Menopause: What to Know, What to Ask & What to Do – Mary Claire Haver, M.D. – #1015

Dave Asprey:

You're listening to the Human Upgrade with Dave Asprey. On today's show, we're going to talk about hormones. We're going to talk about menopause and what to do about it, what to ask, and how it affects you. And if you're a guy listening to this, you could say, "Ah, I think I'll skip to the next episode." And you could.

Dave:

However, I am just going to tell you that menopause is already screwing up your life. That's because if you're young, it's happening to your mom, or your aunt, or your grandmother, and it's probably happening to your boss or your boss's boss. And if you are a woman who's premenopausal, it probably is going to happen to you.

Dave:

And what you do now is going to affect how you feel in the future. It's going to make a really, really big difference. So, with no further ado, let me introduce you to today's guest who is actually not named after a magazine, even though her name is Mary Claire Haver, who's a medical doctor.

Dave:

And she made it onto the show today because like a lot of my favorite hormone experts, she's a doctor, but the stuff didn't work. So, she walked into the buzz saw that can be menopause when you don't manage it correctly and had to deal with it. And these are always the best doctors. Like, oh my God, I had to learn a bunch of stuff that I didn't learn in medical school for my own uses.

Dave:

By the way, why am I a biohacker? I had to do the same thing because toxic mold and chronic fatigue syndrome and all the mitochondrial dysfunction, that stuff actually, it was such a big thing, you had to do it. So, someone who has doctor training and is hacking themselves, these are the people you want to learn from the most. So, she's a board-certified OB/GYN.

Dave:

And she has a track record that I checked out about being curious and listening to patients. And not every doctor does that in the same way because of insurance companies and because of even sometimes regulations. So, she's the one who hacked herself using a medical doctor's training. So, Mary Claire, welcome to the show.

Mary Claire Haver, M.D.:

Thank you. Thank you for having me.

Dave:

Now, what happened? So, tell me about your menopause experience.

Mary Claire:

Yeah, so I'm 54 years old and I am fully menopausal, but we're going to back up to about 2017. Through most of what I realize now was my perimenopause, I was actually on birth control pills for treatment of polycystic ovarian syndrome. So, I kind of masked a lot of the symptoms at that point.

Mary Claire:

And in late 2016, my oldest living brother died basically. And at that time, I was 49, my practitioner and I had decided time to come off of birth control pills and kind of see where you're at. And through his end-of-life care and the immense depression that ensued after his death, I kind of forgot about that. So, I ended up in full menopause and this incredible grief state all at the same time.

Mary Claire:

And I was blaming the way I was feeling, the lack of sleep, the hot flashes, the fatigue, everything on grief and depression. And certainly, it was playing a part of that. And I was also gaining weight, and I've not had weight problems in 20 years. But I knew I was not eating the right things. I was not exercising. I was just barely getting out of bed and going to work.

Mary Claire:

And so, six months after he passed away, the depression starts lifting, the grief is getting better, and I look at my body and I'm like, "All right, time to get back to it. Let's get healthy again." And I went back to the old tricks that I used to do, the working out, the severe calorie restriction, the two a days at the gym. And I'd lose a couple of those pounds, but it was just popping right back on.

Mary Claire:

And at the same time, I was not sleeping, hot flashes, severe brain fog, getting in the car and I can't even remember where I was going. That was new, all these new things. And joint pain, I was having severe hip pain. I was getting an X-ray and all this workup and no one, including myself, was saying, "Hey, this all is probably your menopause." So, I got so frustrated with the weight gain.

Mary Claire:

I remember my husband works overseas and he was leaving for a long trip. And I said, "Hey, when you get back, you're going to have the wife you deserve. I'm going to lose all this weight." And he said, "Honey, you are beautiful. I don't care what size you are." He said, "But what you're doing is not working. This is what you tell me, what you tell the kids. You're a scientist, you got to figure this out."

Mary Claire:

So, then I was like, okay, challenge accepted. I'm like, why isn't this CICO (calories in calories out) thing that I've been taught my whole life, this law of thermodynamics that is infallible that must work. Why is it not working for me and all of my patients who had complained of the exact same thing?

Dave:

So, you were telling your patients just work out more and eat less. The same thing my doctor told me.

Mary Claire:

Yeah, for 20 years.

Dave:

For 20 years. Have you apologized for that?

Mary Claire:

I mean, I apologize on social media. And every patient who came back to me, I'm like, "I am so sorry."

Dave:

Wow.

Mary Claire:

And sadly, it took happening to me.

Dave:

Kudos.

Mary Claire:

So, then I called up the Ph.D. nutritionist at the university I was employed at because I delivered everyone's baby. I was friends with everybody. It was a small academic community. I'm like, "What the heck is going on here?" And they're like, "Well, there's lot's going on with inflammation. We know there's some ties to menopause. Nutrition's going to play a big role here."

Mary Claire:

So, they just sent me a bunch of articles and I just went down the rabbit hole had. There was just such a black hole of menopause information still, but lots of nutrition information. And so, I was just kind of putting things together and deciding, I kind of like this fasting thing.

Mary Claire:

There seems to be some benefits to lowering inflammatory levels and bringing down insulin levels. I was thinking of things totally differently than just calories and calories out. I realized I'm more than just a simple machine. I'm very complex.

Dave:

Hold on a second. Humans aren't meat robots?

Mary Claire:

Yeah.

Dave:

Oh my God, who would've thought, right? Someone should tell Elon.

Mary Claire:

Alpha Mega Alpha is an honor society for medical students, and I was in charge of the med students doing that. And so, we had a guest speaker come in. And he had started this medical nutrition, kind of

like a master's for doctors in nutrition and I was all over it. And so, I enrolled in the program through Tulane online, had to fly out to New Orleans to do these labs and stuff.

