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[00:00:00] **Dr. Makeba Williams:** Thanks for watching!

[00:00:06] **Ronni:** Welcome to This is Probably a Really Weird Question, the podcast where a medical doctor

[00:00:12] **Dr. Makeba Williams:** and a

[00:00:13] **Rebecca:** doctor of history talk about sex, history, and the not at all weird questions we hear from patients, students, and colleagues about our bodies and our sexualities.

[00:00:24] **Dr. Makeba Williams:** I'm Dr. Ronnie

[00:00:26] **Rebecca:** And I'm Professor Rebecca Davis.

[00:00:29] **Dr. Makeba Williams:** And

[00:00:29] **Ronni:** today's question is...

[00:00:31] **Dr. Makeba Williams:** Could

[00:00:31] **Rebecca:** this be menopause?

[00:00:39] No jade

[00:00:39] **Dr. Makeba Williams:** eggs then? Uh, no. That's not gonna help you out, Becky. Save your money. No vaginal steaming? No. You don't need to steam your vagina. Please stop. No pellets inserted under your skin.

[00:00:58] Hey, Rebecca. Hey, Ronnie. How

[00:01:00] **Rebecca:** you holding up these days? So much better today than I was even

[00:01:04] **Ronni:** 36 hours ago. Really? Tell me everything. So

[00:01:07] **Rebecca:** the everything is that words formed in the brain stuff and they, they arranged themselves and they went to the fingers and the fingers made the words come onto the screen and then suddenly I had paragraphs.

[00:01:23] So I had written an introduction to my new book and I'd sent it off and the editor Very kindly said he thought it needed a quote unquote rethink, which was the nicest possible way of saying, throw it out the window and start over again. He was correct. And it was like the most physically excruciating writing I've ever done.

[00:01:44] But it was such a lesson in phoning a friend. I just along the way found key people who would still love me even after they read. A really not so great draft and just be like, I just need you to read this. Tell me, is there an idea in it? I should keep and I got little bits of suggestions along the way.

[00:02:04] And then I realized what I'd been missing all along was a dirty joke. You know, I feel that

[00:02:10] **Ronni:** way about a lot of things in life, to be honest.

[00:02:14] **Rebecca:** And so a dirty joke was my entry point for figuring out how to write the introduction. So it is now back to the editor. I hope by the time listeners hear this, he's told me if he likes it or not.

[00:02:26] But it was. To the point that my son was like, you know, Mom just takes these things too seriously. You know, Dad, we really need to talk to her about maybe some breathing exercises. I was

[00:02:37] **Dr. Makeba Williams:** just, I was like, I have to

[00:02:38] **Rebecca:** send back the advance. It's all over. There's no, you know, I could never do this. Um, so for anyone out there who, who has ever reached that moment in a writing project, I think it's universal and it is so excruciating.

[00:02:52] So that's where I was Saturday and I'm just in a better place today. So that's my story. Oh,

[00:02:57] **Ronni:** I'm so glad. Boy, yeah, it's like very humbling, right, when you've worked so hard on something and you get very, you know, very appropriate but constructive feedback. It just takes the wind out of your sails totally.

[00:03:09] **Rebecca:** No, it was the right feedback. So anyway, how are you? You know,

[00:03:12] **Ronni:** I'm doing all right. It is finally cooling off here in Madison, Wisconsin, so it's, it doesn't make me want to peel my skin off every time I walk outside. It is a blessing.

[00:03:22] **Rebecca:** Wonderful. I'm glad to hear it. It's good weather. Good fall weather coming

[00:03:25] **Ronni:** in.

[00:03:25] So I, I'm so excited

[00:03:27] **Dr. Makeba Williams:** about this topic.

[00:03:28] **Rebecca:** Yeah. Today's topic is something that I know I talk about with my friends all the time, and even with people I don't know that well, you'll just be at a cocktail party hanging out and suddenly you and a woman you've known for three minutes are describing your symptoms, you know, Oh, my God, do you sleep anymore?

[00:03:46] Oh, I just noticed you took off your jacket. Do you need me to fan you? Are you like this sort of collective experience of symptoms overtaking your body and not knowing what the heck is going on. So I'm really excited that we're going to dig into it a bit more.

[00:03:58] **Ronni:** Yeah. And you know, I am definitely of the age I'm, you know, I'm 47 now, so I'm definitely of the age where some of these symptoms are coming to the fore of my brain a little bit more.

