Female Hormone Disruption Resolves with NT

Gender, Age, Occupation, Nationality, height and weight.	**Miss P.W. Is a 31 year old living in London, working as a manager for a retail company. She is 5ft 5 ins and weighs 10 stone 8 lbs (165 cm, 66 kg).**
Presenting complaint – list and duration	Miss P.W. presented with an array of female hormone & gynaecological signs and symptoms have become increasingly frequent over the previous 10 years. In particular she has experienced heavy & painful periods, which lasted 6 to 7 days, an erratic length of cycle and detriorates from about day 12-14 (ovulation) until the end of her cycle, some 2 weeks later. Her premenstrual tension (PMT) included many emotional and physical signs and symptoms associated with this syndrome: extreme sensitivity & irritability, mood swings but mostly low, irrational thoughts sometimes bordering on paranoia, swollen & painful breasts (She needed to wear a bra to bed). Her skin quality had changed and became blemished and spotty, she gained water weight, felt extremely bloated, had significantly increased hunger which she resisted strongly. In spite of her measurements, she said she was carrying a stone more than was comfortable for her. She also had a coated tongue and suffered with low grade vaginal thrush just shortly before her period was due. She was unaware of her mother's health & hormone history but her one sister, 3 years older than her, had been diagnosed with polycystic ovarian syndrome (PCOS) when she was just 18 years old and had struggled with fertility issues, although after 6 IVF attempts had produced two children. P.W. was in a relationship but was not planning to have children in the immediate future, but she wanted to be able to do so if and when the time was right. She was very aware of what her sister had to go through to have her 2 children. Her long-suffering partner, as she described him, was the person she most often expressed her irritability to / at and she was very conscious of this, which made her feel guilty. P.W.'s work was stressful and she worked long hours.
Any Investigations	Visits to the doctors for the previous 10 years had involved blood tests, laparoscopies and one hysteroscopy and ultra-sound scans. She had been diagnosed with small ovarian cysts, a very small fibroid, and stage one abnormal cervical cells. This was being monitored, but no action had been taken. She had been prescribed a variety of contraceptive pills which had made her feel worse, not better, even though they did regulate her cycle. She was not currently taking any medication on a regular basis except pain killers on the first few days of her cycle. She had also taken tranexamic acid, a drug which helps to control excessive bleeding, and this had helped to some degree, but P.W. wanted to be free of medication and address her health 'holistically'. The blood test results, most often on or around day 21 had not found anything awry with her hormones. The abnormal scans and physical examinations which had been revealing were linked to her discomfort. She had a normal level of insulin, testosterone and DHT when tested 6 months previously. However, as one off measurement of these hormones do not exclude grades of insulin resistance, or an

	elevated level of DHT locally, in her skin. She had not been given any lifestyle or dietary recommendations. The questionnaires completed prior to the consultation were replete with under-linings and asterisks indicating the degree of symptomology she was experiencing, and she scored highly in the female hormone section, the adrenal section, the thyroid section, the blood sugar handling section and the vitamin and mineral need section. Her diet reflected the way she felt and was relatively sound for 10-14 days and then fell apart due to the cravings she experienced. She always ate breakfast but this was a carb dominant meal of a cereal or toast. She did not snack much in the first phase but then could not stop snacking in the second, and because she did not want to gain any more weight she would consequently avoid her healthy option evening meal. Her lunch consisted of a chicken salad with a piece of fruit or a grazing option including biscuits and cheese on crackers plus chocolate. She drank water during the day along with 1-2 cups of tea she was not a coffee drinker and hardly drank alcohol because she felt so tired and awful afterwards. This indicated a potential need for liver support and the possibility of some kind of dys-metabolism of oestrogens. Exercise She walked 3 miles to and from work and did some cardio work in the gym 2-3 times a week, but again this stopped completely in the second phase of her menstrual cycle. Test The one test that was recommended was the urine test called 'Oestrogen Metabolism Assessment' which measures 2-hydroxy-oestrone and 16-hydroxy-oestrone. She completed this test before commencing any changes. The results revealed that she had a marginally elevated level of 16-OH (12.4 in a range of 2 – 10) and a very low result in the range of 2-OH (3.5 in range of 2 – 17). The ratio was therefore disturbed. This indicated a measurable and identifiable alteration in the metabolism of female hormones.
Strategy	The primary focus was on improving the metabolism of her female hormones. I explained how to balance her macro-nutrients in a different way. We discussed suggestions for each meal, the need to consume protein at breakfast and we discussed an anti-inflammatory, higher vegetable intake diet. We went through a long list of colourful vegetables making notes of their individual phytonutrients and potential benefits and established how she might include them in her daily diet. The purpose was to educate and therefore instil motivation for change. She was one of those patients that needed to know something and then she could follow it.
Diet & Supplements: name and dose	P.W. agreed to include a protein at breakfast, to drink more water during the day, to consume at least 4 different vegetables a day and keep a colour record to tick off the 6 colours over the week: green, blue, orange, red, purple / blue, tan / white. I also recommended change to the snacks she kept at work and P.W. agreed to empty

her drawer at work and replace with almonds and sunflower seeds.