Mary Claire:

And it took about a year and a half to get through the curriculum and really learned so much about nutrition that was just lacking. And I was pulling in my own menopause information and just kind of came up with my program based on that. Based on research, personal experience, talking to patients. Then I just started talking about it on Facebook and that's when it exploded.

Mary Claire:

And people were like, "Whoa, what's going on here? Tell me more, tell me more." And as that grew, I got more and more questions just about menopause in general. And so, what became me just talking about nutrition and menopause, became me talking about everything menopause. Which is kind of where we are today.

Dave:

Now, there's something that happens before menopause and perimenopause, and that's like our fertile years. My first book from about 12 years ago took five years to write. It's called A Better Baby book. It's a book on fertility and what do you do before and during pregnancy to have a smarter, healthier babies.

Dave:

And it still sends the test of time today. And people still buy the book and get pregnant magically without IVF and all that. And it's because my wife at the time, who was a medical doctor, the mother of my kids, she had PCOS and was infertile. Her medical colleagues at the hospital where she worked. "Yeah, we ran all the tests, you're not going to have babies."

Dave:

And I'm like, "Yeah, we can hack that." So, we did. But the birth control pill is a major contributor to problems. And PCOS is oftentimes fungal or it's a metabolic thing. Are you still recommending the birth control, like hormonal birth control pill for patients?

Mary Claire:

So, now most of my focus, I've left traditional OBGYN practice and now I just focus on menopause care. And so, in a very early perimenopausal patient who's symptomatic, occasionally I will, because of cost, insurance, a low dose birth control pill is a good option sometimes for them.

Mary Claire:

But for most of my patients, I'm doing estradiol and micronized progesterone to support the gaps that they've got. Or try to stabilize them through transition and then keep them going into menopause.

Dave:

Got it. So, because you don't really deal a lot with women who are fertile, one of the-

Mary Claire:

Not anymore.

Dave:

Not anymore. One of the things that I just want to make really clear on the show, and I've said this lots of times. The abundance of evidence that I've seen is that the risks of hormonal birth control for women far outweigh the benefits, almost always. But there are certain cases where it just makes sense where it controls some other symptoms. But that the overuse of that I think is, it's a crime against women, it's not for women.

Dave:

Birth control is necessary for women to have full rights and be healthy. The hormonal disruption that comes from that method of it seems like it's really causing an increase in risks. And we just don't tell people the changes in personality and their life that can happen as a result of it. So, I just want to make that really clear.

Dave:

That's not what our topic is today because you brought it up and it's in the context of perimenopause and menopause. If someone's been on birth control, well the hormonal birth control most of their life, and then they hit perimenopause, what would be different versus if they had had their natural cycle and then hit perimenopause?

Mary Claire:

Hit perimenopause. Sometimes some of the bigger symptoms like the hot flashes, the easily identifiable symptoms can be attenuated because you've stabilized their estrogen levels. In perimenopause, we see this. In a normal menstrual cycle, for someone without PCOS or without any endocrinological disruption, you have a cycling. So, our estrogen levels are kind of at baseline and then we ovulate, and they peak and then they come back down.

Mary Claire:

And then progesterone kind of follows that phase after ovulation. It peaks about seven days later. And then we have a period and the whole thing starts all over again. So, when we're in perimenopause, we begin to see the disruptions. Perimenopause is very much like PCOS in many, many ways. I have a whole chart for PCOS patients that I show what you see in perimenopause side by side versus what you see in PCOS.

Mary Claire:

And there's like eight out of 10 boxes checked the same as far as symptomatology that they're going to have. Disrupted periods, acne, change in body composition, weight gain in their midsection, the apple shape rather than the pear, brain fog. Some of the things that they might notice. Joint pain is something that's new and that happens in menopause. We don't see as much in PCOS.

Mary Claire:

And migraine, headaches, things that are inflammatory. So, increasing of migraines or new onset migraines. Interesting enough, I just looked at this because I did some research on mental health and it looks like depression more than anxiety seems to flare in perimenopause. And it is a precursor for severe depression. So, if you were doing great and then you go into perimenopause.

Mary Claire:

You get in your '30s and '40s and all of a sudden, you're having a new onset depression without a big life event that would contribute to it. That is something that should key you, this might be part of my perimenopausal journey.

Dave:

Got it. So, you said in your book that you think menopause is a privilege.

Mary Claire:

Yeah. So, if we're lucky enough, 100% of us, if we live long enough, are going to go through menopause. And when you talk about biohacking and personal, I'm one of eight siblings, so I have four older brothers and two younger brothers and a younger sister. Three of my older brothers have passed away. I don't have a surviving sibling past the age of 60.

Mary Claire:

So, I'm very, very focused, at least on my own healthcare, on what can I do to limit, to increase my lifespan and my health span as well. I want to be healthy, not just live forever. And so, I personally can't take that for granted. Sorry, the point of all that being the fact that I'm menopausal and really healthy. Because as you do, I check my own labs. I'm very much on top of my own health and modifying as much as I can.

Mary Claire:

If I make it to 60, it's an honor and a privilege. And I think by knowing what could happen to you, being able to recognize the symptoms, putting changes into place that will improve your quality of life and health through this journey, I think is going to go a long way. The first problem we have is not enough women are talking about it. Know about it, understand what's happening to them, what could happen to them.

Mary Claire:

And besides the symptoms, the hot flashes, the night sweats, the mood swings, all of that, which is important and affects your quality of life. I'm talking about cardiovascular health, neurodegenerative disease, mental health. These are things that we... It's looking like now that people are actually looking at the data, if we put these interventions into place, we could not have some of these long-term health effects associated with menopause outside of just aging.

Dave:

If I was a young woman and I had the means, I would actually take some of my ovarian tissue and bank it. So, when I hit menopause, I could have it reimplanted and do another 20 years without menopause. What do you think about that?

