Testosterone Replacement, Womb Transplants, and Shingles

S1 Ep 53

Dr. Kipper discusses the use of testosterone replacement therapy and provides updates on recent advancements in uterine transplantation. He also shares developments in the early diagnosis of Alzheimer's disease and the increasing incidence of shingles in younger people.

Peter: [00:00:01] Well, hello and welcome to Bedside Matters. This happens to be a podcast that addresses the medical issues that impact all of us every single day. We're going to hopefully give you the answers you're looking for so you can be more informed and healthier. I'm Peter Tilden, one of your hosts. I'm joined by Anna Vocino and Dr. David Kipper. And we've got a lot of topical issues to discuss today.

Anna: [00:00:21] This week we're talking about testosterone. And then we're going to talk about that – not to worry, we'll get right back to women's health. And there's been news of a womb replacement.

Peter: [00:00:32] That's huge. And in This Just Happened, some Alzheimer's news about information you need to know. And the Alzheimer's thing, it just affects almost everybody in some way. And then we've got a call from you in our Hey, What About Me? segment that is about shingles. And it's really interesting because usually understood that shingles affects older people. But this one happens to be about younger people getting shingles and why that's unusual. And it begs for a different kind of treatment.

Anna: [00:01:00] Young people, pay attention. Testosterone. Doctor Kipper, are we doing this like a quiz?

Dr. Kipper: [00:01:07] We're absolutely going to do this as a quiz.

Peter: [00:01:10] Also, David, to start off, the testosterone thing was big. There's a big push for testosterone. I forget how many years ago where it was in the news and they were selling it. Every ad was about if you have low T and as I haven't heard as much of that and I'm wondering if that is a cancer connotation and the fact that they overdid it, they overdid it with pushing testosterone.

Dr. Kipper: [00:01:30] I agree with you, Peter. There was certainly a lot of publicity about low T and that's provoked a lot of men, certainly in my office to ask about this and the real issues here have to do with how testosterone works in the body, what it does, what it doesn't do. But I'm going to ask you some questions that are very common questions in my office and let's see how you do. First of all, what is testosterone?

Anna: [00:01:58] A hormone.

Dr. Kipper: [00:01:59] A sex hormone. Yes. And why is it important?

Anna: [00:02:05] Builds muscle mass.

Dr. Kipper: [00:02:06] It builds muscle mass.

Anna: [00:02:07] Makes babies.

Dr. Kipper: [00:02:09] It's good for male growth. It helps with hair. We'll get to this in a minute, it can also hurt with hair. It helps develop the penis and the testicles and it deepens the voice of young adolescents. But, in later in life, the testosterone has other effects. It actually can create balding if you're supplementing. But it also, as Anna said, it starts to go down: your muscles, your bone, your sperm count, your libido, your mood. All of those things start to change as your numbers go down.

Anna: [00:02:47] What do you mean mood? Like what is the mood?

Dr. Kipper: [00:02:50] Well, there are people that with low testosterone comes some depression. And we do think this is a cause and effect and not just an association, because these other things are happening. It does seem to have a direct effect. Anna, you mentioned something that will be my next question about testosterone in women is, is there testosterone activity in women?

Anna: [00:03:15] There must be, because my doctor gave me a little bit to rub into my arm or leg every day.

Dr. Kipper: [00:03:21] You know where it's made, by the way, in a woman? Testicles, make it in men. Where do you think it's made in women?

Anna: Ovaries?

Dr. Kipper: Ovaries, absolutely. And the adrenals. But, absolutely.

Anna: [00:03:32] Oh, I didn't know that.

Dr. Kipper: [00:03:33] And what function do you think it plays? Well, I don't know why your doctor gave it to you, but if you're comfortable sharing that.

Anna: [00:03:41] I believe it's for libido in a woman. And so and also for muscle mass and not having as much sarcopenia, right?

Dr. Kipper: [00:03:50] Yes, exactly. And it is the single best medicine for this change in libido, particularly at menopause, when all these estrogens take off.

Peter: [00:04:00] David, does it have to be monitored as carefully as it does in men, as far as cancer regulation, etc.?

Dr. Kipper: [00:04:05] There's no great way to monitor it, Peter. So the answer is probably yes.