The supplements recommended were:

Supplement Name	Dose
AR – DIM (Enhanced Delivery)	2 with breakfast & 2 with dinner
BR – Ca-D-Glucarate	1 with each meal
AR – Gluta-Ascorbs	1 with each meal
BR – EFA-Sirt Supreme	2 with breakfast & 2 with dinner
AR – Flax Seed Meal	1 heaped tablespoon in water before lunch & dinner

DIM (Enhanced Delivery) (AR) - this brassica plant extract is well absorbed and is the most consistent means by which to alter the metabolism of the 2-OH and 16-OH, in my clinical experience.

Ca-D-Glucarate (BR) – provides the substrate for glucuronidation, which is one of the pathways through which female hormones are conjugated.

Gluta-Ascorbs (AR) – a combination of reduced glutathione and vitamin C. Despite the lack of evidence to support oral glutathione supplementation on raising blood levels of glutathione, this product consistently helps to support those patients with liver detox needs. It may well be that it supports these processes within the gut which are as abundant in the GI tract as the liver itself. By supporting the glutathione pathway, it helps to reduce inflammation and the burden on the other pathways such as glucuronidation and methylation and sulphation.

EFA-Sirt Supreme® (BR) - Dr Mark Houston MD formulated this omega 3 & omega 6 fatty acid formula to maximise the anti-inflammatory effects of the fatty acids. This is achieved with a ratio of 2:1 in favour of EPA + DHA to GLA.

Flax Seed Meal (AR) – provides lignans that support the level of SHBG (sex hormone binding globulin) which can then temper the expression of an excess of oestrogens. When added to water it expands noticeably. It can also serve to support healthy bowel motions.

Duration

P.W. followed the supplements for over six months and the programme was revised over time. We met a total of four times in that six month period.

She managed to make some changes to her diet and whilst very challenged by the cravings she experienced she did her best. As the months went by, she was more and more able to choose healthier options.

She also repeated the oestrogen metabolism test after 4 months on the programme.

Outcome

P.W. returned for her first follow up 5 weeks after the first consultation. She had managed to take the supplements 90% of the time. She reported noticeably more energy and about a 30% reduction in her PMT signs & symptoms overall and a friend told her she was definitely less snappy and irritable. Her partner confirmed that there

were definitely some positive changes.

She told me that the protein at breakfast and the increased water intake were positive for her energy and sense of well-being.

The supplement programme was changed slightly to accommodate the introduction of Equi-Fem (BR), and 2 of the supplements were reduced in dose.

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AR – DIM (Enhanced Delivery)	2 with breakfast & 2 with dinner
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AR – Gluta-Ascorbs	1 with breakfast & dinner
BR – EFA-Sirt Supreme	2 with breakfast & 2 with dinner
AR – Flax Seed Meal	1 heaped tablespoon in water before dinner
BR – Equi-Fem	1 tab with each meal before ovulation, 2 tabs with each meal after ovulation

Equi-Fem (BR) – is a potent multi vit & min with glandular extracts that has clinically been effective, for years, for a wide range of female hormone signs and symptoms.

We met 6 weeks after that, and P.W. reported more significant changes after 2 months on the programme. Her energy was more stable, she was less emotional after ovulation, her partner was very certain there were very positive changes to the way she was, her physical symptoms were much less but she still had heavy & painful periods.

P.W. continued with this programme and we met after a further 6 weeks, and she was consuming the colourful veg every day and every week as she had set out to do. She had consumed much less refined sugar and salt than she would have done. She reported that her overall she was 80% improved, except for the heavy periods. I recommended she reduce the Ca-D-Glucarate & Gluta-Ascorbs to once a day but keep on with the rest of the programme.

A repeat urine test was conducted whilst on the supplements at this stage, 4 months after the first test. The results were markedly improved. Her 2-hydroxy-oestrone had risen from 3.5 to 7.4 (in a range of 2-10) and her 16-hydroxy-oestrone had reduced from 12.4 to 8.6 (in a range of 2 – 10). The ratio was now completely normal.

She is also due for a repeat scan to determine if the size of the ovarian cysts remain and if the fibroid is the same size as it was.

Comments

P.W. engaged in a comprehensive programme designed to support her female hormone metabolism, but one like so many nutritional programmes that nourished her more comprehensively than before. She ingested more antioxidants from supplements and from food, had balanced her blood glucose better than before and thereby helped her cortisol & insulin levels. She may also have increased her SHBG levels with the Flax Meal but this was not tested. Perhaps most importantly, she gave her liver the vital support it required for more optimal hormone metabolism, and detoxification.

She still has heavy periods and this is probably linked with the presence of the fibroid

	and we will learn more about whether this NT programme has helped reduce it or not after the scan. P.W. and her partner can hardly believe the transformation that has occurred within her and she feels so much less wired and stressed and guilty; it has been a tremendous process for her. She wishes she had done something like this years before, but said she had no idea that nutrition could make such changes. She had been told that there was nothing she could do, it was familial, and it was all a question of finding the correct hormone pill. She is half a stone lighter and feels better in herself than she has ever done in her adult life (except at the start of her cycle, that is). It is hoped that with perseverance that this can also be successfully addressed.
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