[00:04:08] And I hear about it in clinic a lot too. So, you know, oftentimes People are coming in for symptoms and they want to know like, is this because I'm in menopause or perimenopause and like the most common ones that people know about are, you know, hot flashes and menstrual changes, right? So like your period either becoming irregular or stopping altogether, but I'm hearing so much more from folks about like headaches and mood changes and sleep disruption and brain fog and acne changes in the way that their body is holding on to weight and things like that.

[00:04:39] And. You know, usually my answer is, sure, it could be, maybe. And so, luckily, we have somebody who's able to say more than, uh, I don't know, maybe. We have an expert with us today to shed some light on, uh, menopause and periodic menopause. Would you like to introduce

[00:04:56] **Dr. Makeba Williams:** yourself? Yes, my name is McCabe Williams, and I am a certified menopause provider.

[00:05:06] I'm certified through the menopause society. I serve as an associate professor of obstetrics and gynecology at Washington University in St. Louis. And I have been practicing menopause medicine for almost 20 years now.

[00:05:25] **Ronni:** I love it. You know, Rebecca, you probably know this already, but Dr. Williams here is kind of a big deal and the consummate professional.

[00:05:34] And one time, Makeba made the mistake of asking me, to give some suggestions for names for a lecture that she was giving at a very important academic conference. She should have known better than that because, because the list I came up with was certainly not appropriate for the venue, but let me give you a few.

[00:05:56] Uh, Baron is the new black. One

[00:06:00] **Dr. Makeba Williams:** of my

[00:06:01] **Rebecca:** personal favorites

[00:06:01] **Ronni:** is Keeping Up with the Hot Flashians. Nice.

[00:06:05] **Rebecca:** Very nice.

[00:06:06] **Ronni:** Um, let's see here. Toto, we're

[00:06:09] **Dr. Makeba Williams:** not in menarche anymore. I love that one. I love that one.

[00:06:14] **Ronni:** Hot for teacher, what Van Halen can teach

[00:06:16] us

[00:06:17] **Dr. Makeba Williams:** about menopause care.

[00:06:21] Uh, the atrophic vagina monologues.

[00:06:25] **Ronni:** So there you go. Note to self, if you are giving a big important professional lecture, please don't come to me for big professional important titles, because I'll just make a joke out of it all.

[00:06:36] **Rebecca:** Or do, because there's nothing better than laughing before you get up to give a

[00:06:39] **Dr. Makeba Williams:** talk.

[00:06:40] I will echo that. It was a really great exercise that we engaged in, so I thank you.

[00:06:47] **Ronni:** It was so fun. So, Makeba, can you just give us the 411 on like, what is

[00:06:53] **Dr. Makeba Williams:** menopause? Happy to. So, I'd like to think about menopause as a Physiologic change that our bodies are going through, and it results from a decline in estrogen.

[00:07:08] So our ovaries have been producing estrogen since we were born, and we reach this point in time when we get to about midlife. We have fewer than about 3 to 400 eggs to ovulate out, so we see a decline in progesterone and the amount of estrogen being produced by the ovaries declines. And this is critically important to understand because estrogen is a really terrific hormone that acts in every organ system in the body.

[00:07:43] It works in your brain, your bones, your muscles, your vagina. It's much more than that reproductive, um, hormone that many people associate estrogen with. And so consequently, when we reach midlife and we reach menopause, which is defined as going one year without any menstrual cycles, we will experience a number of changes in many different areas in our bodies.

[00:08:15] And

[00:08:15] **Ronni:** can this happen at any time? Yes.

[00:08:19] **Dr. Makeba Williams:** While the average age of menopause is 51, and we begin to make this transition somewhere about 45 to 47, we do see menopause occurring in earlier stages and ages. There are women who will undergo menopause, so their ovaries are no longer functioning as we would expect them to even in the thirties.

[00:08:47] So if we have menopause. diagnosed before the age of 40. We call that premature menopause. And then there are those who will experience menopause before the age of 45. We call that early menopause. So we do need to broaden this perspective that this is a condition that is impacting only women beyond mid forties, when, in fact, There are women who are in their thirties, twenties, even who are experiencing these menopausal symptoms and conditions.

[00:09:26] And if you're somebody who

[00:09:27] **Ronni:** started your period really early in life, are you more likely to have menopause earlier?