Anna: [00:04:10] I go every four weeks to have all the hormones tested. But, you know…

Dr. Kipper: [00:04:14] Testosterone testing is difficult also because during the day the testosterone values and levels change all day long.

Peter: [00:04:22] So how did they, when I started this and I said there were ads everywhere for low T, how do they decide if somebody comes into the clinic and needs T?

Anna: [00:04:30] Yeah, what's the arbiter of that?

Dr. Kipper: [00:04:31] Well, that's coming in another question, but it is done through a blood test. And the blood test will identify what your testosterone levels are. But if you're looking for nuances in how you're regulating therapy, it may not be so simple as just doing a random blood test. And here's a question. This I found interesting. Do you know where testosterone comes from? Like, what is it made from? What other compound in the body is it made from?
Anna: DHEA?

Dr. Kipper: No.

Anna: [00:05:03] Cholesterol?

Dr. Kipper: [00:05:05] Yes. Cholesterol. Very good. So here's a question. So, if people have high cholesterol, do they also have high testosterone levels?

Peter: [00:05:16] Not necessarily.

Anna: Yeah, that's what I would say.

Dr. Kipper: [00:05:18] Right, bingo. Hey, boy, you guys got very smart over the last week.

Anna: [00:05:24] I know, we've been studying.

Dr. Kipper: [00:05:25] Here's a theory about testosterone. And tell me what you think, whether this is true or false. The theory is, or the myth is, that people that have high levels of testosterone have trouble with anger, road rage, sexual promiscuity. What do you think? You think that that's accurate?

Anna: Yes.

Peter: [00:05:49] I think that's probably a yes with an asterisk, because then not everyone with high testosterone is a road rager. There must be other things that enter into it.

Dr. Kipper: [00:05:58] Yeah, it's a no, actually. So the testosterone levels have nothing to do with that. But if you remember that landmark book called Override, there is a discussion of how neurotransmitters create those kinds of issues, those anger issues. And that's a dopamine problem. So people that have a dopamine imbalance, have those issues. It's not from testosterone.

Anna: [00:06:24] When you said road rage, I thought of roid rage and then I get confused. Are steroids same as taking testosterone or are they different chemicals?

Dr. Kipper: [00:06:33] They're different chemicals.

Anna: [00:06:34] Okay.

Dr. Kipper: [00:06:35] What happens if you have high testosterone in women? What's the most common thing that happens?

Anna: [00:06:42] Hirsutism.

Dr. Kipper: [00:06:43] Yes. And there is a syndrome. You know the syndrome?

Anna: [00:06:48] Polycystic ovarian syndrome or androgen.

Dr. Kipper: [00:06:51] Oh, my goodness. Wow. You know your male hormones.

Peter: [00:06:55] I think we found your area.

Anna: [00:06:57] I find it very interesting because it seems to be what's powering us.

Dr. Kipper: [00:07:01] So, high testosterone in women. The most common thing we see, and this is about up to 10% of women have polycystic ovary syndrome. And what does that mean? It means that you masculinize the woman. So there's hair growth where you don't want it. There's obesity, there's a metabolic syndrome which can lead to diabetes. And it's very, very uncomfortable. And, interestingly, to that point, the treatment for this is a diuretic called Spironolactone. And that specific diuretic actually is successful by blocking the male sex hormone.

Anna: Oh, wow.

Dr. Kipper: So, yes. So that's how that works. So getting back to another myth about low testosterone, and this is a question I get so often in the office and just for some background, our testosterone levels start to drop in our mid-40s, about 1 to 2% every year. Then there's the question of, you know, what are those symptoms? And this is a question that I get specifically. What do you think those questions would be? What do you think those symptoms would be from having low testosterone?

Anna: [00:08:12] Erectile dysfunction, maybe?

Dr. Kipper: [00:08:15] Yes. So libido goes down and your muscle mass goes down. You start losing your body and your facial hair. Something interesting happens to the breasts. They get bigger and more tender. You can also get bone loss, which is osteoporosis. And your sperm count goes down.

Anna: [00:08:35] A man can get osteoporosis?

Dr. Kipper: [00:08:37] Yes. Men get osteoporosis.

Anna: [00:08:39] I didn't know that.

