Webinar Transcript
NCMIC Women's Health & Chiropractic Roundtable
March 17, 2022

[00:00:00] **Mike Whitmer:** Hello. My name is Mike Whitmer. I'm vice president of NCMIC's chiropractic insurance programs. And welcome to our webinar. Before we get started, I have a few notes I'd like to share with you. First of all, today's webinar is live, but it is being recorded. The recording of the webinar will be emailed to those who registered following the webinar.

[00:00:28] And it will be posted to our resources section on NCMIC.com. While out there in the resources section, check out the other resources that we have available. We've been doing monthly webinars now for quite a while, and there's a great library of past programs out there for you. They're all free and on demand.

[00:00:52] So, have a look. Also mark your calendars for our April webinar. The webinar will be broadcast on Thursday, April 21st at 2:00 PM central time. I hope you'll be able to join us for that one as well.

[00:01:13] So let's get to today's topic. March is women's health month. So we thought that it would be fitting to host a panel discussion on the topic. Chiropractors face a variety of women's health issues in their practices. So we've invited a few experts in the field to discuss this important topic with us to lead our discussion today. It's my pleasure to introduce our moderator, Lori Holt. Lori has been with NCMIC for many years, as a corporate relations representative.

[00:01:33] And many of you have probably met her as she travels around the country representing NCMIC at association and college events across the profession. Lori's a registered nurse and worked as a nurse in a variety of settings for 30 years. So Lori, thank you for helping us with this topic. And with that, I'm going to turn it over to you to introduce our panelists.

[00:01:54] **Lori Holt, RN:** Thank you, Mike. First I have to say before I introduce our panelists, while yes, I have been nursing for 30 plus years, I started at the age of five. So that tells you how old I am, but no, really I do want to introduce it's my pleasure to introduce our panelists today. First I'm gonna introduce Dr. Kris Petrocco-Napuli. Her interest is women's health, especially related to natural healthcare plans. And this has been her focus for two decades. She's been actively involved in research related to pelvic pain and females, and has authored both clinical and educational articles on the topic. Her practice and research centers on chronic pain, the female population, lower extremity amputees, and gates, and integrative collaborative practices. Dr. Kris. Welcome.

[00:02:43] Our next guest is Dr. Georgia Nab. Dr. Nab currently owns Authentic Life in Shawnee, Kansas. Their clinic that focuses on functional medicine, genetics, nutrition, and chiropractic patients.

[00:03:11] Dr. Nab also writes and speaks on health topics around functional medicine, genetics, nutrition, chiropractic, and lifestyle. Thanks for being here today. So I think what we'll start with is the, new year is almost three months behind us every January I don't know about y'all, but I know about myself.

[00:03:32] I make these plans to lose weight and it lasts for about eight weeks and then I'm done with that. So I think we'll start that off. Because a lot of women are interested in that and see how we can educate our doctors to help us as women to actually become more healthy. So my first thing is, and I think this aggravates me, men lose weight faster than women.

[00:03:58] That's not fair. We're the ones up doing everything. So with the focus and respect to weight loss, what is the healthy pace for, or women to actually lose weight? Who wants to take that one?

[00:04:12] **Dr. Georgia Nab:** I can take that one. Okay. So this so I think a healthy weight loss for women is somewhere around a half a pound to a pound a week.

[00:04:21] And I know that sounds slow, but what I tell patients is the key to losing about hormones about losing weight is balancing hormone. And that the weight loss is a side effect that when they can't lose weight, they've got hormones that are out of balance. And until we get those hormones back in balance, the weight is just gonna hang on.

[00:04:45] And if we compound that inability to lose weight, those imbalance of hormones with an autoimmune that can make it even harder to lose weight. And so you take those two things in context that we see autoimmune far more in women than we do in men. And we have far more hormone imbalances in women because we have so much fluctuate with our hormones, those two alone, make it more of a challenge, but not impossible.

[00:05:14] That's the thing to, to stress is it's not impossible, but let's focus on balancing these hormones and think about weight loss in terms of, I just want to be a healthy me.

[00:05:25] **Lori Holt, RN:** Dr. Kris. Yeah. What's your thought?

[00:05:28] **Dr. Kris Petrocco-Napuli:** Yeah I, agree with Dr. Nab and I think the, other thing too is sometimes women are a little bit harder on themselves.

[00:05:36] Where Dr. Nab just said a half a pound to a pound is, average for

women and healthy for women to lose. And I think that with that being said, we're a little bit harder on ourselves when we're not losing a lot of weight and we're wanting to take things a little bit faster than we should. I also think it comes down to stressing ourselves too, right?

[00:05:58] Hormones have so many different components and so many different effects. And if we have high stress levels and we're not focused in, on taking good care of ourselves, that's also gonna be a contributor.

[00:06:10] **Lori Holt, RN:** And I'm just gonna bring out a point here. There's so much on television that we see, or just in talking with each other.

[00:06:16] To me, I call 'em fad diets when we're talking about Atkins and those that are out now. And I have to say, I did not research them, have not researched them, but both my husband and I tried Atkins. And he pretty much told me that I needed to eat about the third day or he was gonna put me out in the garage somewhere.

[00:06:35] So what Dr. Nab, your thoughts on that? Is it a healthy way to go? We're talking about fad diets, bad diets and adding in good nutrition, or should those be avoided all the way?

[00:06:51] **Dr. Georgia Nab:** When I talk about diets with patients, I try to avoid the word diet and I try to use lifestyle that. I want to focus on foods that are healthy for them and the lifestyle that they want, that they can maintain for long term So my, concerns, a lot of times ketogenic is a big one out there, right? A lot of, a lot of people stress. Oh, just do the ketogenic diet. For women, the challenge with the ketogenic diet, with a lot of my patients anyway, is that one, they either have had their gallbladder removed or they've got to really sluggish gallbladder.

[00:07:26] So when they're eating all these fats, they can't digest them and they actually gain weight on the ketogenic diet. And, it goes again, back to these hormones that we've got to, we've got a healthy, have a healthy liver, healthy gallbladder. If they don't have a gallbladder let's, figure out how do we nutritionally support that gallbladder and a ketogenic diet oftentimes isn't ideal for them. The other thing with the ketogenic diet that I see is that when they're doing a ketogenic diet, they're doing it in a very unhealthy way. That they're doing a tremendous amount of processed fats that are just clogging up their whole system. And so I have I do a six week keto green class that I offer my patients that stresses that can put them into ketosis, but the real focus is on the greens that we can still get into ketosis, but we can really focus heavily on these green vegetables.

[00:08:23] And I have a food list for them and recipes that are fairly easy. And I graduate, I work them into it that we don't just jump right into that with my female

patients. I get them to a place of where their liver and their body is ready for it. And then we put them into a ketogenic diet if that's the right diet for them, but it's not the right diet for every woman.

[00:08:48] So the diet that I recommend to my patients, it's very individualized. And it's really, again, focused on getting these hormones healthy.

[00:09:01] **Lori Holt, RN:** Absolutely. Dr. Kris, Dr. Nab has talked with us about doing the hormone healthiness and all how she does care plans for her patients, which I think is great instead of doing just one for everybody.

[00:09:14] So if a patient is having problems still losing weight by diet and exercise, is there anything else that a patient could do outside of Dr. Nab's suggestions?

[00:09:28] **Dr. Kris Petrocco-Napuli:** I wish I had the silver bullet answer for that one. Cause that's often asked. Patients come in all the time back, I've been diet, I've been exercising, I've been looking at everything under the sun.

[00:09:39] They can give you the whole list of things when they come in and talk to us. And I really do think it's individualized. I really do think one of our greatest skills as chiropractic physicians is to look at the patient from the whole aspect. Absolutely. Absolutely. And I always say what else is going on that we might be missing?

[00:09:58] Absolutely is there. And I go back, I keep going back to the stress component, but that, that, seems to be a very significant thing in a lot of our female patients. And there's also the other screening questions that we ask in our history. How is your mental health?

[00:10:14] How are you sleeping? Sleep is another big component that we know that impacts metabolism. Our chronic pain patients, if they're still going through this and they're not sleeping well, they're not eating well. And they're trying to lose weight and be healthy at the same time. There may be something else underlying.