Mary Claire:

So, I think that's very interesting. You're the first person I've ever heard say that. But what I tell my patients in clinic is, the best thing I could ever do for you is reimplant your 25-year-old ovaries, and I can't do that.

Dave:

I know. There's a study-

Mary Claire:

That's so funny, I say that every day in clinic, "The best I can do to you is to give you back your 25-year-old ovaries and I can't. So, here's the next best thing." I say that every day in clinic, "The best treatment for you is to give you back your 25-year-old ovaries, and I can't. So, here's the next best thing." And now I'm like, "That would be amazing."

Dave:

They did it in the UK. There's actually a trial of that where they've been doing it, and at least it was in animals. I don't know if they're doing it in people. I'm pretty sure that they are. But it works it.

Mary Claire:

Yeah, I think you just put it under the skin. I mean, that...

Dave:

So, what's stopping us from doing this?

Mary Claire:

They're doing pancreas.

Dave:

Yeah. And I don't know where they re-implant it, but the bottom line is it seems like even though you would consider it to be a privilege, it's an inconvenient privilege. Even though you might come out the other side with wisdom. You could also just have wisdom and still have your period and have normal hormonal cycles on a body that thinks it's 25 again.

Dave:

Because the little mitochondria in the ovarian tissue, which is very dense in mitochondria, they're like, "Oh, hey guys, we're 25 again." And all the other mitochondria in the body are like, "Oh yeah." And then all of a sudden, the youthfulness happens. And that's what they found in animals. So, why not bank ovarian tissue? I mean, you could do that.

Mary Claire:

That would be amazing.

Dave:

Well, why aren't you doing it? You're an OBGYN, you know how to pull that shit out. I don't know how to do that stuff. I have scissors. I don't know how that works. But you're a doctor.

Mary Claire:

It actually is a pretty simple procedure. I mean, it would be laparoscopic, but you could totally do it.

Dave:

So, can I send my daughter?

Mary Claire:

I don't know if anyone who's doing it officially, I wouldn't know how to bank it, but let me-

Dave:

But you're a doctor. I don't know how to bank it.

Mary Claire:

You go to a fertility specialist who actually preserve that tissue.

Dave:

We bank eggs, we bank sperm, we bank stem cells.

Mary Claire:

I mean, why not?

Dave:

We have freezers. Oh, I'm challenging you, Mary Claire.

Mary Claire:

Yeah, that is amazing. That would be amazing. I'm going to go down the rabbit hole with my fertility buddies.

Dave:

You're good at rabbit holes. That's why I wanted you on this show because I do the same thing. I've been down this rabbit hole and there's nothing stopping us other than maybe some regulator who's a politician. And those guys actually aren't in charge of us anymore. They haven't been for a long time.

Dave:

They just think they are. We just do what we want to do. That's why we're biohackers like, "Oh, a research chemical? Oh no, heaven forbid that I used that on myself because you wouldn't let me buy a medical grade one." That's the world we live in. So, I'll fly to Thailand, I'll fly my family to Thailand.

Dave:

And hey, you just turned 25, honey. I'm going to do you a favor that's going to give you an amazing life a long time from now. Even I plan to be alive that long, but maybe I won't be, who knows? But let's do it. So, let's open the clinic in Thailand or Mexico where everyone could go and bank their tissues and go to the beach.

Mary Claire:

Yeah, that would be amazing. And then like 45-ish, do some testing, kind of see where you're at, and re implant and just.

Dave:

And then no menopause.

Mary Claire:

Get another 20 years.

Dave:

Young hormones for the rest of your life, at least not for the rest of your life. But for another entire adulthood.

Mary Claire:

20 years, yeah.

Dave:

Without all the weight gain in the brain fog and all the changes, it feels like that might be a really good use of time. Because there was a study also out of the UK that found that perimenopause was costing them billions of dollars every year.

Mary Claire:

No doubt.

Dave:

And just lost productivity.

Mary Claire:

Oh, yeah. And misdiagnosis.

Dave:

Yeah. All right, this is your next big book. The bank and beach book, that's the new strategy.

Mary Claire:

I'm itching to.

Dave:

All right. And it’s funny cause I've talked about that. I've had three other doctors who kind of had the same problem. What's going on with menopause? What do I see in my patients? What do I see in myself? Cynthia Thurlow, Anna Cabeca and Suzanne Gilbert Lenz have been in other episodes where we've gone through this. But it feels like we're biohackers and the time has come for a relatively inexpensive procedure. What is it? A couple grand to do a laparoscopic surgery these days?

Mary Claire:

I mean, especially in Mexico or Thailand.

Dave:

Yeah, where they have great medical care and then you bank it and banking's going to cost you a few hundred dollars a year. And then magically you turn 45 and no menopause.

Mary Claire:

Replant.

Dave:

Oh my God, we have to do this. Sign me up for helping because I have family, I have friends who need this. But it does feel like for the first time since I started the show 10 years ago, that people are really in the mass media. They're just way more open about perimenopause and menopause.

Dave:

And even just anything I would do with sex and reproduction and women's body parts and all that than ever before. Why do you think that's happening?

Mary Claire:

I've asked on social media, why is menopause having a moment? And they think it's a generational thing. I'm 54, so I forget what generation. Am I Gen Z, X, Boomer? I don't know. I'm somewhere on some cusp. But this next generation behind me is not willing to put up with it anymore.

Mary Claire:

They're willing to be unmarried, they're willing to bring home the bacon. They're willing to not have children. They're willing to break all of the norms. And they're not willing to be silent about suffering. They're not putting up with, oh, you're just getting older. And I think another thing that social media has done is allow people to have all these shared experiences where they had no idea other people were going through the same thing.