Dr. Kipper: [00:08:40] Yes, so men listening, if you are in your 50s and beyond, you might ask your doctor, not only to check your testosterone, but you should also get a bone density scan because men do get osteoporosis.

Peter: [00:08:55] But what about the question about the low T and T replacement and the danger of that?

Dr. Kipper: [00:09:02] So, Peter, that's the number-one question and that's the real issue. The answer is, if you have a lower testosterone level and if they're coming in and asking about these symptoms and they're in the right age group, their testosterone levels are

going to be low and you can replace testosterone for these symptoms. There's no proof, by the way, that most of these symptoms are bettered by replacement.

One of the problems, if not the problem, with replacing testosterone, is its effect on the prostate. So testosterone can be a nutrient for prostate cancer. It won't cause a prostate cancer, but if you have an existing prostate cancer, it's going to make it blossom. So what we do when people come in and they want their testosterone replaced, you have to make sure that you work up their prostate, that their PSA is normal, that, if there's any family history of prostate cancer, they have to be followed very carefully. So that's the one thing that we have to pay attention to.

Peter: [00:10:04] How do you figure out dosage? Is the dosage standard dosage? If somebody has low testosterone, this is what you give them?

Dr. Kipper: [00:10:10] Yes. And you start out by giving a low dose. There's an injectable form, a shot. There's a rub-on, it's like an underarm rub-on. And there's also now a nasal product. But the nasal product is not well tolerated. It's very expensive. But there are a couple of different ways to deliver the testosterone. So you did very well, by the way.

Anna: [00:10:35] I find it very interesting, you know, and I am in the low-carb world because of the cookbooks that I do. And so I like talking about it because, obviously, the way that you eat affects your hormones. Well, it's not just your food hormones, it's your sex hormones, etc… It's all the hormones, it's all the endocrine system. So I always find it really interesting because I just want to learn more about how we work. So that was really interesting.

Dr. Kipper: [00:10:56] There's one problem I've seen in my practice a few times, which testosterone replacement, not only does it build muscle mass and do these things, it can also raise your red blood cell count. And by raising that blood cell count too high, it promotes clotting. So people that are on testosterone, we have to measure their red blood cells.

If it gets too high, they have to be phlebotomized. They have to have their blood taken to reduce the amount of red blood cells. And then it becomes a really interesting conversation because if you have that person that is relying on their testosterone for their libido, their muscle mass and their physicality, and then they don't generally care if they have to have their blood drawn off periodically, which to me seems nuts. But so that's another issue that we have to contend with.

Anna: [00:11:51] Well, and one last question before we move on. Is it the type of thing where if you are supplementing testosterone, will your body cease to make it because it thinks you have it enough of it, or is that not an issue?

Dr. Kipper: [00:12:04] Boy, that's such a smart question. No, your body will continue to make what it's making; we're supplementing beyond that. Also you're monitoring this, so you measure the levels of testosterone so you don't let it get too high because you do have a normal range that you refer to. But that's a good question. But, no.

Anna: [00:12:24] All right. Well, thank you for that. Womb replacement. Now, I'm assuming this is a uterine replacement. Like, what is the womb replacement? This sounds fascinating.

Dr. Kipper: [00:12:35] This is not new technology. This has been developing for 25 years.

Anna: [00:12:40] Wow.

Dr. Kipper: [00:12:40] Ninety people so far in the world have had their uterus implanted.

Anna: [00:12:46] Like an organ transplant.

Dr. Kipper: [00:12:47] Yeah, well, it is an organ. So it's exactly that.

Anna: [00:12:52] Hey, guys, guess what I learned today?

Dr. Kipper: [00:12:54] But there's a problem that this is addressing because 1 in 6 women worldwide anyhow have problems conceiving and they might have a problem because their uterus doesn't work normally, they maybe have had a hysterectomy and there's a genetic condition pretty rare, but there's a genetic condition where they're born without a uterus.

Anna: [00:13:18] So you can have had a hysterectomy and then down the line get a uterine transplant?

Dr. Kipper: [00:13:24] Yes. As long as they haven't taken – and this is the nuance here – as long as you still have your ovaries and your fallopian tubes. The case that really came to my attention that I thought was fascinating was a 34-year-old woman in England who had that genetic issue and she was born without a uterus. She had her tubes and she had her ovaries, so she couldn't conceive. Her sister had her family, so her sister donated her uterus to her sister with the genetic issue. And what's interesting about that is, like any transplant, when you transplant an organ, you have to go on transplant medicines, these anti-rejection medicines, so that they don't reject it.