[00:10:30] So again that, history component is huge. And I wanted to jump off as something that Dr. Nab said, she mentioned the gallbladder, right? And a lot of times our patients don't think to tell us that they have their gallbladder removed. If we don't ask. . And so if you're, talking to them, especially women we know that sometimes too, the gallbladder can be a source of housing ES estrogen And so a lot of times when it's removed, there becomes a whole nother component related to that. So when we miss or, don't ask that question, we can be missing a lot of de different things as it relates to coming up with that correct treatment plan for, our female patients.

[00:11:10] **Dr. Georgia Nab:** And so can I add into just a little bit on the gallbladder who's the most common type of person to have their gallbladder removed?

[00:11:21] It's a woman in her forties who's overweight, who's having a lot of hormone issues. And so what happens here is that this type of woman is heading, she's having some hormonal changes as the ovaries are beginning to shut down and the adrenals are supposed to kick in well, estrogens tends to be in excess in these women.

[00:11:42] What does estrogen do? It thickens the bile from the gallbladder. And so that thickening and oftentimes they can develop stones from that. And what is the what's traditionally done? We'll just take it out. No, wait a second. Let's get these hormones back in and, use natural things to thin the bile down so we can get these lipids moving, get rid of these estrogens so that these female patients can keep their gallbladder.

[00:12:13] It's really heart wrenching when I have, when I think, oh, we could have, if I'd only known I could have saved your gallbladder. And it's really in interesting because one of the simple things that that I tell patients that thins the bile is coffee. Sometimes coffee gets a bad wrap.

[00:12:31] Good or bad, but I tell my patients coffee, not in excess, but one no more than two cups. Coffee has the effect of thinning the bile down and it's rich in antioxidants. So it's actually really quite good for your liver and your gallbladder. And I encourage them to drink it black. Don't put all this stuff in it.

[00:12:51] You just drink it a good black coffee to help keep your, gallbladder and your liver flowing and to help support it. And, tangent off of that, we can talk about enemas but a coffee enema can also be effective in helping to thin the bile and support the liver and the gallbladder.

[00:13:13] Back to you, Lori.

[00:13:14] **Lori Holt, RN:** Okay. So I just lost track of thought. So if a patient is following, we've talked about hormones, little bit about nutrition, but if a patient is following exactly the care plan that you have put for that patient and still not losing our, losing the weight that you as the doctor feels that they should be.

[00:13:36] What are some other symptoms, as far as the endocrine, that kind of thing that maybe you could rule out for that patient to see if there's a problem there that's causing the weight loss, not to. Be like, it should be

[00:13:50] **Dr. Georgia Nab:** To me if, it hasn't been checked and I always check, I always, because autoimmune is huge.

[00:13:56] And it's one of my specialties. So I'm automatically checking for autoimmune, but if they have auto immunity, it can take three to six months before they start to really realize some, weight loss. But the other challenge is if they have insulin resistance, which is pretty common metabolic syndrome, that also can take three to six months to get again to get those hormones back into balance before they'll start to realize weight loss.

[00:14:24] So, those are two biggest factors that I see that slow down or, even halt weight loss and it's all about the hormones.

[00:14:34] **Dr. Kris Petrocco-Napuli:** And I think there's is something really important as practitioners that we have to remember. And so a lot of times female patients in their forties and close to their fifties, they'll be like, oh, it's just perimenopause or menopause.

[00:14:49] Or they've been to a provider that's dismissed some of their symptomatology telling them this. And so I think it's really important that encourage them as they're, as we're helping them and we're guiding them that we educate them on it may not just be menopause or perimenopause that it could be your thyroid or metabolic syndrome or insulin resistance and, help to encourage them to learn about all of the different components and also advocate for the care that they need and deserve and want.

[00:15:21] Especially as they're moving through this.

[00:15:26] **Lori Holt, RN:** And now let's get back, get to exercise just a little bit. I'm gung ho when I'm actually exercising, it's all or nothing. But there are some people who really don't know where to start because they haven't exercised in a while. So what would be some suggestions that you would give your patients to safely start exercising instead of go out there and try to flip a tire or something over.

[00:15:56] **Dr. Kris Petrocco-Napuli:** You think that’s a natural way to start Lori? (laughing)

[00:15:58] **Lori Holt, RN:** Well, yeah, I'd have to work up that up to that just a little bit. I think

[00:16:04] **Dr. Kris Petrocco-Napuli:** And I, think you raise a really good point because every female has a different story on what they a looks like, right? Whether it's kids or caring for parents, or having a job where they're there long hours.

[00:16:19] And so finding that time is the first piece. Really identifying, okay, when can I fit this into my schedule? And what does it look like? I think my first recommendation to patients a lot is don't start something that you already know

you're gonna hate. When patients say I hate going on the elliptical.

[00:16:36] So I forced myself don't do that. So I think the recommendation to patients is well, what to like to do. And it could be as easy as going out and walking, trying yoga, looking at different ways to move through and do Tai Chi. If, yoga's not for you swimming. And just really giving them options.

[00:17:01] But I always say, go with what you're going to like. Don't force yourself into something that you already know is, going to be something that you're going to not be motivated to try.

[00:17:16] **Dr. Georgia Nab:** For me, I don't use the word exercise in my office unless they come in and tell me they are exercising. They're pretty active.

[00:17:23] But for this general patient, I don't use that word. I talk to them about movement because to them, if I say the word exercise, then they're gonna think immediately, they're gonna think I'm, gonna tell them they need to be in the gym for an hour or three to five times a week and immediately that wall comes up.

[00:17:40] So when I talk about movement, then they're like, what do you mean movement? And if they're not used to moving, I start them with five minutes in the morning. And what that means is when they get up in the morning, they go to the bathroom and then they get their cell phone and set it for one minute. And then I teach 'em do something for one minute that gets your heart rate up.

[00:18:00] That might be doing modified jumping jacks. That might be doing some running gently in place, whatever it takes to get their heart rate up for that one minute. And then they walk and get their heart rate back down and start by doing that just three times. So that's five minutes, that's all. And I have them do it.

[00:18:21] Just start Monday through Friday, because most people are working. So we start Monday through Friday, you're just gonna do five minutes. And then as that gets easier, I want them, I push them to start, get going. Now seven minutes now go a little bit longer. So one of my patient that I had, she was a mid sixties and hard time walking, just she was only five foot, 268 pounds.

[00:18:46] She's got a lot of weight that she was carrying and I started her with just the five minutes in the morning. In one year, she went from 268 pounds down to 218 pounds. So she was down 50 pounds and instead of five minutes, she was at 45 minutes of movement a day. Again, we never used exercise.

[00:19:07] We used movement and this was the key thing that I focused with her on. So when you start small with these patients and, allow them to do what they do and just gently push them, it can make a profound difference in their movement because you can imagine how much better she felt. I don't know if I was offending her, but I said, think about that.

[00:19:29] That's a, big old bag of dog food that you just dumped off your shoulder.

[00:19:34] **Lori Holt, RN:** And congratulations to her. That's awesome.

[00:19:36] **Dr. Georgia Nab:** And she kept it off because now we had developed this habit right. With of, gently moving and it was a habit. It was now her lifestyle. So she felt tremendously better. And she kept it. She's kept it off.

[00:19:51] **Lori Holt, RN:** Awesome. And, just listening to you, Dr. Georgia talking about, you're talking about the words that you use when you're talking about nutrition and weight loss that with your patients and I, think it's great. We have a running joke here.

[00:20:07] My doctor doesn't need to tell me I'm fat. I know that. I see it every day in the mirror when I'm getting ready for work and a lot of people, as we've discussed here the reasons for being overweight differ. And someone who has, depression or some type of mental illness that that's their think way to get out is through eating.

[00:20:30] The last thing they need to hear from their doctor that they trust so much is that they're fat. So I like how you're using lifestyle and that kind of thing. So with all, with that being said, are there other words, or can you give some examples of what you could say to patients so that the patient doesn't feel like they're being belittled because they are overweight?

[00:20:54] **Dr. Georgia Nab:** Yeah. There's a number of things. One is I ask them if, you're eating or snacking or like that late night snacking, you can you stop and ask yourself, why are you eating? Are you eating because you are alone. So you're lonely. Are you eating because you're stressed. Are you eating because you're dehydrated.