Mary Claire:

So, it's really just kind of opened up the conversation. And then this next '30s, 20 plus, my daughters who are 19 and 22 are going to be as prepared as possible for perimenopause. They're going to know exactly what's happening. And at that time, it's 20 years from now, what their treatment options are. And maybe they will bank their ovarian tissue for future use to keep them healthy and functional for much longer than they would be otherwise.

Dave:

All right. And you're going to help?

Mary Claire:

I could.

Dave:

Let's talk about something that's going to be more likely to help listeners right now. And that's hormone replacement therapy. What's your take on it? Should women be replacing?

Mary Claire:

I'm a fan.

Dave:

You're a fan, all right.

Mary Claire:

I'm a fan. Yeah.

Dave:

What about all the risks? I mean, people talk about cardiovascular, breast cancer, dementia, stroke, all these bad things that might happen if you have a young person's health.

Mary Claire:

Here's what the latest data has shown. The American Heart Association just came out with a review. They looked at the WHI, the women's health study, the nurse's study, Framingham, and followed those patients out for 20 years. And they took two cohorts of people. And they said, "All right, starting young, starting healthy." There's something magical about estrogen being protective.

Mary Claire:

If you start later, like late '50s, '60s, then it may exacerbate preexisting health conditions like Alzheimer's, dementia or cardiovascular disease. But if you start young at the very... If don't have an estrogen free interval, or a very small one, the women who were on hormone therapy in the form of estrogen plus or minus progesterone versus those who weren't, and we follow them, have less cardiovascular disease.

Mary Claire:

Less death from cardiovascular disease, less all-cause mortality and less mortality from cancer. So, that's what the latest. It's an issue of timing seems to be it. So, as far as what kind of put in your body, I don't recommend Premarin. Which is from pregnant mare urine. I don't do synthetic.

Dave:

Do they still make that?

Mary Claire:

They do. It's heavily prescribed

Dave:

That's for horrible people. You don't need to do that to Premarin.

Mary Claire:

I know. I say, look, I have an ethical issue with this. I have great options for you that are completely... I go with what your ovaries used to make, which is estradiol. That's my drug of choice. And so, I have lots of options. I usually stick to a transdermal option because oral will bump up the clotting factors.

Mary Claire:

So, about seven out of a thousand women will have a blood clot on oral versus transdermal. So, I usually go with a transdermal option, a patch of cream, whatever her insurance will cover. Or if she's out of pocket, we get out the apps and we start looking for the best affordable option for her. And then if she needs progesterone, again, I'm trying to get as close to what the ovaries used to make. And that's going to be a micronized progesterone

Dave:

Do you find it offensive that insurance companies have anything to do with this?

Mary Claire:

Absolutely. Every day I fight this battle and it makes me insane. The same with testing, the same with blood work. It's like I decide a patient needs X, Y, Z test based on my clinical experience and my level of expertise. And it is a battle. So, in the clinic that I built for menopause, I don't take insurance.

Mary Claire:

I try to keep the cost reasonable. I cover the labs with their visit costs. And then I have the freedom to order what I want to order. I also contract with a lab to get better pricing. So, I try to keep the costs down, but my patients are so happy because they're getting individualized care this way.

Dave:

And there's so many connections between the insurance companies and big pharma. That's why Premarin, which is horse mare urine, that provably causes problems when women use it, that that's still on the list. Because it's covered by some insurance companies somewhere.

Mary Claire:

Yeah.

Dave:

So, I'm getting a lot of questions from our live audience. And by the way guys, if you're listening, you can go to daveasprey.com and you can sign up for the Upgrade Collective. You can be in the live audience and ask questions and all. And it's really fun because we have this whole community of people who are part of the Collective.

Dave:

And a lot of them are asking, "All right, Dave, Mary Claire just kind of dropped a bombshell there saying that if you've been off of hormones after menopause, that maybe starting isn't a good idea. How long of a gap is too long?"

Mary Claire:

So, that's a great question because we just don't... So, when they looked at the WHI, which was the original study that kind of left a generation of women bereft because of flawed science. The average age in that study was, I believe, 62 or 63. So, they were starting women on hormone therapy.

Mary Claire:

So, the average age of menopause is 51. So, more than half of these women had been menopausal for over 10 years. And so, that's when I start counseling patients. Look, they come in and their '60s, never offered hormone therapy. They come in, they're interested in the discussion. I'm like, "Okay, well let's look at your risk factors. Let's get a calcium score. Let's talk about Alzheimer's and dementia, and does this run in your family?"

Mary Claire:

Because these were the diseases that seemed to get worse if there was a preexisting condition when they started the hormone therapy. So, it's not for everyone. It's absolutely not for everyone. But every woman deserves the conversation about her individual risks, benefits, potential health goals. What does she want out of this?

Mary Claire:

So, today, this morning I was at my exercise class. I do a workout with a bunch of ladies and one of them is my patient. She said, "Hey, can I ask you something on the side?" I said, "Yes." We went in another room. So, she's a breast cancer survivor and she's in my menopause clinic.

Mary Claire:

And she said, "I just saw the oncologist and I had stage one cancer lumpectomy chemo. And they want to put me on whatever." It's not tamoxifen, it's something new. And she said, "I'm reading everything and the risk and benefits." And I said, "well, what percentage or chance is it going to decrease your risk of getting recurrence?"

Mary Claire:

And she said, "I don't know." And I said, "Well, that's probably what you want to ask." And she said, "I'm worried that my quality of life's going to be so poor from the side effects of this medication." I said, "Look, the oncologist's only concern usually is that you don't get cancer again. That's their job."

Dave:

Even if you're locked in a prison, as long as you're in cancer, they win.

Mary Claire:

And so, your quality-of-life matters. Your ability to sleep at night, worried about getting recurrent cancer matters. So, it's all a balance. So, I gave her a list of questions to ask. What am I gaining by this? What percentage? And I said, "For you, the risks of poor quality of life might outweigh any potential 1% chance decrease of recurrence. Think about it that way."