Anna: [00:14:08] Right.

Dr. Kipper: [00:14:09] So what this woman, specifically this woman and other women have done, is that they've taken the new uterus, made their babies, been on these medicines, and the medicines are not without problems. And then as soon as they've had their families, they give the uterus back. They have a hysterectomy so that they can go off of those transplant drugs.

Peter: [00:14:34] I'm curious because the sister donated her womb, was there less resistance to the transplant?

Anna: [00:14:40] Yeah, because of the genetics?

Dr. Kipper: [00:14:42] One would think so. But they're, even siblings can have very different genetic makeups. And there's 43 things that we check when we transplant an organ. So, but, yes, Peter, it would seem that would be the best place to go.

And for all transplants, if someone's looking for a kidney or a liver or a heart, you start checking your family, because, to Peter's point, there tends to be less rejection. The surgery I thought was pretty interesting. Harvesting the uterus takes a little over eight hours. And transplanting it, takes about nine hours. So this is an incredibly long period of time.

Peter: [00:15:22] So before they start with the first person, before they even put the other person under, I'm guessing. You're not going to have someone there for nine hours waiting.

Dr. Kipper: [00:15:31] Yes. Why does it take totally, what, 17 hours?

Anna: [00:15:34] Because you don't want to damage anything.

Peter: [00:15:35] The blood supply?

Anna: [00:15:36] Yeah. You don't want any necrotic tissue.

Dr. Kipper: [00:15:38] Bingo. Bingo. So it's blood vessels. You know, these blood vessels are pretty small, so you have to be able to connect all this. And one last question on this and we can move along. Do you know how they know it's a successful transplant?

Anna: [00:15:52] When you get a period?

Dr. Kipper: [00:15:54] Yes.

Anna: [00:15:55] Because I was just thinking how, in a woman who was born without the uterus, but has the ovaries and the fallopian tubes are they ovulating every month and then the ovary just kind of like falls out of the fallopian tube but it just dissolves or whatever?

Dr. Kipper: [00:16:08] Yes, absolutely right. In other words, they're not going to engage in a pregnancy if these three systems are not working together. So as soon as a woman's had three periods that have been relatively normal, then they can proceed.

Peter: [00:16:23] So since they've been doing this for a while, when you put your check on the donor card, is it assumed that the uterus is also transplantable because you signed your donor card?

Dr. Kipper: [00:16:35] It's a very good question. I don't know the answer to that.

Anna: [00:16:39] I'm an organ donor, but I don't think at this point anybody needs this uterus.

Peter: [00:16:44] Interesting fact, because you have to be within a certain reproductive age, etc…

Dr. Kipper: [00:16:48] No, Peter, that's a really excellent question.

Peter: [00:16:52] Because you're not saving somebody's life, but you're providing the opportunity to create a life. I mean, it's a really interesting twist on signing, putting that mark on your license.

In This Just Happened, we talk about weight a lot because weight can affect a lot of different things, not the least of which is we have a diabetes and a pre-diabetes problem in this country due to obesity. But this one blew my mind because Alzheimer's is in the news

every day, because it not only affects people with Alzheimer's, people who are in their 40s and 50s are doing quizzes and stuff to make sure that their minds stay nimble.

Anna: [00:17:25] Yeah, brainteasers.

Peter: [00:17:27] Every time I see an article, it's are these the signs that you have Alzheimer's and you got to read that article. But also the caregiver thing is insane too, because for everybody with Alzheimer's, it impacts the entire family. And we're all looking for answers to this. And there's no cure yet, but there have been advances. This one is interesting because it has to do with your belly and Alzheimer's, which I would have never guessed, David.

Dr. Kipper: [00:17:51] And we're all looking for ways to diagnose this disease early, because what we typically do is diagnose this once people are in their 70s and beyond, and by then the culprits, which are the amyloid proteins and the tau proteins, they've already done their damage. They've already nested in the brain around these neurons. And it's very hard to reverse that at this point. So if we could find something that would identify this earlier, then we would have an advantage of trying to mitigate those issues.