[00:21:17] You're actually not having enough water. Hold on. I've got to look at my sheet here. Are you angry or are you tired? It's called HALT. Are you eating out of habit? Are you eating? Because you're angry, emotional, lonely, or tired and you stop and it helps them if they think of the word HALT to stop eating like that then they can stop and analyze the, and why am I eating like this?

[00:21:46] And tell them that when you like, if it's eight o'clock at night and you're thinking, oh, it's time for some ice cream, then you've got to change your state. And so I'll say you've got to, if you're starting to think I've got to have that ice cream, I really want it. Your mind automatically is in this state.

[00:22:03] And so I want you to do something to get out of that state that might be doing some wall pushups, just 20 of them to get into a different state. And

then drink some water. And it helps them to shift their thinking to get out of that, habit of having something at night. The other thing is that I tell them that it's not that you can't, it's that you don't. It's not that it's not for me to tell a patient that they can't have their ice cream at eight o'clock at night.

[00:22:33] Or their dessert. It's that they don't want the diabetes. They don't want the weight gain. They don't want the insomnia. And when you use those words of Oh, yeah, the doctor, she didn't say I can't have it do I really want it? No, I don't. I don't. You want to change their mental thinking and it gets them thinking, it gets them outta that, that vicious cycle.

[00:22:56] So those are a couple of things that I use to help with that mental because it's a lot of this is just mental there's one more thing. Can I add one more thing? I absolutely. I call it a vacation meal. Let's say there's a wedding and the patient's “but I'm going to this wedding and there's gonna be all this stuff.”

[00:23:19] “And I want to have the cake” and I said okay, this is a, vacation meal. We're gonna call this a vacation meal. And what do we tell our kids when they want something. It's 1, 2, 3 that's enough for me. Because I don't want them to be thinking that going down the mental route of, oh, I can't have it.

[00:23:38] And then they become depressed and angry. I don't want that. But I also don't want them eating the whole big piece of cake or kind of grab the biggest piece. So I tell them, take that cake and allow yourself three average size bites. 1, 2, 3, that's enough for me. Push it away. Now you're not gonna be angry or feel deprived, but you're also not gonna be mad at yourself because you overate and you feel sick but you had just a little bit and that makes it okay.

[00:24:05] And you're not gonna beat yourself up for it. So those are the three things that I use when it, comes around soon. That's true.

[00:24:11] **Lori Holt, RN:** What about you, Dr. Kris? Do you have anything to add to that?

[00:24:14] **Dr. Kris Petrocco-Napuli:** Yeah I always say go for two things. If they're craving something cold, go for the ice cold, big glass of water.

[00:24:22] And if you feel like you need flavor, throw in a lemon or a lime whichever way or on the opposite side, those people sometimes at night that feel like they need something sweet or whatever I say, go for the hot herbal tea and see if that takes your mind off of really needing something.

[00:24:39] As Dr. Nab said, sometimes it's just that they're dehydrated and they need more fluids. Sometimes just doing either the hot or the cold based upon what they're craving will help calm some of that down.

[00:24:51] **Lori Holt, RN:** Good. I do want to stay just on weight loss just for a few more minutes, but I want to shift it to talk about adolescence. We know just looking at what society paints for our children, and of course the three of us have been young teenage girls and they make young teenage girls think that they have to look this perfect, that kind of thing. And a lot of times that does lead to eating disorders such as bulimia and anorexia.

[00:25:18] So how would you how could a doctor ask that patient or what would be some signs or some symptoms that they may be having that would alert the doctor to that they may be faced with a young woman who's having problems with eating disorder.

[00:25:43] **Dr. Georgia Nab:** I think it's a lot of times they're actually coming in, that case they're coming in because they're not having a cycle. They've some menstrual cycle amen that's going on. And then we're able to connect that there's actually underlying either hypoglycemia or blood sugar type of issue.

[00:26:06] And then we get into the what are you eating? And they're not or, they're going down that pathway. So that's how I see it. And then it's working with the parent and the child themselves, a teenager to pull out of it. How about you, Dr. Kris?

[00:26:26] **Dr. Kris Petrocco-Napuli:** Yeah. And I would say adolescences are probably our most challenging population, right?

[00:26:32] Either they want to tell us everything or they want to tell us not as providers. My mom and dad made me come here and just do what you need to do. And I want to get out right. Or they're gonna fill us in on everything that's going on. And I actually think it's a really good conversation to have with adolescence at, the first visit, just identifying what do you eat?

[00:26:54] How's your sleep? and really doing just a general overview as that patient entering into your practice. The other big thing that we see with these young women, and I know this is a little bit of a tangent, but the use of caffeination right, and oh, if they're not sleeping well, what are they doing in the afternoons. They're drinking caffeine to stay awake.

[00:27:16] And so that's impacting their wake sleep cycle, which is also impacting the way that they're eating or some of the choices they're making when it comes to foods. So really having a good baseline on getting an established. Okay, what is your normal? And then as you're starting to treat and see this patient, if you're recognizing they're coming in and they're looking really thin, or mom and dad are noting.

[00:27:41] Things are changing. Then you've got to start asking those questions. So how are you still what's your diet? What are you eating? A while ago I used to

tell this story that I was working with this young teenager and we were talking about making good, healthy food choices.

[00:27:58] And we were talking about the different vitamins and one day she came and she was so ecstatic. She's like Dr. Kris, you're gonna be so happy and proud of me. I have found this wonderful thing that has B vitamins in it. And I'm thinking I wonder what this is and this was when they used to advertise 5 Hour Energy.

[00:28:17] and it would say that 5 Hour Energy is filled with B vitamins. So as a teenager who wanted to have extra energy to stay up and study and be slim and fit and all of these great things, but this was the best thing on earth. And going through that educational process, but it may advertise that, but if you actually really look at the chemicals and the components of what's in 5 Hour Energy, it's not the best choice.

[00:28:44] So again, I think having those good conversations and educating our patients, especially our adolescents on the what good choices are and what, healthy meals look like.

[00:28:55] **Lori Holt, RN:** Something interesting for them. And so with that being said you're talking about making the young female feel comfortable in your office.

[00:29:05] And how are, have your female patients or your adolescent patients discussed with you some maybe some current concerns in your office setting that they felt could have been done better for them, or have you had anyone give you an example or is there something that you've actually done in your practice that would make that adolescent feel better when they came in a more comfortable being there?

[00:29:34] **Dr. Kris Petrocco-Napuli:** I think a couple things, I think talking to them where they also and with their parents, when you're establishing that first visit, giving autonomy to them and having them be a decision maker along with you and their caregiver, their parents, I think starts to set that stage for good open communication.

[00:29:58] Listening to what they have to say about how they feel about the treatment plan that you're coming up with or what you have found in your assessment and your exam. So, I think that piece becomes really important to get them to be comfortable moving forward with you.

[00:30:16] **Dr. Georgia Nab:** Yeah for me. Definitely sometimes when the parent typically it's, the mom is there with a teenager and sometimes the mom can be dominating I make it a point to really focus on the teenager in front of me of asking them, looking 'em in the eye and asking them questions, even though the mommy may keep butting in and putting in her opinion or cutting the child off, I'll

still redirect and look right at the teenager and try to pull them out.

[00:30:46] So that they're so that they can understand that this is between you and me. I know your mom's here. And but, this is between you and me. And sometimes it's really nice because sometimes the mom will look at me right. When they walk in and say can I be here?

[00:31:02] And I will immediately look at the teenager and say, what do you want? Because for me it's okay either way. How comfortable is that teenager right with the parent being there. So I leave it to them and I think that gives them some confidence in, saying yes or no, I don't.

[00:31:23] **Lori Holt, RN:** And like you said, gives them ownership of their body. That's what it is. It's theirs. And they can help make that decision for their own care. So there are times when treating adolescents that you have to discuss, especially with girls are they sexually active, when their periods start, those kind of things.

[00:31:43] And you've asked the parent to leave the room. What do you - how do you asked that first? Because like you said, Dr. Nab, the mom that's always there butting in and that kind of thing. How do you ask them to leave? And if they, and then when you ask them if they refuse to, how do you handle that?

[00:32:16] **Dr. Georgia Nab:** I've been doing this almost 30 years. I don't think I've ever had a parent refuse. Here's my, we all have our personality and if you've done strengths finders, my top five and my top five, and maybe it's number one is harmony.