[00:09:33] **Dr. Makeba Williams:** We don't know. That can vary, right? So we would say the best sort of signal for when you might experience menopause is when your mother experienced menopause, or if you have an older sister who experienced menopause.

[00:09:48] So speaking with them can provide you with some guidance about when menopause may begin for an individual. Thank you.

[00:09:56] **Ronni:** And what are some of the common and uncommon symptoms that folks can experience with menopause?

[00:10:03] **Dr. Makeba Williams:** Well, I think, you know, when we were in offices and communal workspaces, I'd say people would stand around the water coolers, water fountains and talk about hot flashes and night sweats like that's socially acceptable to talk about.

[00:10:18] I was just in one of those big box stores where you have to have a membership and I was checking out and I saw this woman with a fan on her neck and I said, Oh, are you having hot flashes? She said, no, I just have a fan on my neck, but you know, like, it's okay to ask that. What I would not ask this woman is about a symptom that really impacts about 80 percent of menopausal women and that's vaginal dryness.

[00:10:48] Like the vagina that is no longer well lubricated, doesn't have the elasticity or the wrinkles that it once had because Estrogen is no longer in robust supply and estrogen stimulates blood vessel production and blood flow to the vagina. So when someone goes through menopause and estrogen is no longer there, you're not going to have this plush vagina that one had.

[00:11:18] So that is one symptom that we know can be very impactful for menopausal women. that we don't really talk about. And while hot flashes and night sweats may last on average 7 to 10 years and they go away, the vaginal symptoms are chronic. They're progressive. And, you know, It can even impact your urination.

[00:11:47] So there are folks who have to go more often or feel an urgency to go. There are those who will experience more urinary tract infections or have infections in the vagina as smelly discharge. All as a result of the decline in estrogen and the changes that go along with that. You know, you were talking

[00:12:11] **Ronni:** earlier about what you experienced in your early medical training with menopause treatment, and I was thinking about, I haven't been in practice that long, but even since I have been in practice, right, the pendulum of menopause care has just like been swinging wildly, right?

[00:12:28] When I first started out. Everybody was getting hormones, right? And then when I was in medical school, right around the time that the WHI study came out, we were like, nobody gets the hormones, right? So this pendulum is just swinging wildly. And now we're kind of coming back into the middle where like, well, maybe some people can have hormones.

[00:12:44] And, you know, I feel like that history is so, so short. Rebecca, I'm curious about what sort of things you have found even from further back history.

[00:12:53] **Rebecca:** So, I mean, really further back, you know, there are ancient Greek myths about a woman who, often it's sort of told as like her husband goes off to war and never comes back, and then in his absence she grows body hair and her voice deepens and she becomes a man, so it's sort of describing some of the secondary characteristics of menopause, including, you know, stubbly facial hair and things like that.

[00:13:16] Uh, so there have been myths about what exactly this phenomenon is, usually It seems, you know, one's authored by men, uh, but more, more recently, there's a fascination with the connection between menopause and what it means to be a woman. Both sort of what womanhood as a social role means, but also often because most physicians were men.

[00:13:40] It was about sort of what are the. sexual possibilities for a menopausal woman. And, you know, this is significant because by the 19th century, British and American medicine defined women as wombs. The most important thing that made one person a woman and not something else was the presence of a uterus.

[00:14:02] And this was also the reason why women shouldn't go into higher education because You know, we would divert too much blood to our brains instead of having it go to our uteruses, which were, you know, really our whole reason for being, um, and there were all these theories about, you know, why couldn't women, you know, be in political office?

[00:14:18] Well, what if they gave birth right in the middle of giving a lecture on the floor of Congress? You know, we all know that's how it works. So. Because women were medically so associated with the uterus, menopause opened up all these broader questions about women's social role. So as women's roles in the world change, a lot of the theories about menopause also change.

[00:14:39] One of my

[00:14:40] **Ronni:** favorite, like, history of medicine nuggets is that, you know, the definition of hysteria. Back in the day, they thought that the uterus would actually, like, wander around the body and make people

[00:14:51] **Rebecca:** feel wild. Yes. Yes. The Wandering Uterus.

[00:14:56] **Ronni:** The Wandering Uterus. That's going to be the name of my next band,

[00:14:58] **Dr. Makeba Williams:** travel band.

[00:14:59] I'm getting some new, new titles for talks even just in this conversation.