And that's exactly what this study did. And this was done in St Louis at the University of Washington Med School. And what they found was they identified some brain imaging markers of inflammation that were linked to belly fat, specifically visceral fat. And what they found was that people that had more neuroinflammation on these imaging studies, they had brain dysfunction, they had a couple different things that happened with that. One was that the gray matter was atrophying even at this age. They took people in their 40s and 50s, as opposed to all the other studies with Alzheimer's are going on in people in their 60s and 70s and beyond. And they found that people in that age group, when they did these neuro imaging studies, the gray matter had atrophied, which was something we didn't know about.

Anna: [00:19:25] So is the only way to get tested for that to be in one of these studies, or is this something that they're going to be able to have people get tested in their 40s and 50s for early damage?

Dr. Kipper: [00:19:35] No, this is something that we can do pretty easily because these are noninvasive imaging studies, MRI's and scans, and they can identify the amount of fat in the belly and determine who's at great risk. And so this is really good information.

Peter: [00:19:52] You can tell physically just by looking at somebody, David, what are the differences between this, there are some people who have big bellies and then some people who have a higher fat content in their belly that may not be as big as somebody else's.

Anna: [00:20:04] Like the higher visceral fat?

Dr. Kipper: [00:20:05] Good question. So there are two types of fat. There's belly fat, which is the subcutaneous fat right under the skin. And that's the stuff you can poke and you can see. And then there's visceral fat (the visceral just means around the organs) that is behind the abdominal muscles. And that encapsulates all the vital organs in the system. And what that does is creates inflammation around those organs. And one of those organs is the brain. So the brain is inflamed. And with these imaging studies, you can identify the visceral fat.

Peter: [00:20:45] So, it's the visceral fat that you're looking for, not necessarily the other fat?

Dr. Kipper: Yes.

Peter: So a thin person can have visceral fat?

Dr. Kipper: [00:20:53] Absolutely. Can you think how that might happen?

Peter: [00:20:56] Boy, I would think because of the way their food is stored, by the way the nutrients are stored and processed.

Dr. Kipper: [00:21:03] Yes, indirectly. These are people that are exercising regularly to diminish their subcutaneous fat.

Peter: [00:21:11] In appearance. Wow. Okay.

Dr. Kipper: [00:21:12] But they're eating terribly. So the bad eating is creating more of the visceral fat.

Peter: [00:21:19] Is that the same thing that can happen now with all of these diet drugs?

Dr. Kipper: [00:21:23] Another great question. No, these diet drugs tend to work on the belly fat, on the subcutaneous fat.

Peter: [00:21:29] Wow. Okay.

Dr. Kipper: [00:21:30] Yes. And what's interesting also is that the visceral fat is more bioactive. It responds best to diet and exercise. That's something you can actually control. Diet and exercise doesn't do so much for the belly fat, for the subcutaneous fat. And 90% of our fat is under the skin. It's the subcutaneous fat.

So this is a really interesting study. And it not only showed brain atrophy in these people, but it also showed the white matter, not just the gray matter, but the white matter was also highly inflamed. Just to review, gray matter is where all the neurons are made that actually tell the body what it needs to do. And the white matter is the highway that runs through the gray matter that carries that information. So the white matter being inflamed, you can't get these messages from the neurons to where they need to go. And most of these changes are seen in the hippocampus. And the hippocampus is where memory comes from. So it all makes sense. So what can you do? You can get these scans, to your point, Anna.

Anna: [00:22:46] Yeah, what do we ask for?

Dr. Kipper: [00:22:47] Well, you're asking for an MRI of your whole body. You want to see what's going on in your abdomen and pelvis and brain. Once you've identified yourself in your 30s and 40s and 50s as an at-risk person, then you start taking care of buildup of fat, whatever that is. So diet and exercise is really going to be important. Whereas before, up until this study, you didn't really put those two together, you didn't connect those dots.

But now we're connecting those dots and you put yourself on a program that helps, you know, dissolve this visceral fat and you are protecting yourself against these

neurodegenerative diseases. And I don't think it's just Alzheimer's. I mean, they tested Alzheimer's, but I think that if they look at Parkinson's, I think they're going to find similar effects. But those studies, I think, will come next.