[00:32:35] So I am confrontation, or that is really, hard for me to do so to confront a, parent would be it would be really it's just, it's hard. But I've never had a parent actually say, no, I'm not going to. So it's usually pretty respectful in that sense. Dr. Kris?

[00:32:57] **Dr. Kris Petrocco-Napuli:** Yeah, I don't I, don't think so as well, which was my why my immediate reaction.

[00:33:05] I think that here's the other piece. When parents are bringing us adolescents, children, whatever it is, they're coming for a reason. And they're looking for us to provide good care. And I think there's also that mutual and it's, I think it's more so when they bring us adolescents and children, that there's that piece of trust.

[00:33:27] And so when we're moving through this and we're having conversations with them, whether it's we ask them to leave or stay or whatever the scenario is, I do think there's a level of mutual respect. But I think we also have to be really conscious, right? If we have a minor and we have to make sure

that we have that care or parental permission to examine those children or, adolescents that's also something we have to be cognizant of as providers.

[00:33:56] **Lori Holt, RN:** And I just, I know that this is a women's help panel, but I just want to add a little bit of risk management in there. It's unfortunate, I think today that our doctors face more challenges just and not in giving care with patients to make sure that this goes right or that goes right.

[00:34:14] And unfortunately we are seeing more people accusing the doctor of things that didn't happen. So my and this is to all doctors. You really need, if you are in the room with a different sex patient, you need to have someone to be in there with you whether it be a CA or your front business person. Do either one of you have a suggestion that might make it easier to have that ther, to keep the patient from feeling uncomfortable because there's two people in the room with them, any thought on that?

[00:35:03] **Dr. Kris Petrocco-Napuli:** Yeah, I think it's I think it's always a good idea. If you think as a practitioner that you need to have a standby in the room to just say and introduce, this is my assistant, they're gonna be in here helping me.. And just making sure they're not in a location that might make the patient feel uncomfortable.

[00:35:21] You are, you have a patient that's wearing a skirt or that they might feel like somebody might be looking inappropriately that they're just standing in a place that doesn't actually put the patient in a compromised position or feeling.

[00:35:36] **Lori Holt, RN:** And how about you, Dr. Georgia?

[00:35:38] **Dr. Georgia Nab:** Yeah. Same thing. I think when it comes to HIPAA my, where I have to be really mindful is the age again, that now at the age of 18, as soon as that teenager turns 18 years old, the parent can no longer have rights to any of the medical information on that child. And what's really hard is when I have an 18 year old, who's a senior in high school, the parent brings them in and the parents sitting here and I.

[00:36:09] I can run labs on that patient, but I look at the parent and I say, but I can't send these to you. You know that I have to it's, this is between me and your 18 year old, even though they're still living at home there's this HIPAA real balance that we've got to go through.

[00:36:28] And I always make sure that and it's part of just our intake that we have consent if they're 18 and under, no matter what their age is, if they're 18 and under, I've got the parents' consent to do labs, to do chiropractic whatever would do. So that consent is really important, but that 18 year old that's really you've got to be careful.

[00:36:53] **Lori Holt, RN:** Okay. Thank you for that. So we'll just, we're just gonna take a different turn right now, just since we have talked about some of the things that our teenage patients do face, and I just want to talk about some of the patients that we do care for, unfortunately have had different traumas in their life, whether it be mental abuse, sexual abuse, physical abuse, whatever.

[00:37:15] And I can see where someone who's new to chiropractic not really understanding what a chiropractor does when they come in to see the doctor and how if the they've had that trauma, how they would feel uncomfortable with that doctor touching them or whatever. So in the years that you've taken care of these young patients, were there any, was there anything that helped you to see, or maybe patient may have said to you that'll alerted you to that trauma so that you could make that patient more feel, more comfortable in your office setting?

[00:37:56] **Dr. Georgia Nab:** For me my intake is 17 pages. It's pretty detailed. So it's gonna come out in my intake. For me, but so it usually comes out on that initial intake in that initial cause my initial consult is one hour. So it'll usually come out if there's any flags there that I need to be aware of.

[00:38:22] But even before that I and maybe this is just how I am, I was raised very conservative. So I have always talked to the patient, like if I'm gonna do an anterior move and I've got a big, even if it's a a big busted woman, I'm gonna say, we're going, I'm gonna cross your arms over here.

[00:38:42] We're gonna hug as I'm doing blah, blah, blah, this and this. So I'm verbally telling them if I need to and I don't address my patients, but if I need to do a low sacrum Cox adjustment I'm I never do anything internal but, I'm listen, I'm gonna touch a little bit low here. We're gonna do some soft tissue work.

[00:39:02] So I, before I do anything, I tell them, Hey, this is what I'm gonna do. So then they're not they're not shocked.

[00:39:09] **Lori Holt, RN:** Right, so does it come up from behind them. How about you, Chris?

[00:39:12] **Dr. Kris Petrocco-Napuli:** Yeah, and I, think the same thing is true. The history is really where it comes down. And there's a lot of things that patients can tell us that initially.

[00:39:24] As providers may not be alarming to us but, one really important thing. Laurie is none of us as chiropractors were ever trained as being trauma informed practitioners. And so many of us can miss some of these signs and symptoms that these individuals are actually telling us. And so as a provider when you're talking about sleep with your patients, some really easy areas to further investigate are how are you sleeping through the night?

[00:39:53] Do you have any nightmares? Do you dream well? And in asking those questions in a variety of ways. Do you have any difficulty feeling safe at home or when you're outside any feelings of depression or any past or current problems with alcohol and drugs. Do they feel isolated from other people now?

[00:40:16] We say this and trauma can be in so many different forms and we look at absolutely we all just went through, with COVID and that's traumatic for a lot of people. The isolation piece for some really had big effect. Problems with anger or irritability or really strong emotions.

[00:40:43] All of those pieces can be areas to ask some other questions or further investigate if you're hearing a yes from your patient. And again, some of those things are not always in our intake forms as, chiropractic practitioners. And so we could miss it.

[00:40:59] **Lori Holt, RN:** I do think that's important that you ladies are talking about telling your patient, I'm going to do this. I'm going to do that. And I know that you've seen some of your patients for as long as you've been in practice and you still continue to do that. I think that coming from a patient standpoint, I think that is very important because that trauma, like you said, Kris, could have happened just two years ago.

[00:41:26] That you might not catch it when you first start seeing the patient, because everything is fine. My other question, the other thing I want to bring up is we were talking about having the parent leave the room with the adolescent child. I just, food for thought out there for me when we're treating our patients.

[00:41:49] And I think Dr. Kris you brought this up, talking about treating the patient as a whole. We do. You're not treating the patient because they only have back pain or neck pain or whatever. They are a whole person in that person has to be treated. And I think today this is brought more to our attention as far as handling or knowing the culture of our patients when we care for them.

[00:42:11] Because there are some cultures that you will see in your practice that the head of the household is the one that makes the decision for the patient in this story, and so you have to think about how are you gonna handle that? Because that is a different culture. So have either one of you had to deal with a different culture and explaining to them why they needed to leave the room, or because you needed to be alone with the patient.

[00:42:40] How did you, was it hard for you to maybe I don't like to say put your foot down, but that's probably all that comes to mind right now. So have either one of you had to deal with any of that type of culture?

[00:42:54] **Dr. Georgia Nab:** I don't think I have, not that comes right to mind.

[00:43:00] **Dr. Kris Petrocco-Napuli:** Some other areas though, where females that perhaps weren't, like you said, weren't able to make the decision and with that also couldn't show their skin.

[00:43:12] Or were not able to disrobe. And so there were conversations about how can you safely and effectively as a practitioner really do a good exam if perhaps you're wanting to look to see if there's any abrasions or bruises or, things of that nature. So, some of it is really being culturally aware and absolutely.

[00:43:34] And I'm gonna say that again, Lori, that's another thing as chiropractic practitioners. And it all really depends upon when you entered into practice, work, practice school. But a lot of us weren't trained on, how to ask those questions right and say, okay, is this safe for me? And, to do this and not how do I want to say offend your patient by asking

[00:43:58] **Lori Holt, RN:** Because again, that goes with the whole patient, where their culture from. I didn't realize how much different culture was in the United States until we moved from Alabama to Iowa. I thought everybody was the same. Oh, it's a whole different culture here and I would just suggest to doctors if you have an employee that's a different culture in your office, do a lunch and learn, let them teach you about their culture and how the best way would be to handle that patient.