Mary Claire:

And I don't think we're having those conversations with patients. We're all so worried about getting sued or the 1% that we're just missing the boat that this is someone's life. She's got to sleep at night, she's want to enjoy her... And sexual intercourse. I mean, it's going to take everything out of her vagina and just leave nothing left.

Mary Claire:

So, I think it's really important that the patient goes in armed with questions, armed with information. Asking the right questions to make sure making the right decision for her and her quality of life. It's not cookie cutter for everyone.

Dave:

It's not. So, it sounds like the answer is that if someone's been menopausal for 10 years, the study showed a slight increase in potential risk. Which by the way, you could offset with some basic supplements.

Mary Claire:

Exactly.

Dave:

Like, oh, if your clotting factors go up, take some sera peptides and there you go. Now your clotting factors go down. You have less fibrinogen because you took a cheap enzyme on an empty stomach that breaks up thrombin and fibrinogen, stuff like that. So, then it comes down to, is quality of life higher when you're on hormonal replacement, when you're in menopause. Is it usually?

Mary Claire:

Yes, the quality of life is higher. Anytime you sleep better, especially if your sleep's disrupted, everything gets better. First thing I ask my patients is, how are you sleeping? Tell me about your sleep patterns. What's going on there? Because it's tied to so many things.

Mary Claire:

And when I talk about the menopausal toolkit, HRT is just one small part of what I counsel patients about. Now again, I went back to school, I have a nutrition background now. We talk about nutrition, we talk about exercise, we talk about stress reduction, we talk about sleep, we talk about possible other pharmaceuticals. And of course, we talk about supplementation. It's like a tackle box and everything is important.

Dave:

Many people out there are saying, "Oh, fasting doesn't work for perimenopause or for menopause." And I think it's because they're over-fasting. Talk to me about fasting for perimenopause.

Mary Claire:

For when I first got into the studies, when the nutritionist were throwing things at me, I was really looking at lowering inflammation levels. Because perimenopausal and menopause become a pro-inflammatory state. And I'm like, what can we do with our world outside of medication to lower that naturally? And so many studies, Mark Matson's work from the NIH on neuroinflammation.

Mary Claire:

I mean, he's this wonderful PhD. He doesn't make any money. Work for the NIH, and this was just his passion. And I was so intrigued by it. So, when I started looking at the very few studies that were done for women in menopause, it looks like a 16 eight seemed to be pretty much the magic window where weren't starting to chew up protein, chew up your muscle to get amino acids going.

Mary Claire:

It seemed to be enough to get the anti-inflammatory benefits without moving into starvation. And so of course, do I work 24 shifts at the hospital? Did I do a perfect 16 eight every day? No. Do I do one now? No. So, it's like most of the time I hit a 16 eight roughly if I'm traveling or ill or whatever. I eat when I'm hungry, but my body's just used to it now and I'm enjoying all of the anti-inflammatory benefits and hopefully some longevity as well.

Dave:

It's really hard to know how much of the anti-inflammatory effects of fasting are. Because you didn't eat inflammatory plants or man-made chemicals or all the things that we don't know are causing inflammation. But we do know that even if you eat low inflammation foods, it's still having an empty stomach works. In the Galveston Diet, you talk about intermittent fasting, that's your main recommendation.

Dave:

And you have a list of inflammatory foods. People who know my work, Bulletproof Diet was all about. Here's the foods kind of stack ranked. Tell me your basic theory on what types of foods cause inflammation in the Galveston Diet.

Mary Claire:

So, there's things that disrupt your gut microbiome. There's things that those little bugs in there who need to be happy and well fed, don't know what the hell to do with. And there's things that actually cause direct inflammation on the lining of the mucosa.

Mary Claire:

And so artificial colors, artificial flavors. I mean, I'm not talking the occasional snickers or handful of... But I'm talking about people who are consistently eating this on a regular basis.

Dave:

So, basically highly processed candy, junk food with artificial colors and flavors.

Mary Claire:

Exactly. Advanced glycation end products. So, when meats and things can be overcooked, those have been shown to be highly inflammatory and disrupt gut microbiome.

Dave:

Look at you. Do you know how few people talk about that one? Cooking methods is part of the recommendations I made. Thank you for saying that. Charred meat and charred veggies actually, both of them. The black stuff is really bad for you.

Mary Claire:

The black stuff can be harmful. Occasionally fine, but I'm talking people who are smoking meat every week. That stuff, we weren't meant to eat it like that.

Dave:

It's true though. Smoking meats increases disruption of your microbiome, and it directly adds a lot of advanced glycation end products as well as polycyclic aromatic chemicals that disrupt hormones.

Mary Claire:

Right.

Dave:

Bottom line is you probably don't want to actually smoke your meat, but I do use smoke salt. So, if you want smokey flavor, you can get it because smoke on salt doesn't make those compounds.

Dave:

It's burning fat and burning protein that makes the negative compound. So, you get the smoked flavor by burning wood with salt and adding the salt to your meat. And then you can even slow cook the meat, so you still get your barbecue flavor.

Mary Claire:

That's a good point.

Dave:

And so, there are die-hard people listening to this who barbecue, and I like I want to have a barbecue too.

Mary Claire:

It's Texas.

Dave:

Yeah, right. So, just what about some way to counteract that?

Mary Claire:

So, filling your body with things that naturally fight inflammation, things with anthocyanin. In Galveston Diet, we talk about eating the rainbow. Every color of that natural fruit and vegetable has a compound in there, a phenol that is anti-inflammatory.

Dave:

Yeah.

Mary Claire:

Naturally it's absorbed well into the bloodstream, and it goes to work as an antioxidant doing whatever the hell it does inside. That's a whole another talk. Filling your plate with as much variation of your fruits and veggies, of your legumes, of your whole grains that you can't.