[music]

Anna: [00:25:36] We have a question from a caller.

Caller: [00:25:38] Hey, Dr. Kipper, I have a 32-year-old brother who just got diagnosed with shingles. And I'm a little confused because I thought that this was something that only happened in older people.

Peter: [00:25:48] Really interesting, David, and that's kind of true, right? Partial credit.

Dr. Kipper: [00:25:52] It's absolutely true. And it's increasing in younger people. And just to go backwards for a second, shingles is, remember, the reactivation of the varicella virus, which is the chickenpox virus. And it can come back later on in your life. It lives in the nerve root and it can come out for different reasons.

It comes out when you are immunocompromised, when you have an immunocompromised illness, when you have cancer, when you have HIV, there are a number of different immune-compromised illnesses that we have. They can come out under stress and this is, I think, more common now in younger people.

Again, if we think about why is this showing up more in younger people, I don't know if social media factors into this, but I think it probably does. There is a group of people, a large group of people as youngsters after 1995 that had the chickenpox vaccine. So some people did not get vaccinated. And, as we all know, there's an anti-vax campaign going on and it started long before Covid. And so a lot of people that were not vaccinated for chickenpox, they're showing up earlier with shingles.

Anna: [00:27:08] Wow.

Dr. Kipper: [00:27:09] If you were vaccinated for chickenpox, by the way, you have about a 78% chance of never getting shingles just from that vaccine that you got as an infant. So that's something.

Peter: [00:27:22] But, David, if you got it and you got a 78% of not getting it, and you still got it, does that mean you're immunocompromised?

Dr. Kipper: [00:27:29] Yes. I don't know what Larry, the caller's issue was with his brother. I don't know what his clinical situation was. But, Peter, to your point, and I found this to be a really interesting story. Magic Johnson. Got HIV. And months before that diagnosis was made, he got shingles.

And we've always known that people that got shingles, as a young person, you had to look at these people to see what else could be going on in their system. Do they have an underlying cancer? Do they have an underlying immunocompromised disease? So the HIV's first expression was shingles. So if you're a younger person and you present with shingles, you need to talk to your doctor about checking things out to make sure.

Peter: [00:28:19] David, so I come in and I'm in my late 20s and I got shingles. If you do a blood workup or of whatever, can you always find that thing that caused the immuno…?

Dr. Kipper: [00:28:29] No, you can't, Peter, because stress being one of the issues is not diagnosed in a blood test or an imaging study. But you can ask people but everybody's stressed. So it's really hard to get that as a as a clear reference point. But there are people the question really not is, are you stressed? The question is, are you more stressed than you normally have been? And so that can do it.

Peter: [00:28:56] And, are we saying societally we know we're stressed more, we know that we have a firehose of information? My dad, to reference my dad, again, I was convinced he worked hard. My mom said how hard he worked and he did work hard. He worked long hours and he worked half a day Saturdays. But he also had an answering machine and that was it. Once work was done, work was done, and I'm sure there was stress or whatever. Now, we're a 24/7 society, where that firehose of info is on constantly, where we never shut down. And even on vacation, you go on vacation, David, you're taking calls, Anna, it's 24/7.

Anna: [00:29:29] Oh, yeah. No, it's never enough.

Peter: [00:29:30] Do we see this compromise exploding in our society?

Dr. Kipper: [00:29:35] I think it's been so insidious, that it is just, yes, it's part of our DNA now. I always have my phone with me, and, if I'm not getting a call, I'm getting a text. And if I'm traveling and I'm in a different time zone and someone calls you and you're three hours behind them or seven hours ahead of them, yeah, it's complicated. It's more stressful.

Peter: [00:29:59] You see more shingles now in your practice than you ever had before?

Dr. Kipper: [00:30:02] I have seen shingles in younger people that surprise me for all these reasons. And, yes, you do the workup, you hope that you don't find anything. And then, by process of elimination, you determine that it's probably stress.

Peter: [00:30:17] Wow. That's stunning to me that, first of all, it's fascinating. The younger person, you do the workup to find what the underlying cause is to eliminate. I wondered, do most doctors, you think, do that, David?