[00:44:30] You know what the culture is as far as touch and explaining different. The, and then if you don't check with the leaders in that community and have them come out and educate you and your staff, because to me, that's just a better way to care for our patients, meaning we can do that. So now we're gonna move on to our menstrual cycles.

[00:44:56] **Lori Holt, RN:** Sounds like a bunch of fun to talk. And if there any, guys listening, they're going, oh my God, are they? I know that to be true. One of the questions we got was the importance of cycle sinking. So why is that important?

[00:45:23] **Dr. Georgia Nab:** By syncing, are they? I was trying to decide what they mean by syncing. Are they talking where they have a regular 28 day cycle? Are they talking about syncing with other women that they are around?

[00:45:39] **Lori Holt, RN:** There was not a lot of explanation there. So why don't we go with the first suggestion.

[00:45:46] **Dr. Georgia Nab:** It's just to harmonize their cycle. One of the biggest things I see when, cycles are, whether it's amenorrhea, dysmenorrhea or they're having very heavy excessive cycles, I'm still gonna go back to the hormones and blood sugar. Because if you look at something like PCOS or even endometria the

underlying issue there is metabolic syndrome.

[00:46:14] And with that's insulin resistance. So there's no fixing the PCOS. There is you've got to get the blood sugar in balance. And so I have two handouts and on one of those handouts it's my dysglycemia handout that I go over with most of my patients, because most of the patients I see have blood sugar issues.

[00:46:36] **Dr. Georgia Nab:** In my handout, I walk them through this handout and I tell them, okay so, here's what I list what normal is, how they should normally feel through the day. And then it says post parametal, that means after a meal, their blood sugar start gonna go up and down. And if that continues, they develop insulin resistance.

[00:46:58] And so I have the symptoms there of what that looks like. And the question to always ask your pain is you experience any change in energy after a meal? Because a patient needs to understand their, when they wake up in the morning, they should just wake up and be ready to go, lots of energy, and that energy should maintain until evening when it should come down.

[00:47:20] And as cortisol is going down, melatonin is coming up, but their energy should stay very stable through the day. But if they ever experience any type of fluctuation, especially after a meal, that's a red flag that they've got some level of dysglycemia, whether it's hypo or hyper or insulin resistance. What your patients come in and tell you is, Hey doc, I've got fatigue or I've got mood issues, depression, anxiety, or they're in pain, or they're losing their hair.

[00:47:49] Or they have sleep issues or these hormonal issues. And so anytime they come in with those symptoms, your flag should be let's check these blood sugars because once you get the blood sugars under control and imbalance and their diet, then a lot of times the hormone issues will clear up and their hormones, their cycle will begin to, sync.

[00:48:14] It will fall back into place. And so to me, blood sugar is one of the key things to sync or to get their hormones back into place. And then there's an herb one herb that I'll use, especially if they have a lot of irritability, a lot of breast tenderness, a lot of cramping. Chasetree is by far are the number one herb that you can use with these women to get to clear up those cycle.

[00:48:44] those symptoms because those are sign that their prostaglandins are too high. They've got an excess there, and Chasetree is just this beautiful herb that upregulates, it helps to balance LH and FSH. So it's talking to pituitary. Balance that LH and FSH, which then helps to balance all those downstream hormones.

[00:49:04] And it helps with the natural production of progesterone. It helps to

balance that progesterone estrogen hormone, so they can use Chasetree along with the blood sugar to really get those hormones back into sync and clear up a lot of those symptoms. Because I tell my patients, my young female patients, one, you shouldn't know that your cycle is coming.

[00:49:27] It should just come. And then it should be three to five days. It needs to be clean. And then boom, it's done. And so it shouldn't linger for this one or two weeks. You shouldn't have a lot the symptoms, it should be clean. And so any of those symptoms we get this idea that PMs is normal, but PMs is not normal.

[00:49:47] Any symptom that's there is your body's saying either something needs to come out or something needs to come in. And a lot of times it's what needs to come out is the sugar. And what needs to come in is maybe some herb like Chasetree to get those hormones back into sink. And my success rate is that the vast majority of my women, within three to six months, their hormones are beautiful.

[00:50:12] They're back to how they should be. And so some of that depends on how much insulin resistance, how much blood sugar issue we really have going on. It can take longer but, my experience is in three to six months and they are humming.

[00:50:29] **Dr. Kris Petrocco-Napuli:** The same thing and, really, truly I actually talk about this in some of my lectures with practitioners because it's really helping your patients maximize their hormonal power. And so when women are in tune with what's going on with their menstrual cycle and we can talk about all the abnormal stuff, because that's, that is really important.

[00:50:52] And as Dr. Nab just said it's not normal to have menstrual cramping. It's not normal for any of those things. But meanwhile, most of the general population thinks it's normal. When we're looking at our women, I often say that actually having knowledge about your menstrual cycle and knowing where you are hormonally, you can actually use that to your benefit.

[00:51:15] So like looking at different types of exercise and or movement as Dr. Nav educated me on today it, and making that choice based on your menstrual cycle actually can be beneficial because we actually do know. And, I'm gonna throw in just a hair of a caveat here. If our women are using any sort of birth control, some of this goes out the window, depending upon what type of birth control they're using.

[00:51:41] And again, because remember they don't ovulate and we can be about adding more estrogen or progesterone just to. Upon what they're using. Looking at when a female is having her menstrual cycle, a lot of times they're really tired, right? There's the fatigue component that comes with it.

[00:51:58] So that's not gonna be when they're using this high powered, like you said earlier, Lori, flipping tires kind of exercise. This is the time for you to use some yoga, use some deep breathing or movement therapy that really they like to do as they finish their menstrual cycle and they move into more of the follicular phase the idea is now you can start ramping up do some of those high intensity things. Especially if you're training some of our women that you know are looking at doing 5Ks or are trying to compete in other things now is the time to use that and use that power from your hormones to ramp up.

[00:52:43] And again during the ovulation phase is when women truly do have the most power because they get that spike in testosterone. They feel very strong. But during ovulation is also really high time that they can actually injure themselves. So they have to be careful because there's a strong correlate with the hormones and injury.

[00:53:07] On that down phase, again, that's when progesterone starts to get high, you get closer to the menstrual cycle and they start to fatigue a little bit. So that's when you can start maybe lowering the amount of weights you're lifting and maybe increase the reps or looking at different modifications.

[00:53:24] With that, this is great to talk to your adolescents about. So talk about spinning the positive to the menstrual cycle. If you've got girls that are athletes that are in basketball or and they're really trying to be strong and improve.

[00:53:39] This is a great conversation to have with them. The other piece is I always talk about not just sinking the exercise piece, but also looking at nutritionally what your body needs during this time. Because when women are sinking with their hormones, the other thing is what do you feed yourself?

[00:53:59] Because a lot of times as women gets towards their menstrual cycle, they crave carbs. And so they'll binge on carbs when actually your body doesn't need that then. You should be really focusing more on protein and maybe even some good fats at that time. And really at that ovulation mark is when I say, okay, that's when you want to like up some really good fats and that will hopefully prevent you from wanting to binge on those carbs.

[00:54:27] Now what I often tell women if they're a carb binger, as you're powering up after your menstrual cycle and you're maybe doing some more exercise or more movement. You can add a little bit more carbs there because you'll burn it with that extra exercise or movement. So, that's my take on thinking and how women how we can educate our female patients on using their hormones to have more power and strength.

[00:54:54] **Lori Holt, RN:** Dr. Georgia, that one herb, was it ChaseTree?

[00:55:02] **Dr. Georgia Nab:** ChaseTree or ChaseBerry is another name that it's used as. And so one more thing, Laurie. Yes. And that is encourage your female patients to use an app to watch their cycle. There's some great free apps.

[00:55:18] The one I've been using, I've been using it over 10 years. They don't go away and it's just, it's another one of those awarenesses of where you're at, of tracking your cycle.

[00:55:35] **Lori Holt, RN:** So you were talking about blood sugars, either hypoglycemia or hyperglycemia. So would prior to, or is it part of the patient's care plan that you do like a glucose tolerance test on them? Or are there certain labs that you will check prior to the patient starting the care plan and then along to see how those labs improve?