Dave:

What is your take on nice shade family and things like that?

Mary Claire:

So, I haven't seen enough randomized controlled studies. I mean, I think a lot of that's in theory. And all the people that I trust are like, as long as you cook it, you're fine. You'd have to eat the things raw to get the level of, I think whatever the derivative is to really be harmful. I love an eggplant. I cook it well.

Dave:

It works for you.

Mary Claire:

And it works for me. But there's also, we're all different human beings.

Dave:

We are.

Mary Claire:

With different microbiomes and different chemical makeups and different reactions. You sometimes need to do an elimination diet to figure out what your body's not reacting well to. What's causing the bloating? I can eat all the dairy and the world doesn't touch me.

Mary Claire:

But 20% of the population is not that way. And so again, Galveston Diet is not about restriction, or you have to eat this or that. It's just getting a different understanding nutrition wise on... And allowing yourself to be who you are.

Dave:

Yeah, I think you've nailed it. So, you get intermittent fasting in there, that solves a huge number of problems. And you avoid the obvious inflammatory foods for everyone, what I would call the kryptonite foods in the frameworks that I use. You've just now got a 75% coverage and then you get the 25% people going, "Well, a lot of my problems went away, but I still have X."

Dave:

And that's usually when you get into the realm I just talked about where nightshade lectins don't get destroyed by pressure cooking, but legumes do. And there's all these nuances. And it's funny, my son has the same jeans for lectins I do. Each of us, we take one bite of potato, it's like neck pain and back pain and joint pain for a week.

Dave:

My daughter doesn't have it. She eats potatoes all the time. It's black and white. And I don't think everyone needs to avoid nightshades, but many more people than you'd think. So, I'm glad you didn't include them as you have to not eat them in the diet, in the Galveston Diet. Because what you're doing here is going to get the vast majority.

Dave:

But when people come in still having problems saying it doesn't work. No guys, the Galveston Diet did work. It reduced inflammation, but you had other factors that were outside of it.

Mary Claire:

Other factors. And then that's when the work begins. We start really saying, all right, what is it with you and your body? We just start checking the box off one by one.

Dave:

And there's a third pillar. So, in the Galveston Diet, you've got intermittent fasting for perimenopausal women, you've got avoid the common inflammatory foods. And then the third one, what's that?

Mary Claire:

So, we call it fuel refocusing. It's kind of a catchall. It's kind of where we do our coaching around the emotional aspect around looking at food as nutrition. So, we talk about protein needs, we talk about healthy fat needs, we talk about our healthy carbohydrates and in what proportion you should consider that.

Mary Claire:

And then we talk about micronutrients, magnesium, fiber, how important they are, what they can help with, and what a deficiency would look like. And so, it really helps us kind of drill down to the nitty gritty for each. We teach people how to track their nutrition in a different way. The tracker, my favorite was my daughter's, she used in school is chronometer.

Mary Claire:

You can use lots of trackers but have a really, really clean database for nutrition. I'm like, just track your magnesium for a week. See where you're landing. Are you getting enough? That's a difficult one to do by blood tests because it's an electrolyte, and you just pee it out. Whole body magnesium's hard to measure. So, I'm like, "Let's just see how much you're getting for the week."

Mary Claire:

How much fiber are you getting? How much omega-3s? What about your vitamin D? And so, it's looking at things at a more granular level and then seeing if you're maximizing that through nutrition. And then if you're not, then we talk about supplementation. Or if you can't, if you don't have access, you're allergic to fish, whatever, then we start talking about supplements.

Dave:

Ketosis for menopause, yay or nay?

Mary Claire:

I don't track ketosis. We naturally go into it when we're fasting.

Dave:

There you go.

Mary Claire:

And so, it's not a goal for Galveston Diet.

Dave:

It just happens sometimes.

Mary Claire:

It's inevitable in the way that we do and we welcome it. But it's not something that we're like peeing on sticks. I'm not recommending that you track to make sure that you're in... Your body is going to go in and out. It's a normal part of it.

Mary Claire:

We talk about if you're in ketosis for a long time, what you might feel. Some things that you might be able to do to limit some of the side effects of when people go into keto early in the game, the keto flu or whatever. But because of the fasting, because we're kind of limiting carb, not limiting, but because we're really paying attention to carbohydrates, ketosis is inevitable. And it's just a normal part of how our bodies fuel themselves.

Dave:

So, when people are following your recommendations and they're getting 16 hours without food, which means you eat dinner, don't have a snack, and then eat a late breakfast, you got 16 hours.

Mary Claire:

Yeah, exactly.

Dave:

Then magically your ketones are up some and enough to get the metabolic-

Mary Claire:

You're burning factor fuel, which is-

Dave:

Yeah, it's not a keto diet though. And it doesn't need to be. And I've been saying this for years, you can do it, but cycle in and out and intermittent fasting is most of it. What about MCT oil maybe in coffee? I kind of know some stuff there.

Mary Claire:

A lot of my patients come in and they're doing that and they really like it. And I'm like, "Okay, you do." I'm a fasting purist personally, so I'm really zoned into nothing during my fast. I just have black coffee, water, tea. But we have a couple of recipes in our cookbook that do use MCT oil, but we say try to do it after you break your fast.

Dave:

I find it really does increase fasting compliance and it means people don't feel pain. And since it can't be stored as fat and it doesn't get processed in the liver, it's hard to argue that it's breaking the fast. But maybe it is if you redefine fasting. I don't know, I think coffee breaks a fast if you're going to...

Dave:

By the way, this isn't a debate, I'm kind of teasing you for listeners. I define things in a fast as if it doesn't raise your insulin and blood sugar levels and it doesn't raise mTOR, which is a compound that protein and carbs turn on, which means going to growth mode, then you're fasting. Which is why you can have coffee, you can have prebiotic fiber and you can even have fat in limited amounts, especially MCTs.

