

[169: Resiliency Radio with Dr. Jill: Dr. Howard Elkin, MD talks about Integrative Cardiology](#)

**Dr. Jill 00:12**

Well, hello, everyone. Thank you for joining us again for another episode of Resiliency Radio with Dr. Jill. Today I have special guest Dr. Howard Elkin, whom I'll introduce in a moment. We're going to talk about medical advocacy. But we have an integrative cardiologist with us today, so we're going to talk a little bit about heart health as well. Before we begin, let me introduce you, Dr. Elkin.

**Dr. Jill 00:37**

Dr. Howard Elkin has practiced cardiology in Whittier, California, since 1986. He graduated with the highest honors in the Medical College of Virginia in 1979 and completed his internship and residency in internal medicine at Michael Reese Hospital and Medical Center in Chicago, followed by a fellowship in clinical cardiology at Northwestern University. We share some Chicago roots too. Dr. Elkin moved to Southern California in 1984, where he completed an additional fellowship in invasive cardiology at the Los Angeles Heart Institute. He realized in the early '90s that mainstream cardiology focused on diagnosing and treating patients, and patients were not staying healthy long-term. In 1994, he added a preventative component to his practice with the HeartWise Fitness Institute, combining sound nutrition, exercise, and stress management. His patients are empowered to live happier, healthier, and less stressful lives. Welcome to the show, Dr. Elkin.

**Dr. Howard Elkin 01:36**

Thank you. Thank you so much for having me! I'm delighted to be here today.

**Dr. Jill 01:39**

You're welcome. And I'm delighted to talk to you about all things cardiology, about your own journey, about your new book, and about everything there. But I always love to start with [one's] story as far as: Where did you grow up? How did you get interested in medicine? Were there any other doctors in your family? And then how did you get interested in integrative medicine?

**Dr. Howard Elkin 01:57**

No one has asked me that. That's a great question. Well, I grew up in Richmond, Virginia. I didn't have a medical family. My father didn't graduate high school. My mother did. I'm the second of four children, and I never had a doctor's kit when I was a kid growing up. I didn't have any of that, but I was fascinated by anatomy. I

remember that. I don't know if you remember the World Book Encyclopedia—those little cellophane pages. I would study all the layers. I would study all the—

**Dr. Jill** 02:27

All the layers, right?

**Dr. Howard Elkin** 02:59

Yes. It was so much fun! And then I wanted to be a writer. And I said, "Well, maybe you should be a lawyer because that kind of goes hand in hand." But I really didn't like law. So I got interested again in medicine. But it wasn't until my senior year of high school that I decided to pick that. In college, I was kind of a double major in biology and also in English. So it was good. So how I got into cardiology: When I started my medical school training, they take you through the various organ systems. In the first year, it's normal physiology and anatomy. The second year, it's pathology. And then the third year on is clinical.

**Dr. Howard Elkin** 03:14

When I got to the cardiovascular system, it just made sense to me. I didn't have to memorize things like in endocrinology and infectious disease. It just made perfect sense. So I was always interested. I didn't make the final decision until I was doing my internship in residency. But I always had a penchant for the heart. Then I came out to California. I was married at the time and had a child. I was actually brought out here for a large multi-specialty group in cardiology. But it really wasn't my thing. So after a year, I went back to training in invasive cardiology and then subsequently started my own practice in 1986.

**Dr. Howard Elkin** 03:55

Here I was, this young cardiologist, and I was traditionally trained. We knew nothing about functional medicine. I don't even think the term was coined then. That was in '86. In the early '90s, I saw the writing on the wall. People were flocking to HMOs. And I saw the same patients come back. They'd have a heart attack, and then they'd have a stent. Then they'd have another stent. I said: "Something is not right about the system because patients aren't really getting better. We're putting a band-aid on, and then they come back with the same problem within a couple of years." And it goes along with cardiac rehab and people who choose exercise

programs, because 50% of these people are no longer exercising within six months. So there's something about lifestyle that I saw was truly lacking.

**Dr. Howard Elkin** 04:42

Then, I devised what I called the HeartWise Fitness Institute back then. I had a trainer, we had a nutritionist, and we counseled people. We even had group meetings once a week, kind of based on Dean Ornish's group studies on having cardiac patients talk about issues that they don't normally talk about. So that was exciting. Then I got into the longevity side. We're almost finished. And then I took the fellowship, and I basically added hormones and longevity medicine in the early 2000s. And that's where I'm at. So I call myself an integrative cardiologist practicing functional medicine.