[00:56:04] **Dr. Georgia Nab:** Yep. Absolutely. All my patients get labs so I do a pretty thorough panel depending on the patient if I'm running hormones or not, that's gonna vary, but I always look at for blood sugars, I'm looking at their fasting glucose for Thomasine, insulin, C peptide, their triglycerides, as well as their A1C.

[00:56:30] Those are my key markers initially. When and just my general my initial intake one of the first places you're gonna see blood sugar issues is actually in their triglycerides. If their triglycerides are running over a hundred, then they're already showing signs of not being able to manage carbohydrates and sugars very well.

[00:56:48] The last place you're gonna see it is on the A1C. Because that A1C tells us over 90 days and when it comes up there, their blood sugar issues have been going on for years And then these younger individuals, more of what I see is hypoglycemia and the one lab marker that can point towards that is your LDH, which is actually a liver enzyme.

[00:57:11] But when you LDH is 140 or less, and I use LabCorp, but when it's 140 or less, that is your red flag that they have hypoglycemia. And then you can look at the A1C and if it's running low or low normal, and you talk to the patient, that can be your flag, that, okay, we've got some hypoglycemia and the concern there as if they don't manage that hypoglycemia, it will eventually flip into insulin resistance.

[00:57:40] And we see that a lot in our teenagers and our young adults, we see a lot and their symptom might be I never eat breakfast, because I feel nauseated in the morning. If they have nausea, when they wake up, they've probably got hypoglycemia because their blood sugars have dropped too low. And what they actually need to do is force themselves to eat a little bit.

[00:58:01] And that might just be a couple of bites. But what they'll find is if each

morning, if they eat just a little bit, within three to five days, that nausea will dissipate and go away but they've just got to work through that those first few days to get over that, and then you've got to work with them on, okay.

[00:58:20] We can't go too long without eating. We've got to keep these blood sugars. Healthy and those patients, the last thing that they need to do is fasting because fasting is only gonna to aggravate their hypoglycemia.

[00:58:34] **Lori Holt, RN:** So now let's just turn over to infertility. Dr. Kris, you do specialize in pelvic care. So we looking infertility. Are there dysfunctions or what type, let me rephrase that. What type of dysfunctions are with the pelvic area to the pelvic floor area that could cause infertility in your patient?

[00:58:56] **Dr. Kris Petrocco-Napuli:** These are really good questions, Lori. You know, it's fascinating because one of the things that I think I learned really early in practice is that a lot of times when our women come to us and they're talking about trying to get pregnant or conceive, or they talk about their journey and they haven't been successful, it always seems that their journey has always focused right around the pelvis.

[00:59:21] And no one has really honed in on and going back to treating the whole patient, the whole physiological journey of this individual and you know I think that's the first key for practitioners is when you are really honing in and focusing in on the history to really think, and really ask questions about all of the pieces that can be impacting these women. But from a biomechanical structure and really thinking about the anatomic structures that we have, as females and, really honing in as a practitioner, obviously we do, we go we look at the pelvis, we look at the sacrum for restriction hypomobility subluxation, whatever it is that you would like to term it.

[01:00:15] But one of the areas that we often forget about is always looking above and below. So like the TL junction and the correlative of the motion relative to the TL junction and the structures that attach. And so I always tell providers that when you're assessing your patient, there's not again, there's not one magic button that we can press and help our patient get pregnant.

[01:00:40] We have to be thinking about the entire biomechanical structure and how is that impacting the mechanics of the pelvis? Whether it's posterior, whether it's anterior, whether it's the pelvic floor. My favorite, and I always joke about this in my seminars, because I love to put up, there's a picture of the uterus and there's a ligament that attaches to the sacrum.

[01:01:08] And at some point we all dissected it when we were in anatomy labs in chiropractic school, but it's the uterosacral ligament. And a lot of times patients come into us and they'll say, doc I've been told by my practitioner that my uterus is tipped, and a lot of times we'll go in and we'll palpate the sacrum and what's

going on with the sacrum. The sacrum is also either subluxated or nutated in one direction versus another.

[01:01:36] Or it favors one side relative to another. And so as a practitioner I often say use those clues that patients are telling you and help that with your diagnosis of these patients and really take time to look at the biomechanics of the pelvis.

[01:01:54] **Lori Holt, RN:** And with the biomechanics of the pelvis, are there certain exercises that a patient could do at home to maybe not hurry but be more can't think of the word to help that injury so say get better so that their infertility would get better.

[01:02:21] **Dr. Kris Petrocco-Napuli:** So pelvic floor if, we're talking about pelvic floor dysfunction it's interesting because I don't have a really good correlative with pelvic floor dysfunction and infertility. It can happen. We can see it. I always say pelvic floor dysfunction happens at any age. We actually know young girls in their teen years actually can experience public floor dysfunction.

[01:02:44] So really focusing in on making sure whatever exercises they're doing, doesn't have greater force or impact to that pelvic floor. A lot of times when women lift objects they'll hold their breath. And one of the big things that we know about the pelvic floor is that the diaphragm and the pelvic floor move together.

[01:03:07] So they like a piston, right? So if you breathe in the pelvic floor and the diaphragm are gonna move with you and they're gonna move out when you exhale. And so when women are lifting, if they're actually tightening their pelvic floor to lift up, they're actually doing a disservice to their pelvic basin.

[01:03:25] And so a lot of times I will tell women, even if it's not even just lifting, if you're doing crunches and you're using a medicine ball, a lot of times you can feel that that pressure on your pelvic floor. So anytime you can feel that that's actually not a good option. So that means you need to find a different exercise or a modification of that exercise.

[01:03:47] I know a lot of women will do planking for core because we do, we need great core strength when we're talking about pelvic floor and planks can actually cause a lot of pelvic floor pressure. So the modified plank is actually a good to choice think about that, but I just want to make sure that I'm clear that I don't have any good data or statistics. Maybe Dr. Nab does.

[01:04:22] **Dr. Georgia Nab:** On pelvic floor dysfunction and infertility, I think there's maybe two different things happening there with these patients. For me instead of fertility, more so for incontinence is a big issue. And so the two things that I check with them is the pubic bone. I'll adjust the pubic bone if it's out and you can do soft tissue adjustment.

[01:04:39] So this is one of those where I'm talking to the patient. If we, if I need to adjust their bladder or their uterus, because it's prolapsed and I either use their hands or I say, listen, I'm gonna go right above your pubic phone, and I'm gonna put pressure, and you're gonna be doing this as I'm doing this.

[01:04:57] So that we adjust either the uterus or the bladder to help pull it and help balance the structural issues that are going on there. And you'll hear it. It's amazing when you adjust that you can get an audible sound out of that region and, it helps tremendously, especially more so with incontinence issues with those patients.

[01:05:22] **Dr. Kris Petrocco-Napuli:** Okay. Yeah. I actually, Lori, it's funny, because I actually say that it's in my experience, it's more embarrassing for women to talk about leaking than it is to talk about their menstrual cycle. For some reason there's - I don't know if it's culturally ingrained or there's almost like a level of shame that goes with talking about I leak. And as a practitioner asking those questions is so important and putting it into your history or your initial intake cause we actually know that there's a correlative, there's some excellent research that talks about the correlative of women that are coming in and reporting low back pain that are actually also leaking with pelvic floor dysfunction, not leaking because of anything else neurological. But that correlative is there.

[01:06:12] **Dr. Georgia Nab:** But they think it's normal, right? Dr. Kris, I mean they think, oh, it's just normal or I'm getting older. It's no, wait a second. Oh, it's not. Let's see if we can use, chiropractic and fix this. And it's really quite successful.

[01:06:28] **Lori Holt, RN:** Awesome. Awesome. So I'm not, we're not gonna go too much in to who treating pregnant women. Because we don't have enough time with that, but just thinking about your pregnant patients when you are treating them, what just kinda safety concerns for that patient go through your mind as you're taking care of that patient, let's say in the exam room, Dr. Georgia.

[01:06:55] **Dr. Georgia Nab:** Okay. Chiropractically my table, I have a flextion distraction that has a drop piece. So I will tell you, my female patients love my table because I can put them on their stomach. Tummy just drops through there, and then I'm stretching them. They don't ever want to get up

[01:07:13] **Lori Holt, RN:** I'm sure!