Dave:

You're technically not breaking fast. And it sure is easier to fast that way. But you talked about some other stuff that I thought was intriguing and a little bit daring in a book. And this is something that biohackers who are listening to the show, and not everyone who listens is a biohacker, but there's lots of us. You talk about the stuff that most people have heard of like insulin, and leptin, and ghrelin, and cortisol.

Dave:

But then you go into cholecystokinin, which almost no one writes about. I think I have a paragraph about it in my big diet book. And you talk about pancreatic peptide YY and glucagon-like peptide one. Can you walk through some of these kind of fancy compounds that most biohackers don't know about and what they do in your gut and your body?

Mary Claire:

So, these are all the group of hormones, some better study than others that seem to control hunger and satiety very much. We have the best information for that on leptin and ghrelin, those have been studied extensively. But it seems that cholecystokinin, PPY, they also have similar properties as far as turning things on that drive our need to eat and turning things on that makes us feel full and happy. And those are driven by the quality of your nutrition.

Mary Claire:

So, I put those in there. They're not studying all that well. But it seems that getting protein with each meal, getting fat with each meal, getting something complex with each time you eat seems to help those hormones work for your benefit. If weight loss is your goal or staying full and staying healthy is your goal. I don't want to say all weight loss equals health.

Mary Claire:

That's not what I'm here to propagate. But they all have a part and there's more emerging research coming out. Now GLP one is being blown out of the water right now with all the GLP one agonists out there. I have first my initial reaction to those medications being used for weight loss. I mean, I knew about them for type two diabetes really kind of made me step back.

Mary Claire:

But then I talked to some obesity medicine specialists. And they have really kind of made me think differently about... Because obesity is such a complex problem, it's not just a function of overeating. There's so many things that feed into it.

Dave:

What you said earlier is you don't want to say that weight loss equals health, but doesn't it in obese people?

Mary Claire:

In obese people, as long as you're not sacrificing muscle to lose weight, as long as you're losing fat.

Dave:

There you go.

Mary Claire:

And as long as you're doing it in a way that you can sustain for the rest of your life. And just the society we've created that weight loss at any cost is killing people and not making people healthier in the long run.

Dave:

Lettuce and aerobics is really, really, really harmful. Don't do that. I'm with you.

Mary Claire:

And I grew up in that generation, literally lettuce in aerobics. I mean, that was me in college and a cigarette, anything that we can.

Dave:

[inaudible 00:44:50].

Mary Claire:

So, of course I've totally reversed my stance. And having family members and loved ones who've struggled with weight and realizing this is just not simply about that they can't resist a plate of cookies. This is everything in their world leading to their failure, what they feel is failure.

Mary Claire:

I have one of the monitors in my office that measures visceral fat, that measures muscle, that measures water. And so I'm really able to give them a better picture of their bodies outside of just what the scale or their BMI says. And I think that BMI, I agree with experts, it's a terrible measure of health.

Mary Claire:

And so now my whole focus for my health is I'm really focused on 20 years from now, if I'm lucky enough to be alive, I want to be climbing that mountain. I want to be hopefully tossing up a grandbaby. I want to be doing the things. And frail little Mary Claire, I've got to stay strong.

Dave:

I wanted to talk with you specifically about something I haven't covered on the show before. Neuropeptide Y, what does that do?

Mary Claire:

So, neuropeptide Y seems to be driven by protein intake. If you go without protein for a long period of time, the neuropeptide Y, I believe increases. And so that seems to drive more hunger when you're not really hungry, when your calorie level is not down.

Dave:

Your cravings.

Mary Claire:

Yes, and carb cravings. So, by getting that level, in an optimal level for you, whatever that may be, and again, this is new and emerging. I just thought it was so interesting that the quality of our nutrition affects these things that drive our cravings.

Mary Claire:

That push us to eat when we may not actually have low energy needs or low energy and need to feed our body. And so, it was just one of the newest ones. The most information I could find on it was just a few paragraphs, but I was like, I'm just going to add this guy in there.

Dave:

It's a cutting-edge book because you did that. My understanding of neuropeptide Y is definitely, it increases your motivation to search for food and it gives you those carb cravings. And if you're getting likely 30 grams of protein, and that's probably a rough number. It may be higher than 30 grams for some people, depending on body weight and muscle and all that.

Dave:

But for most women, 30 gram's probably enough. And that's complete protein, then you're less likely to have neuropeptide Y, which means you won't think about food as soon as you finish eating. Which is what happened when I was a vegan for sure.

Mary Claire:

The studies that I saw were done using meat and not plate rice, these were omnivores, and they were measuring protein intake through that. And I think it was 30 per meal and 10 per snack. And so, trying to hit that 70 to 80 range for women.

Dave:

Why would you snack if you intermittent fast and know how to eat?

Mary Claire:

I pretty much eat throughout my entire eating window.

Dave:

But that's only eight hours. Got it.

Mary Claire:

Yeah, to get my 80 grams in, I have to just keep at it.

Dave:

It's actually really good point. A lot of women, especially if you're not feeling hungry during perimenopause, which can happen, you might not be getting enough protein if you're intermittent fasting just because it's actually hard. God, three eggs really? You only eat three eggs twice in eight hours in order to get there? Yeah, we kind of do. So, the answer is steak because steak is delicious.

Mary Claire:

So, women tend to stack. And when you look at eating patterns, they'll have very little protein when they break their fast. Or if they're eating the standard Western, they'll have cereal or something heavy with carbs that they think is healthy, maybe a little yogurt for breakfast. Lunch, they'll have a small little bit of protein.