**Dr. Howard Elkin** 05:26

I use the functional medicine principles that we all use but mostly from a cardiologic standpoint. But you can't [inaudible] gut. I'm really interested in gut [health] because most of the patients that come to see me as a cardiac patient—about 60% of them—have a gut issue. So that's what I love about functional medicine. You have to be versed in almost all the specialties, at least in the internal medicine specialties, because there's an integration that goes on that we just don't see. In traditional medicine, "Oh no, that's a heart problem." "No, no, you've got to go to the pulmonologist. It's a lung problem." And I see this battling happen all the time. So this gives me a lot of pleasure to be practicing how I am now. And that's the beauty of being in your own practice. If I was in a large group, I couldn't do this.

**Dr. Jill** 06:12

Yes, you're right. I see this all the time with colleagues who are getting burned out and frustrated. The joy of why we went into what we're doing is really revived when we do functional and integrative medicine, because we're usually connecting deeply, having these relationships, and helping people to heal. And again, there's nothing wrong if you have a heart attack or a car accident [and turn to conventional medicine]. In fact, you were in one of the best realms for conventional medicine because you could intervene and save a person's life, really. But like you said, when they come back and they're not doing better after several years or they've fallen off the bandwagon, we both realized there was a lot more. So good for you. I love that.

Obviously, you are interventional, so you're doing stents and all of that. And again, there's a place for those that is lifesaving. But as far as the real—

**Dr. Howard Elkin** 07:01

They're life saving band-aids.

**Dr. Jill** 07:03

Yes, exactly. Exactly. I feel like, as I'm understanding the heart and the endothelium and all this, there is so much more. And really, at the root, it's kind of the endothelium that matters. Do you want to talk a little bit about what you've learned and the kinds of things that we can do to actually heal endothelium and nitric oxide and those basic tenets versus just putting a stent in an emergency?

**Dr. Howard Elkin** 07:27

That's such a great question. Thank you for asking. The endothelium is everything. For your listeners, we have 60,000 miles of blood vessels in our body. Can you imagine that? Sixty thousand miles. And every one of those vessels is lined with a one-cell-thick [layer] called the endothelium. 'Endo' means inside in Greek. So that one-cell-thick [layer] is very, very important because, first of all, it can make nitric oxide, which helps these vessels dilate. And number two, it's semi-permeable, so it disallows things. We don't want oxidized LDL cholesterol and other harmful substances to enter the endothelium, and that's when inflammation begins. And that's really when you have heart disease.

**Dr. Howard Elkin** 08:14

But in traditional cardiology, they don't talk about endothelium. It's not about prevention. If you have high cholesterol, you go on a statin. I'm simplifying things and generalizing, but that's basically how it is. When someone gets discharged from the hospital with a stent, I can guarantee you they're going to be on aspirin, a statin, a beta blocker, Plavix or a platelet inhibitor. They're on four or five medicines, even if they were on nothing before. That's just how it's done. So looking at the endothelium [is important].

**Dr. Howard Elkin** 08:50

Also, I'm very interested in blood pressure control because I think it's still the number one risk factor. I forgot the numbers. It keeps on rising. When I wrote my book, it was like... I mean, there's like 100,000 people out there; usually, 50% of the

population is hypertensive. Why? So I try to look at the preventative side and weight issues. Definitely weight loss. If someone loses 10% of their current rate, they'll drop their blood pressure. I can guarantee that. And it does get more prominent as we get older. There's a genetic tendency. But it's all about the endothelium. You can't treat the endothelium without controlling the blood pressure, because if the blood pressure is hypertensive, it'll destroy the endothelium.

**Dr. Howard Elkin** 09:41

There's one test that I do that most people don't know about. It used to be called the PULS test. Now it's called SmartVascular Dx. It's a fascinating test because it's the only one that I know of that actually looks at the health of your endothelium. So it's a great test. Most doctors don't know about it. You get seven different biomarkers specific for the endothelium. And I tell patients: "We're not treating your biomarkers; I'm treating your risk." You find out with this test whether you're high, medium, or low risk. It's really helpful because then I can intervene with certain supplements before they have a problem. So it's all about prevention and getting there at the beginning.

**Dr. Jill** 10:28

Is this a blood test or an ultrasound or what kind of test?

**Dr. Howard Elkin** 10:31

It's a blood test. It's a simple blood test. They're out of Irvine, California. And again, the name was PULS. But now, if you look up SmartVascular Dx, the website... It's an unusual test. Most doctors don't do it. I don't think most doctors even know about it. But I do it. In other words, when I have a patient come into my office, I tell them from the beginning: "My plan is to assess your risk, not just treat you with drugs. Let's assess your risk and let's figure out what you need." So it's custom care. It's customized care. And I think it's the optimal way of doing it. So I will often do certain tests. I won't usually do this as test number one, but I will do things like Cleveland HeartLab or Boston Heart lab, which we can talk more about and oftentimes the coronary calcium scan. So anyway, it's kind of the way I would start.