[00:15:04] **Rebecca:** There you go. So I mean, initially the, the treatments were things like don't wear corsets. Uh, eat mild, bland food. You know, try not to have extremes of hot or cold. So endocrinology sort of starts around the late 19th, early 20th centuries.

[00:15:20] And so that's also when you start to see the first thoughts about how hormones could treat menopause. But we really get synthetic estrogen around 1938, 1939, and. There are different versions of it that are made and marketed. And a lot of what doctors would do is they would recommend, first of all, reassurance and sedatives.

[00:15:42] And if those didn't fix the problem, then also give one of these synthetic hormones. Wow. That was the official recommendation. But historians of medicine who study this think that probably more women than that would suggest we're actually getting some form of synthetic hormone by the mid 20th century.

[00:15:59] One of the turning points in this whole process, though, is when this physician, Robert Wilson, who's a Brooklyn gynecologist, publishes a book called Feminine Forever. Oh. Yeah, yeah. The book comes out in 1966, but he's already written a whole bunch of articles by this point, some of them co authored with his wife, and he recommended estrogen replacement therapy from, quote, puberty to the grave, and he described menopause as a deficiency disease.

[00:16:25] Can I just read you a couple choice quotes? Yes, please.

[00:16:29] **Ronni:** Do I need to have an emesis

[00:16:30] **Rebecca:** bag nearby? Yes. Okay. He says that women going through menopause had a, quote, vapid, cow like feeling called a negative state and suffered through, quote, a gray veil and live as docile, harmless creatures missing most of life's values.

[00:16:46] Dude. Yeah. But if you took estrogen, his argument was, um, you could return to the sort of natural vibrancy of womanhood and of femininity. Now the sort of conversation we've been having about symptoms like vaginal dryness and the way that that could affect a woman's sense of her self as a sexual person, her ability to experience sexual pleasure, her interest in being a partner to her sexual partners, right?

[00:17:14] That could all play in. But of course, this is the 1960s, and it's packaged as femininity, right? Which is really about a presentation of a gender, of a idea of what it means to be female in the world. Fast forward, Too long, didn't read, uh, big debate over is menopause natural, right? Like the childbirth argument.

[00:17:33] Is it this wonderful, magical, natural thing that we should do without any drugs or is it in fact a medical condition and so therefore it's completely appropriate to take different kinds of medications in conversation with your physician. So and that debate has just yo yoed around in sort of expected ways among different groups of women and physicians and advocates

[00:17:55] **Dr. Makeba Williams:** ever since.

[00:17:56] Yeah, I just, um, think it's very fascinating. And one of the quotes that really startles me by Dr. Wilson is That if we give estrogen, it will cure women of all of their maledictions. And one of these other quotes he says is that breast and genital organs will not shrivel and such women who take estrogen will be much more pleasant to live with.

[00:18:24] And will not become dull and unattractive.

[00:18:28] **Rebecca:** Yeah, he had another choice quote, The unpalatable truth must be faced that all postmenopausal women are castrates.

[00:18:35] **Dr. Makeba Williams:** Wow. So, you know, it's very interesting, Becky, when you talk about this notion of do we view this as a medical condition versus a natural transition.

[00:18:46] This book, written by Robert Wilson, was popularized and supported by pharma in many ways, and Dr. Wilson went on a speaking tour around the country, speaking both to healthcare providers and to lay audiences, and we see an uptick in the use of hormone therapy as a result. It was, you know, Ronnie sort of put forward as If the pancreas cannot produce insulin when we should replace it to prevent diabetes, we should do the same for women who are going through this menopause transition.

[00:19:29] So we have seen these swings and pendulum and how we should approach it. Where we are now is If you are having symptoms that could benefit from hormone therapy, it is quite appropriate. So if you're within those first 10 years of your last menstrual period and you are having bothersome hot flashes and night sweats, if you are having vaginal dryness and urinary symptoms that are bothersome, And two other additional states, which we talked about earlier, if you're in a premature menopause, so your body does not have estrogen, which is so very important for cardiovascular health, for bone health.

[00:20:16] Sexual health and function. So if you're in a premature menopausal state, the data is very clear that you should use hormone therapy and use that to the natural age of menopause. And the last indication would be for prevention of osteoporosis and bone loss. Very clear about this. I think it's also very interesting that you bring up that reassurance and sedatives.

[00:20:42] were often prescribed. And unfortunately, that is still what is happening all too often. So too many women are presenting with menopausal symptoms, and they're either dismissed or they are told to grin and bear it. I have seen too many women present to my menopause clinics saying that their practitioner just said it'll pass, it'll get through it.