Mary Claire:

They kind of stack their evening meal with a lot of protein. But again, I mean the research that I quote, you really can only process that 30 grams every couple hours in a sitting. So, try to get that 40 or 50 in with your evening meal, like a big piece of steak is not your best bet. And I talk to our students about you really should try to spread that protein out throughout your eating window when you break your fast with each snack throughout the day instead of just saving it up for that giant chicken breast at night.

Dave:

I'd be like, have steak or chicken at lunch and dinner. And then If you do snack between the two, but if you eat a adequate lunch, you probably won't. You're eating window is only eight hours. I mean, maybe you'd eat three times in there. But I find a lot of people don't eat enough protein in there.

Dave:

And you recommend fatty fish. And I also have recommended fatty fish for a long time, and I stack ranked them with sockeye salmon is the least mercury and other toxins. But since that time, the amount of microplastics in the ocean has gone up a lot.

Dave:

And the amount of mercury has gone up, and the amount of thallium has gone up. Although that's more of a kale issue than a fish issue. Are you concerned about the metal and plastic content of fish these days?

Mary Claire:

So, my daughter who's studying all this in college is making me very aware of it. And she talks a lot about there's farm raised versus the wild caught and what the potential differences are between the two. Yeah, I think as God intended, it was an excellent way to eat. But the way that modern fishing practices

have turned something that was really, really healthy into something that potentially could be not healthy for you.

Dave:

And it may not be the fishing practice, it may be the burning of coal and the dumping of sewage in the ocean. And really the use of microplastics and plastics everywhere, that's at the root of this. We got to get that stuff out of the ocean. And this goes off a little bit from our main topic.

Dave:

But right now, it's safer for the long-term environment to burn plastic in a high temperature incinerator than it is to let it degrade into small particles that will end up as part of your cells. And we just haven't faced that as a species, so we keep trying to do all this stuff. No, the plastic in the ocean, put it on a barge and burn it.

Dave:

And yes, there will be some chemical pollution that breaks down with sunlight and air over time and it's not great. It's just better than letting the plastic itself be in our bodies. So, I've moderated my fish consumption in favor of ruminant animals. Basically, cows and sheep and clean pigs when you can find them.

Mary Claire:

So, are you supplementing with any of the omega-3s?

Dave:

Oh, absolutely.

Mary Claire:

Or do you feel like you're getting enough?

Dave:

And they have to be animal based or possibly some algae because the omega-3s from plants they convert at a ratio of 45 to one. You can't get enough omega-3s from olive oil or some kind of flax or whatever. So, yeah, I take herring egg oil, which is best, or krill oil as my primary too. And those are low and microplastics just because of the nature of what they are.

Mary Claire:

Interesting.

Dave:

But it's a question for you in your audience with perimenopausal and menopausal women. Yes, you need the omega-3s but then if you get the mercury, how do we balance it out? I don't know the right answer. I take chlorella when I eat fish because it binds to mercury. But I'm just asking you as a doctor who sees a lot of people, what do you do? Because I don't really know.

Mary Claire:

Yeah, I try to stick to more things that are coming out of lakes as much as possible. And luckily, I live on an island and the fishermen are coming right up here. But I do recommend supplementation quite a bit for it as well.

Dave:

So, you tell people to take omega-3s, which is really cool. Interestingly, earlier you mentioned Mark Matson and he's actually been on the show too in episode six 34.

Mary Claire:

Has he? I'm like a geeked out fan. He just changed my life and I just think he's incredible.

Dave:

Oh, that's so cool.

Mary Claire:

I read all his papers.

Dave:

It's incredible how much good research there is around all this stuff out there. So, I'm always grateful to be able to shine a light on people who are coming up with either easy ways to teach something or just new knowledge. And your Galveston Diet book, I mean you wrote it for a very specific audience, women who are going into perimenopause and menopause.

Dave:

And you've got some really new cutting-edge info in it, which I think is really valuable, especially around these compounds that drive hunger. I know when I was obese, I had actually less testosterone than my mom in my early '20s. And I had these profound cravings and obesity. And it feels when I talk with someone going through perimenopause who had control of her body.

Dave:

And all of a sudden, it's like, "I don't know why I gained this weight. I'm really frustrated. I've tried hormones, I've tried all these different things." And I feel like your book is going to be really contributing to that set of knowledge. Because the fact that I had these cravings, and sometimes I gave into them, it wasn't a moral weakness.

Mary Claire:

Exactly.

Dave:

And we're taught that it's just because it's a lack of discipline, it's not. It just isn't. It's biochemistry, it's a hardware problem and it's hackable. And when you do it, you can get through menopause. It just takes sometimes a monthly tuning and tweaking because the changes are so constant.

Dave:

And this is why so many of my friends who are going through perimenopause are dealing with it. And some just are lucky they have a few symptoms. The ones who have a lot of symptoms, they go really deep. I think if they'd have read your book at the start, it probably would've saved them a lot of adjustments, a lot of work. And so, you've done a great-

Mary Claire:

That's my hope.

Dave:

So, thank you. Your website, galvestondiet.com. Correct. And thank you, Mary Claire, for being on the show.

Mary Claire:

Thanks for having me.

Dave:

If you or someone in your life is either going through or about to go through perimenopause, it would be a really good idea to pick up the Galveston Diet and give it to them. And you do that because if it's you, well, you should read it yourself. But the women in your life, it happens. And usually, they emerge at the other side with this weird thing called wisdom.

Dave:

But it can be a really, really painful and extended period. It doesn't have to be. And it's not just painful and extended for the person who's directly affected, everyone around them is affected too. Just like if you had a headache all the time and felt bad all the time, you wouldn't show up as the best version of yourself.

Dave:

So, since this is treatable and it's largely avoidable, especially if you get set up for success ahead of time, that's why this book matters. And it's a very important topic. We need more of this in the world. So, thanks again, Mary Claire.

Mary Claire:

Thanks.

Dave:

Guys, buy the book.