[01:07:15] **Dr. Georgia Nab:** Because how often can you get on your stomach when you're past four months? So that's adjusting is really the other thing, I guess this is just how I adjust. I do a lot of kinesiology. I'm an old AK doc so, I'm muscle testing and using kinesiology. But with me, I don't put them on their side. I

use drop pieces, but that, and you know the breast, especially six months on, they're full. And so you don't want to be doing a PTA because it just hurts. So I will definitely anteriors are huge for them, plus they're carrying so much. Wait anyway. So you tend to see a lot of anteriors on those on the thoracic region, in those patients. And, when you adjust those point, they feel really good.

[01:08:07] Oh, tremendous. And I tell one of the questions they ask is, it safe? And I'm like, absolutely up to the day it's so safe and it helps you and it helps you and it helps the baby and it helps your labor. It makes everything just flow so much better when you're in place. So, I think, the important thing is communicating how safe and how important it's to get adjusted through the whole pregnancy.

[01:08:35] **Lori Holt, RN:** Absolutely. Yeah. I had a friend of mine who was pregnant with quads and she didn't miss a chiropractor visit at all during her pregnancy. And she took 'em to term and she truly believes that it was chiropractic that got her there.

[01:08:51] **Dr. Georgia Nab:** Along with that is everything's getting pushed up. So what do they have? They have hydro hernia, right? They have reflux and so I tell them here's how we can adjust this to relieve your reflux. And you can do this to help relieve that reflux because no, you don't have to deal with that through the whole pregnancy. So, it helps with reflux as well in these patients, in the pregnancy.

[01:09:13] **Dr. Kris Petrocco-Napuli:** Yeah. It's interesting. I'm gonna echo all those things that Dr. Nab said. But I think the other thing is too and I know I keep going back to the history and I keep going back to the exam but to me those, are really important. And not taking for granted that our patients are moving through this without challenge.

[01:09:36] And not being afraid to ask them when they come in, How many weeks are in verifying that in your document? Also documenting if they are far along enough where they should be feeling the baby move are you feeling, the baby move?

[01:09:52] Are you doing your kick counts appropriately? If your patient's coming in and now saying, Hey doc, I'm getting like new headaches, don't miss that opportunity to try to take their blood pressure, make sure they're not moving into preeclampsia. Again, as practitioners, we see them much more than their OB sees them.

[01:10:15] **Lori Holt, RN:** And don't you think that, at least don't you find that sometimes? I think as women, we talk more openly to our female doctors, anyhow, because you can relate what we deal with. And I think that patients are more apt to talk to their chiropractor, but long before their medical doctor,

because of the relationship that you build with your patients. It's incredible the trust that they with you and just the information that you can get out of them for maybe the 15 or 20 minutes and, that they're in your office. It will make a whole change in the way that they're cared for. So I think it's great. So anyhow, now we need to move on to old people.

[01:11:00] That would be me. So I hope I didn't offend anybody, but yes, that's me. See this blonde here is not, I should have gray, but I don't. Anyhow. So we know that women with menopause have a lot of different symptoms. There's hot flashes, there's irritability and hair growing everywhere and the list goes on and on.

[01:11:28] Dr. Nab, when you're talking about menopause and the symptoms with the ChaseBerry that you talked about now, would that be a good combination during that phase of life or there other things that would be matter for them during that phase of life?

[01:11:46] **Dr. Georgia Nab:** Sometimes. I lean, I tend to lean a little bit away from ChaseTree. I'll use some other herbs, like black cohosh is really good. Tribulous, especially if they've got a lower testosterone or a dryness or lack of libido, Tribulous is a beautiful herb and actually Tribulous can help a lot with the hot flashes or the night sweats.

[01:12:11] Sometimes you can find a nice combination formula. I know I'm not gonna say the brand, but I have one that just, it's got a nice blend and it works very well, but it's got the black cohosh, a nice it's a nice balance that works real really well. You still got -not to beat this up, but blood sugar always plays a part.

[01:12:33] The three biggest causes for hot flashes in these menopausal women that I've found is sugar, alcohol, and stress. And a lot of times they'll say, oh yeah, I usually drink some wine or have alcohol at night. And I'm like let's cut that out for a couple weeks, and let's see if these hot flashes go away and oftentimes they'll calm down just by taking the alcohol out.

[01:12:59] Cause it's a big trigger. So you look at their diet and then yeah. There's herbs that are beautiful for that.

[01:13:09] **Dr. Kris Petrocco-Napuli:** Yeah. So, interesting because Dr. Nab had me laughing a little bit about the alcohol and the stress, right? So a lot of times they'll say I drink the alcohol because I have the stress. You know, tell 'em to stop the alcohol, but we also just got to figure out the stress too. Meditation at night.

[01:13:33] **Lori Holt, RN:** and exercise is not the answer.

[01:13:36] **Dr. Kris Petrocco-Napuli:** Movement!

[01:13:40] **Dr. Georgia Nab:** Yeah. Sometimes that stress is coming because their spouse is snoring a lot and they're not sleeping.

[01:13:45] And so they're getting frustrated. I'm like, don't be afraid to go into a different room to sleep, that's OK. It's cause it's more important that you get sleep than being stressed about. Oh, great. I've got to listen to so and so snore tonight and you. Go to another room. Sometimes patients just need permission right to do something so give them permission it's

[01:14:09] **Lori Holt, RN:** That's right. Tell 'em my doctor said I could do this. Yes.

[01:14:23] **Dr. Kris Petrocco-Napuli:** So, going back to the menopause, that conversation

[01:14:27] It's interesting because one of the things, and we were chuckling earlier about dis about periods and menstrual cycles and, all of those things a little bit, when we were saying doctors sometimes, especially chiropractors shy away asking that question.

[01:14:43] And so we actually know, and the literature supports us. The literature is magnificent talking about the shift in the age of menopause that we're actually seeing in women. And a lot of that has to do with the age of their first menstrual cycle or menarch. And so a lot of times providers don't think about asking a 48 year old female, when was your first menstrual cycle, because why would that matter?

[01:15:07] But it actually does. And so the literature tells us and shows us that if a woman menstruated before the age of 11, they were 80% more likely to have premature menopause and on average in the US it's and, again, it's generalization on average about 51 years old is when we see women moving through having menopause or moving through menopause in the US but there's a lot of contributing factors that are actually moving up that age. So we need to be conscious and asking some of those questions that we might not think have value, but actually do when it comes to identifying.

[01:15:48] **Dr. Georgia Nab:** I agree because our risk here is the earlier they're into menopause than the higher their risk for osteopenia and osteoporosis.

[01:15:58] My patients, my goal is that for you to hit menopause sometime in your fifties, and sometimes they'll say, I do not want to be cycling in my fifties. I'm like, but let's think about the benefits of this. Let's think about your bone health and your mental health. How much better that is in terms of putting the odds in your favor.

[01:16:21] **Dr. Kris Petrocco-Napuli:** Yeah. And I think the other thing is how about the women that have hysterectomies because they have to? There's a lot of medical reason why women do opt to have a hysterectomy. However, on the flip side, there are a lot of women that have hysterectomies when there's things that we can help them with naturally.

[01:16:44] I often say save the uterus. If you can save the uterus, you want to save it. And the reason being is that there's again, going into that instant menopause, right? There's not that slow decline of hormonal change. It's instant and it's fast. And so actually it has a really strong correlative, believe it or not, the uterus has a strong correlative with brain health and cognition.

[01:17:11] And so the younger you are when you have a hysterectomy, the greater the likelihood and the correlative with early dementia and cognition challenges. Also when we look at that the other piece is just like Dr. Nab said then you worry about, okay earlier. And, what does the bone health look like?

[01:17:33] So we've got a few different components that really relate back to women's reproductive system and really maintaining them well.

[01:17:45] **Lori Holt, RN:** And I just want to add to that, and I'm gonna steal this from you, Dr. Kris, that we have to remember when women go into menopause, their risk for coronary artery disease increases because they no longer have those hormones to protect them, which is bad.

[01:18:04] Because you have all that protection and, then all of a sudden it's taken away from you. And like you said, someone who surgically has that done, they don't have that digression of the hormones there, so it makes me wonder, okay. So if you've had it surgically and along with your other family history and stuff could you have an MI in an earlier age? And I would certainly think so.

