. But you're a medical expert, so what's your experience been?

Somi:

Yeah. So I am really okay with putting things inside the vagina as far as like the Kegel balls, the Kegel exercisers, I recommend those. I think that's amazing. You're right. It's a muscle, we have to strengthen the pelvic floor, it leads to better orgasm. It prevents incontinence. But if the jade eggs are the ones that are heated and they were trying to do V steaming and change the anatomy, I just don't believe that there's data to support that. And then I worry about things like infection and vaginal burns, and there's no way-

Dave:

Yeah, if they're heated too much ... That wasn't where I was going, just using an egg or two to strengthen muscles. I guess there's all sorts of crazy stuff you could do on top of that, but okay.

Somi:

There's all kinds of differently shaped things that women can put in the vagina. I'm just not a ... There was this heating element that stated that you could heat the inside of the uterus and that it will help with abnormal uterine bleeding, and that was a claim that was out there for a long time. And V steaming, or vagina steaming, would lead to that.

And I worry about the vagina has got a lot of bacteria, the uterus is sterile, and through the cervical opening allowing things into the uterus into a sterile space that could cause infection. So that's why I'm careful about what I recommend going into the vaginal cavity.

Dave:

Well I have learned a lot about vaginas, which for some reason I'm always interested in. I don't know why. And more importantly, about women's sexual health, and thank you for sharing a lot of info here. And there's actually a couple things I didn't know about, including that new form of birth control you just mentioned just came on the market.

Somi:

Good.

Dave:

Thanks for sharing your wisdom and for paying attention to a part of a woman's life that is terribly important and oftentimes doesn't get the attention it needs. I appreciate your work, and keep doing it.

Somi:

Thank you, and I learned so much too. I learned what screen cream was today, and I've got to pickup ...

Dave:

And we can get all of your patients off of kale, okay? Maybe just the ones who shouldn't have it.

Somi:

Okay, got it.

Dave:

Your website is hermdhealth.com, and thanks for being a guest. It's been a lot of fun.

Somi:

Thank you so much.

Dave:

If you guys liked today's episode, you know what to do. Go have sex. Okay, well if that's in the cards for you. If not, you could always check out some of the things that we talked about today to see if they're

applicable for you or your partner. And gee, did we mention intermittent fasting as something that works for women? I believe we did.

If you haven't had a chance to pick up Fast This Way, there is a chapter focusing just on research for women in the book for a very specific reason, and I would love it if you'd read it and leave a review. Have an awesome day.