[00:21:13] And the, the problem with that is it can have. Health consequences. So we know that hot flashes, night sweats are associated with cardiovascular disease. And in fact, maybe a biomarker for cardiovascular disease. We know that there are social and economic and productivity impacts that occur when we are just trying to tough through these really bothersome symptoms.

[00:21:42] So that is definitely not the right approach either. And while not everyone needs to have a hormone therapy or hormone therapy isn't necessarily right for all women, We are fortunate to have some antidepressant, uh, what we call SSRI medications that could be helpful to relieve some of the hot flashes and night sweats that women will experience.

[00:22:11] And we sit in a space currently where we've had newer therapies introduced that are Not in the antidepressant category, not in the hormone therapy category, but reflect our evolving understanding of how hot flashes and night sweats occur and targets that sort of mechanism in our thermoregulatory centers within our brain and our hypothalamus.

[00:22:42] So it's, it's exciting time to. The caring for women and an opportunity for us to answer some of these questions that women are sitting with, um, and the curiosity and the unknown so that they can get the care that they need so that they're leading their most productive lives, that they are living their best lives.

[00:23:06] And finally, you know, at this time. We can prioritize our health and our longevity.

[00:23:12] **Rebecca:** There was a big article out in the last, I want to say, three or four months in a mainstream publication about the sort of revision to thinking about hormone replacement therapy and the problems with the way the data back in 2003 was interpreted.

[00:23:27] And one of the things that really caught my attention was, what I recall from it, is that African American women are more likely to have very frequent hot flashes. And also have higher rates of cardiovascular disease, and that, in fact, not providing HRT to women who are reporting lots and lots of hot flashes, whatever the correlated cancer risks, there's a really serious cardiovascular risk that's not being addressed, and I just felt it was, first of all, very upsetting to think that You know, all these women who could have been getting help weren't getting it because of the way that the data from that one study was interpreted, but also just a reminder about, like, medicine, seeing the whole person and thinking about the ways in which certain people's symptoms are dismissed.

[00:24:17] And I always find it so interesting, like, how the data is weighed in terms of what are the pros and cons. We're women told, like, your, you know, chances of breast cancer are going to increase from 0. 5 to 1. And you will no longer have pain during sexual intercourse. Right? Like, is that enough of a benefit for a woman to decide, yeah.

[00:24:39] You know, or you won't have your chronic urinary problems anymore. And that's less serious, of course, than the cardiovascular issue. But I'm just, I wonder what you've seen in your own career across these 20 years in the way physicians and patients are weighing the pros and cons of different therapies.

[00:24:58] Like, does the physician or does some study decide what risk is too big of a risk for a person to take? Or has there been more of a shift toward letting patients say, I understand that risk, but there are benefits that are more important to me than that. Like, I'm willing to take that. Like, I have my own risk calculus.

[00:25:15] That's a risk I'm willing to take because I want these other benefits. I guess that's my long way of getting to that. But also just thinking about racial bias and the way that those risks and benefits are

[00:25:25] **Dr. Makeba Williams:** weighed. You touch on a couple of things that are. Of professional interests for me and academic interest and one it's the intersectionality of symptoms and treatment and decision making.

[00:25:40] So what you alluded to is true. We know that there are some racial and ethnic differences. In the menopausal experience and I think for far too long we have painted the picture of this menopause transition and menopause experience with a very broad stroke. There is variability in how the symptoms are experienced from one individual to the next and to the extent possible we need to individualize care.

[00:26:13] To touch on those racial and ethnic differences, we know that African American women experience hot flashes and night sweats more frequently, experience them more severely, and for a longer duration. White women on average will experience hot flashes, 6.4 years, 10 years for African-American women. Six years is a long time.

[00:26:43] In years, a whole decade is even longer and can be impactful. And when we look in the broader scheme of things of cardiovascular disease disparity. And we do know that there is an inflection point in this midlife transition of seeing more hypertension, more diabetes develop, and other cardiovascular disease.

[00:27:09] And we know that these vasomotor symptoms, these hot flashes and night sweats can be a biomarker. And so when we see this differential impact that sort of sits squarely on top of African American women to deny treatment does even more harm and drives even more disparity. What the data also shows is that African American women are half as likely to be prescribed hormone therapy and they're half as likely to be treated for their hypertension as well prescribed statin use.