[01:18:28] **Dr. Kris Petrocco-Napuli:** Yeah. And we know and, it's really fascinating, Lori. So we know also the average age for MI and the number one condition that contributes to death and women is heart disease. And that age 51 is the same age that we're seeing menopause.

[01:18:47] And interestingly enough you go back to how many women have symptoms of heart disease that may have been early identifiers and this is all practitioners. It's not just chiropractors. It's all that is all doctors.

[01:19:06] **Dr. Kris Petrocco-Napuli:** And so there are things that, that, again, going back and asking those questions could help prevent early death in some of these females and, help them to live longer.

[01:19:17] **Lori Holt, RN:** And we've talked about treating the patient as a whole. And I think as we learn as we grow in our profession that I just lost track of

thought, sorry, gang. I had this big thing I was gonna talk about. And I just, oh, I know what I was gonna talk about.

[01:19:41] And we're taught through books and we, as we grow in our profession, we learn that patients are not textbook. That it's just to guide more or less. And you were talking about the signs and symptoms that Doctor can miss. And I just want to add in there the different patient when we're talking about our diabetic patients that is a small vessel disease.

[01:20:05] And so if you've got that diabetes your symptoms may not be the same. Unfortunately we lost my husband's mom very early and her complaint was wrist pain, only complaint she had, and she thought it was her. What's that you get the carpal tunnel.

[01:20:28] And it unfortunately was not. Prior to coming to NCMIC, I worked with a cardiology group and a lot of women complaint to me was I've had this bra for a year and it's the tightest thing it's been in the past three days or whatever, when they started with this discomfort. And I've actually had women complain of upper gastric pain thinking that it was reflux. I think that we need to, all of us, as healthcare providers need to be aware that patients are not textbook and that we need to treat the patient, not the book.

[01:21:04] **Dr. Georgia Nab:** Right.

[01:21:05] **Dr. Kris Petrocco-Napuli:** Yeah. And I think Lori you raise such good points about women in general. Women have a higher rate of dismissing some of these things.

[01:21:15] And going back to the example you used as the wrist pain very easy to say I lifted something incorrectly, or absolutely whatever it is sometimes we'll hear that with edema and in women's legs, they'll say, you know what? I had too much salt.

[01:21:31] That's what, or that's what it is. Or I didn't drink enough water when really there's something else going on. And as chiropractic practitioners, one thing that has always rang in my, head was women that are all of a sudden reporting thoracic spine pain that really don't have a mechanism or rib posterior ripping that don't have that mechanism.

[01:21:56] And just being extra cautious and, really taking a really good history and doing a deep dive.

[01:22:03] **Lori Holt, RN:** And you're right. That history's so very important because I think about and, maybe y'all have different thoughts on this, when a patient would come to the emergency room, they would tell me why they were there.

[01:22:19] Then I would take them to the receptionist. Receptionist got a different story. I'd take them to the room by the time the doctor got it, it was a different story, and at times we were able to look at their history and start pulling and asking questions around that, and I just think it's important that the doctor, or if your patient hasn't been in and let's say six months, have them fill out another history form because all I can speak is for myself.

[01:22:48] If I see something, I don't think it's important for you, then I just won't write it down. That's the nurse in me, I guess it's I can handle it all, and you do treat people that way. We're just smart sometime.

[01:22:58] **Dr. Kris Petrocco-Napuli:** Yeah. And I think as the chiropractic practitioner, it's that whole you've got to document, right?

[01:23:05] If you don't absolutely don't document it didn't happen. And so for all of these pieces that you know, were asking and we keep talking about some of the different questions that are really important to make sure that they are in our notes because that's incredibly important, not just for the treatment protocol, but for the history and long term care of the patient.

[01:23:29] **Dr. Georgia Nab:** The only thing I'd add is that I really stress to patients to know your numbers beyond just what your total cholesterol is. There's so much more that you could know about your numbers, that you can begin to understand your risk factors like homocysteine or know your CAC score.

[01:23:46] Your coronary arteries calcium score. Your labs can tell you so much, and there's things that you can dig in, like an NMR to understand what's the risk factor here. Do the labs.

[01:24:00] **Lori Holt, RN:** Absolutely. And of course I'm gonna have another risk management moment here and one thing I would tell to doctors, if a patient is having signs of a heart attack, do not put them in a car and send them to the ER. Call 911.

[01:24:21] They need to get to the ER and they need to be seen and then think about the liability that you would put yourself in or your employee that you have dry there. All my years of nursing, I've never known anybody do CPR and drive at the same time. Call 911 and have them come in.

[01:24:39] And I believe, I've always believed this in healthcare, we are a team, no matter if I'm a nurse doctor, rad tech, we are team caring for that patient. And I think it's so important that we remember the continuity of care for our patients. And if that patient's in your office, you call 911, the medics get there take the time, call the ER and say, Hey, Ms. Jones is coming to your ER, I think this is what's going on, blah, blah, blah. And there you got that continuity of care. So we

don't miss things with our patients when we're treating them.

[01:25:13] **Dr. Kris Petrocco-Napuli:** Yep. And then you document it that you did all of that.

[01:25:17] **Lori Holt, RN:** That is correct. Document it. That is correct. Cause if it wasn't documented it, it wasn't done but it's true.

[01:25:25] It's just true. And I think you both of you can relate to this. And I don't and I want to say it's more women than men. I might get that different from my husband, but I think we had this intuition when it comes to caring for people. We don't do it for ourselves. Now we're the last on the totem pole when it comes.

[01:25:49] If that doctor just has that one thought that this could be an MI, do it. Call 911 This is easiest.

[01:25:59] **Dr. Georgia Nab:** Let's takeaway on that is we've got to not be afraid to refer out that you've got to have, and I've got a listing of different specialists. So I'm ready that when I need to refer, I'm not afraid to refer. I can only do so much. So have your the other doctors that you can work with and refer, if you have any questions referred it out.

[01:26:27] **Dr. Georgia Nab:** Patients will respect you for it.

[01:26:29] **Lori Holt, RN:** Oh, absolutely. Absolutely they will. And my thing is there again, I could get on my soapbox. To me, it'd be no different in like when a doctor refers a patient to you, you should be getting copies of that chart. There again, so you can see what the patient's history is.

[01:26:47] What's been done for them prior to coming into your office. And I don't know why that's not done anymore, but I have been told, I guess I better wrap it up. So any final thoughts from either one of you before we close out?

[01:27:00] **Dr. Kris Petrocco-Napuli:** I'd like to leave everybody with one final thought. Always, remember every female patient's physiological journey is different. Don't take it for granted. Always ask the full history and treat that whole person.

[01:27:16] **Lori Holt, RN:** Absolutely.

[01:27:17] **Dr. Georgia Nab:** And mine would be make your, if your patients know you care, they're gonna stick with you through thick and thin so always let the patient know you care.

[01:27:29] When they walk in, I look and I say, Hey, how are you my friend? I call them my friend. I want them to, I want to that. But I also want them to know that I

care about them to hold them, not just their spine, but all of them.

[01:27:44] **Lori Holt, RN:** All right. Thank you ladies. It's been fun. We'll have to do this again, because we really have more to cover, but we'll, go with that.

[01:27:50] So I think I'm gonna turn it over to Mike so we can close it out.

[01:27:54] **Mike Whitmer:** All right. First of all, thank you, Lori. Awesome job. And thank you, Dr. Petrocco-Napuli and Dr. Nab. This has been absolutely great. I really appreciate it. A lot of really, good information that I'm sure our audience will find useful.

[01:28:11] Thanks again. Before we go, I just have a few quick housekeeping notes to share. Again, doctors registered for the webinar will receive an email shortly. It will receive an email shortly after this with a link to the recording. The webinar will also be posted on NCMIC.com under the resources section.

[01:28:31] That should be up tomorrow. And while there, you can also find our library of past webinars and resources as. Our next webinar will be April 21st at 2:00 PM central time. We're gonna be focusing on Parkinson's disease with Dr. Mike Powell. So I hope that you'll be able to join us for that.

[01:28:49] And finally, you can keep up on new resources from NCMIC by following us on LinkedIn, Facebook, Twitter, and Instagram. So one again doctors, Lori, thank you so much. We really appreciate you and thank you to everybody that that listened in today. We hope we'll see you next time. Thanks very much.