Dr. Kipper: [00:30:29] I think so, absolutely. It's an ugly, horrible disease. If that virus lands in the nerve root that goes through your eyeball, you can lose your vision. If that shingles comes out in your face, you're at high risk of losing your eyesight and the pain can last forever. The rash might go away, but you can have pain. About 20% of people with shingles have lasting pain.

So to those listening, if you're over 50, please get your Shingrix. That's the new vaccine for this. There was an older vaccine that was out several years ago, and that vaccine was about 60% effective and lasted about ten years. This new one, Shingrix, it's two shots given within six months, has about a 95%, you know, elimination rate for this illness.

Anna: [00:31:27] For ten years or for a longer?

Dr. Kipper: [00:31:29] Oh, forever. And so that's another thing. If you're younger, the insurance companies are not going to pay somebody that's under 50 to do that vaccine. And it's I think it's about $300 for those series. But if you are in any one of those categories, if you're immunocompromised, if you are highly stressed, if you have some of those other diseases, diabetes, by the way, it's one of those diseases, get your Shingrix. Get your vaccine.

Peter: [00:32:00] There you go.

Dr. Kipper: [00:32:01] And if your insurance won't pay for it, ask your doctor to write a letter to the insurance company advocating for you because you have these other conditions.

Anna: [00:32:11] Let's do a recap. Today was a very busy day. We discussed all things testosterone.

Dr. Kipper: [00:32:17] So testosterone is in men and women. And a lot of what we worry about having low testosterone is not really proven. We can supplement testosterone with shots and rub-ons and ask your doctor. And if you have a history of prostate cancer in your family or you have prostate cancer, the doctor will know about that and you're likely not going to get the testosterone supplements.

Anna: [00:32:42] Interesting. And then we discussed a uterine transplant, a womb replacement.

Dr. Kipper: [00:32:47] So for millions of women around the world that can't conceive and are relying now on either surrogates or adoption, there's another option now, which is to get a transplantation of someone's uterus.

Peter: [00:33:03] And in This Just Happened, we found out the Alzheimer's has a relationship to belly fat.

Dr. Kipper: [00:33:08] So if you are at risk or you are nervous about this and it's a very common illness, speak to your doctor about getting a body scan or an MRI to look at your brain, your belly, your abdomen. Another simple way to see if you're at risk, if you're a woman and your waist circumference is over 35 inches, you might want to look at that and be particularly careful about getting these scans. If you're a man and it's over 40 inches, you should also speak to your doctor about getting diagnosed.

Peter: [00:33:47] And the caller today, in Hey, What About Me? is shingles and younger people are experiencing shingles also. What you should check.

Dr. Kipper: [00:33:55] So, yes, there's an increase in younger people getting shingles. And I recommend that you get your Shingrix vaccine. It will prevent this.

Anna: [00:34:05] And, by the way, if you guys out there are listening and you have a question for Dr. Kipper, head on over to BedsideMatters.org or follow us on Twitter @BedsideMattersPod and follow us on Instagram @BedsideMattersPodcast. Ask your question. Dr. Kipper might just answer it on the air.

Peter: [00:34:23] And Dr. Kipper mentioned Override, his book about brain chemistry. It's really a must to know how you behave and why you behave the way you do. And it all has

to do with your brain chemistry. It's a wonderful book to get to know yourself and the reason that you can procrastinate and put things off and act the way you do. It's all in there.

Anna Vocino, of course, she has a website that offers recipes, sauces, spices, cookbooks, all about gluten-free, grain-free, low-carb. Go to AnnaVocino.com, and she's in a store near you probably, right?

Anna: [00:34:53] Yeah.

Peter: [00:34:54] You're expanding, your empire is expanding.

Anna: [00:34:56] 32 states.

Peter: [00:34:58] Wow. Congratulations on that.

Anna: Thanks.

Peter: Thank you, producer Lorre Crimi. And thank you for listening to Bedside Matters. If you're sick and tired of being sick and tired, we are here to help. We offer new episodes every Monday, so follow us, like us, and have a wonderful and healthy week.

Announcer: [00:35:12] The information on Bedside Matters should not be understood or construed as medical or health advice. The information on Bedside Matters is not a substitute for medical or health advice from a professional who is aware of the facts and circumstances of your individual situation. Thank you for listening. If you enjoyed the show, please share it with your friends. We'll see you next time.