[00:27:46] So for cholesterol, wow, so the silence around this issue as well, the lack of individualization And attention to how women perceive risk, how they want to tolerate risk is critically important for us to address. So, I have started now two menopause clinics in my career where I focus on teaching the next generation of healthcare providers how to care for women.

[00:28:22] And one of those principles that I focus on is individualization, shared decision making, and culturally responsive menopausal care. What I value in terms of risk may be very different from the next African American woman or for the two of you, so it's really not about my own. personal preference or my tolerance for risk.

[00:28:53] But it is really in the truest sense of shared decision making. It is sharing the best evidence that we have available. What we know about these symptoms, what we know about menopause as a condition, what treatment we have available, sharing the

[00:29:14] risk and the values. of the women we take care of and coming to a shared decision because risk tolerance is very different. I have had patients who have had their ovaries removed because they are at high risk for breast and ovarian cancer and that surgery, removing the ovaries, makes them menopausal instantaneously.

[00:29:41] And I've had women sit in my office and say to me, If I had known that it was going to be this bad. I would have rather have gotten cancer. Those are strong words and they have given me pause over the course of my career Which is why I think it's so important that we are forthcoming with all of the information That we have to help people understand what menopause is and the risks that are associated with it And so if you at the end of the day decide that You value avoiding the risk of a breast cancer or, or an ovarian cancer because of your family history.

[00:30:24] That's fine. And now let us talk about how do we manage some of the risk that will come because now you're prematurely menopausal.

[00:30:35] **Ronni:** Right. You know what you're describing, Makeba, I feel like it's such a paradigm shift in general, how we function in medicine, right? For so long, the paradigm was we hold all the information.

[00:30:46] We tell people what to do. Oh, yeah, that's what you want. But what you don't understand is that, you know, these risks down the road, and I'm not willing to take on that risk, right? If I do this, I could hurt you, which I think is a. Is a noble idea. And you know, I, I find myself in that space as well when we're talking about gender affirming hormones because gender affirming hormones come with significant risk.

[00:31:09] And, and so we talk about it. We say like, look, you could have a stroke or you could have a heart attack. And the vast majority of people that I see say Okay, these medications are going to be life saving for me, and I'm willing to take that risk. And I feel like I'm doing my due diligence by making sure people understand the risk and also helping them

[00:31:29] **Dr. Makeba Williams:** live their best lives.

[00:31:31] Yes, it is. So important that we appreciate the full range of understanding that patients have and that patients are able to show up and express their level of understanding of risk. And where I see my job is to make sure that I have shared all of the information. There are some therapies that I will not prescribe for certain individuals because the risk is, in many ways, they may have a clear contraindication for it.

[00:32:12] And so this could be the 75 year old coming in with hot flashes and night sweats. wanting hormone therapy, it would be malpractice for me to initiate hormone therapy for that individual. And this shouldn't be a cause for an argument. This is, let me lay out the data as we have it, right? So this is what I know.

[00:32:35] Hormone therapy for you when you were In your transition from menopause up into about your 60s, it would have been okay to start that. And even if you continue to have hot flashes and night sweats and you were 65, but we initiated it in that safe period, I will continue it. But you can't just walk in the door and have it, because I do not want to actively give you a stroke, right?

[00:33:01] Like, so, I think what I'm trying to say is that we have to individualize, that we have to share And have thoughtful conversation. I think for too long, there were not conversations. It was, you're coming to me, I'm going to tell you what to do because I am the keeper, I am the holder of the information and I don't really care how you're feeling or what, because I am all knowing.

[00:33:26] I'm the decider. Yeah, I am the decider. Which, that is how we end up doing harm to folks and don't totally appreciate. their authentic selves.

[00:33:38] **Rebecca:** Well, I appreciate all you're saying because, of course, you know, I'm sitting here just listening to the two of you, and you know things that I don't know. Like, my physicians understand these processes and understand how to read these studies very differently than I do.

[00:33:55] And so I think that you layer in the sort of history of misogyny and of racism, and so a lot of people go into these offices and just feel crazy stuff is happening to my body. I feel awful. And you're sort of then at like the mercy of this person to take you seriously and to give you, you know, the information that you need.

[00:34:19] And hopefully, you know, it's somebody like one of the two of you who really listens and presents them with what all their options are. So I feel like that's a big part of the history of menopause, um, is when it's talked about, it's joked about. A lot of the time and or just complain like it's just one of these things that women go through that they complain about they can't can't do anything about it.

[00:34:38] It just happens versus finding, you know. Medical provider who's willing to say, actually, here are the symptoms we can alleviate. Well,

[00:34:46] **Dr. Makeba Williams:** it's as Ronnie alluded to earlier, it's characterizing this as hysteria. You know, we've gone through the seven dwarfs of menopause. Like, you know, itchy, bitchy, crazy, you know, like, on and on.

[00:35:04] That's one caricature, but it's the woman who is falling apart. She's on fire, losing her mind, going crazy. And those sort of depictions have not served any of us well. And it has been quite harmful and... Barrier for having a serious conversation with health care providers about what you're going through.

[00:35:34] And unfortunately, many health care providers as a result of the release of the W. H. I. And and the over magnification of risk. And I would say Overgeneralization of what was learned in that study. Many health providers said, Oh, no, I'm not going to deal with this. I'm not gonna have a conversation about it.

[00:35:57] I'm just not going to treat you with hormone therapy. So don't even show up in my office. Mhm. Just grin and bear it. And so then women don't feel welcomed in many, even ob gyn practices. They feel welcome to come and have their babies. And it's what you speak to. Like we are appreciated for reproductive potential.

[00:36:18] But as we grow and as we mature and we're no longer reproducing, we may not find that we are valued or appreciated in some of these clinical settings. And so therefore there are a lot of women who are tolerating treatable symptoms or suffering in silence because there is no openness to conversation because they're going to be deemed as just losing it and they just don't generally feel appreciated.

[00:36:53] While

[00:36:53] **Ronni:** you were reading those quotes from Robert Wilson's book, it really struck me, like, on the one hand of how regressive and, like, old fashioned and misogynistic that stuff is, and then, on the other hand, before this episode, when I was researching, I just was like, hmm, I wonder what would happen if I Google menopause humor, right?

[00:37:12] And it's all just these cartoons that are regurgitating that same idea, right? That, like, People who are going through menopause or who are postmenopausal like aren't sexy anymore. They're crabby or You know, emotional or unpredictable and no value. And so even though when you read that textbook, it sounds really old fashioned.

[00:37:35] It's still happening, right? And I feel like there's a difference between two people commiserating about like, Oh God, I'm having all this brain fog or, you know, and, you know, seeking solidarity with one another to making light of something that can be enormously impactful and damaging to somebody's life.

[00:37:54] **Dr. Makeba Williams:** And yet, I find hope in that we're in this space where we are beginning to have very serious, legitimate conversations about menopause, and we are beginning to recognize the true value that women bring, and I think part of the conversation is Is a result of having more parity and leadership and now that we have women who are in positions of power and authority who are experiencing some of these things that, you know, workplaces have to understand, like, if you can't create environments for.

[00:38:38] These women to thrive your organization, your corporation is under serious threat because we have seen for far too long that women are stepping away from. Positions from promotions and no matter what you do, it could be the person who is working on a factory line who can't keep up because she is like soaking wet.

[00:39:06] You know, we need a whole space for her. We need a whole space for the professor who told me I can no longer teach advanced level classes. I am a tenured professor. I have stepped away from Teaching those classes because I can't remember the next thought. So like what happens, what a detriment to our societies when we have women who have all of this experience, all of this knowledge begin to drop out because we have unfairly characterized this experience and made light of these experiences so they just fade.

[00:39:46] To the background that is a threat to our economy, even and I hate to, like, even, you know, place this sort of monetary value on women and think about it in those terms. But the great work that we are doing. Outside of our homes within our homes. If we do not hold space, we don't take care of these midlife and menopausal women.

[00:40:09] Our society is going to be adversely impacted. So it is great that we have a group of women who have emerged who are these digital natives who are agentic who are saying enough of this, right? I am owning who I am. I am owning my health care and are impoverished. Seeking out information beyond traditional health care settings so that they can advocate for themselves.

[00:40:37] It's actually

[00:40:37] **Ronni:** a nice segue into what sort of resources do you recommend that folks check out either if they are personally experiencing menopause or perimenopause or if they're somebody who provides medical care for patients? What are your favorite go

[00:40:51] **Dr. Makeba Williams:** to resources? So my favorite resource is menopause.

[00:40:57] org. It is the website of the menopause society, formerly known as the North American menopause society, the full disclosure. I am a member and I have been for many, many years. I love the organization and I love their website because it is geared both for providers and for patients. So I send my patients there because we.

[00:41:24] As a part of the educational committee, we develop what we call minnow notes that are at a literacy level that everybody can understand. And we put out information to guide women through this journey on a variety of different topics. It is what I give to my patients after I you know, counseled them so that they can get some evidence based information.

[00:41:53] It's all evidence based. You can go down to many, many dark places at two o'clock in the morning when you are when your sleep is disrupted and you can get all kinds of stuff to treat your menopausal symptoms. Much of which is not good for you. So I'd like to give them some good evidence based reading on the web.

[00:42:16] Oh, jade eggs then? Uh, no, that's not going to help you out, Becky. Save your money. No vaginal steaming? No. You don't need to steam your vagina. No pellets inserted under your skin. You know, I've seen people go to compounding. Hormone therapist and Ronnie, you'd appreciate this. So they get testosterone to help with their sexual function.

[00:42:41] And then we're giving them spironolactone, Ronnie, to help with all of the, um, hair growth and acne that comes after they have their testosterone pellet inserted. Yes. Yes. Go figure. Right? Go figure. So speaking out certified menopause providers, I think Can be very helpful. And you know what? I am trying really hard doing my best with colleagues to make sure that we are teaching the next generation of health care providers, whether they are primary care physicians, family medicine, internal medicine, OBGYN and beyond to be able to take care of women because they're just far too few.

[00:43:24] Certified menopause providers. We need to democratize this medical knowledge and we need to democratize the menopause knowledge in general so that it is accessible to everyone. That sounds

[00:43:39] **Rebecca:** great. Thank you so much for enlightening. Well, I know I was enlightened.

[00:43:44] **Ronni:** Uh, I am always enlightened when

[00:43:46] **Rebecca:** I talk to Makeba.

[00:43:47] Yeah. Thanks for bringing all of this to us and giving us some of your time. As a woman of a certain age, this was, uh, which is one of my favorite expressions. Uh,

[00:43:57] **Dr. Makeba Williams:** I love now I can, I can own that. I'm a woman of a certain age. And if no one else values, I love it. I don't want to be 20. I don't want to be 30.

[00:44:08] I am loving the liberation that comes with being a woman of a certain age. Love it.

[00:44:14] **Rebecca:** I agree. I am sharing that enthusiasm for no longer being in my 20s.

[00:44:21] **Ronni:** It's a very tumultuous time. It

[00:44:22] **Rebecca:** was. Well, thank you so much. This was fascinating. And, um, I'm so glad I got a chance to meet you.

[00:44:28] **Dr. Makeba Williams:** Thank you so much. This was so much fun.

[00:44:33] Do do do do do do do do

[00:44:34] **Ronni:** do do do do. We have some

[00:44:35] **Rebecca:** late breaking news. My editor didn't like the dirty joke, at least didn't like it as a way to start the book, so I wrote another introduction.

[00:44:45] **Ronni:** Thank you for listening to this breaking news update.

[00:44:48] **Dr. Makeba Williams:** Do do do do do do do do do.

[00:44:53] **Ronni:** You've been listening to This is Probably a Really Weird Question, which is created, hosted, and produced by Rebecca Davis and Rani

[00:45:01] **Rebecca:** Hayoun. You can learn more about us, read our show notes, and find links to resources on our website, www. reallyweirdquestion. com.

[00:45:11] **Ronni:** Follow us on Instagram at reallyweirdquestionpod.

[00:45:16] **Rebecca:** Send us your really weird, not really, questions by emailing us at reallyweirdquestion at gmail. com.

[00:45:24] **Ronni:** Nora Carlson is our website guru and social

[00:45:27] **Rebecca:** manager. Mick Finnegan is our sound engineer. Mark Wurzelbacher

[00:45:31] **Dr. Makeba Williams:** composed

[00:45:32] **Ronni:** and recorded our incredible theme

[00:45:34] **Rebecca:** music. We are grateful for the financial support of the Phil Zwickler Charitable and Memorial Foundation Trust.

[00:45:41] We additionally thank the Foundation for Delaware County. Please rate us and review us

[00:45:46] **Ronni:** on Apple Podcasts. To help other people find us in their feed. Our

[00:45:50] **Rebecca:** website is also where you can find links to our fabulous merch, which helps support the show.

[00:45:55] **Ronni:** Thank you for listening and keep on asking those questions.