**Dr. Jill** 11:29

I love this because I couldn't agree more. Let's maybe talk a little bit about some of

these labs. Like you said, MPO, TMAO, PLAC; hs-CRP [is one] many people know about. But some of these, especially the Cleveland and Boston Heart labs, both have a lot of these inflammatory markers. You don't have to talk about all of them. Maybe pick a few of your favorites. And let's talk to the person listening about why they might want to ask their doctor for some of these tests. Like you said, with functional medicine, we're looking at: Where is someone on the trajectory of wellness or disease? And are they walking towards a possible stroke, heart attack, or incident? And if they are, then you and I could say: "Hey, you're at risk. And this is what we can do to actually reverse your trajectory." So maybe talk a little bit about some of your favorite inflammatory markers or tests that maybe the patient isn't aware of.

**Dr. Howard Elkin 12:18**

Cleveland HeartLab and Boston Heart Diagnostics are both excellent labs. They're very comprehensive cardiac labs. Cleveland is a little more easily available. It was bought out by Quest a few years ago. So you just go to Quest Lab and they can draw your blood. They send it to Cleveland. Boston is a smaller lab, and you have to have a phlebotomist. We have very few phlebotomists that can do this—that can go to your house and actually draw the blood. But they are both very similar. So number one, it's the lipids—the cholesterol and triglycerides. Your average doctor is still getting cholesterol, triglycerides, HDL, and LDL. That's basically it.

**Dr. Howard Elkin 12:57**

With Cleveland, you're not only getting those values; you're getting the size of the particle and the number of particles. So it's prognostically more important. I want your listeners to know, just remember one thing when it comes to LDL, low-density cholesterol: We think of that as lousy and HDL is healthy but it's not quite that simple. Low density or LDL cholesterol really depends on the particle size. So we want large fluffy particles and not small dense ones, because the small dense LDL particles can get easily oxidized and then they can get into the walls of the endothelium if the endothelium is not healthy. And then you've got the beginning of inflammation.

**Dr. Howard Elkin 13:38**

So that information, you get right off the bat with Boston or Cleveland. Then you have the inflammatory markers. Everyone in my practice gets hs-CRP, which is a

highly sensitive C-reactive protein. A lot of doctors don't even draw that, but you have to know where the patients are. And you can follow it. It's an inexpensive test. You can follow it sequentially. Then I do a couple of other inflammatory markers that you can get both with Cleveland and Boston. It's called the lp-PLA2. It's a long enzyme. Anyway, that's looking for vascular inflammation—is there inflammation in the vessel itself? CRP is totally nonspecific but very sensitive. Lp-PLA2 and myeloperoxidase are two markers that you get with these tests and they help determine if you have any systemic inflammation. They also have a test to see whether you have any oxidized LDL. That's the LDL we worry about. It's not LDL. It's not some kind of villain. If we didn't have LDL cholesterol, we couldn't get to the brain. I don't want a good heart with a bad brain.

**Dr. Jill** 14:50

Yes. I always say that cholesterol is not the bad guy. Cholesterol makes our hormones. It makes up our brain. Cholesterol is the thing we absolutely need. However, if the endothelial lining is sticky, there's inflammation, and there's all these other things, even autoimmune disease—which people don't typically associate with heart disease—then that cholesterol, like you said, the oxidized LDL, gets sticky. That's the issue. Not cholesterol itself. Cholesterol itself is neutral, right?

**Dr. Howard Elkin** 15:13

Right. But even most cardiologists I see don't really get into this because it does involve education. But like you, the joy I get from practicing medicine is developing relationships with my patients. It's just very fascinating.

**Dr. Howard Elkin** 15:35

I did leave out one thing. When you go back to the lipids in these sophisticated labs, you also get what's called LP(a). Now that is a fragment of LDL. It doesn't bode well for heart disease because it's very sticky and very inflammatory. It can easily get oxidized and start the inflammatory process if it goes into the damaged endothelium. There's been no treatment thus far for this, which is probably why the cardiologists aren't interested in it. Actually, I've had quite a bit of success using niacin, which is actually vitamin B3. But probably within two years, a biologic will be coming out that will deal with LP(a), which is really important because it's about 27% of the population. It's not small. With this biologic, we'll be able to decrease LP(a) by as much as 50% or more in a period of six weeks.



**Dr. Jill (pre-recording) 16:29**

Hey, everybody. I just stopped by to let you know that my new book, Unexpected: Finding Resilience through Functional Medicine, Science, and Faith, is now available for order wherever you purchase books. In this book, I share my own journey of overcoming a life-threatening illness and the tools, tips, tricks, hope, and resilience I found along the way. This book includes practical advice for things like cancer and Crohn's disease and other autoimmune conditions, infections like Lyme or Epstein-Barr, and mold- and biotoxin-related illnesses. What I really hope is that as you read this book, you find transformational wisdom for health and healing. If you want to get your own copy, stop by [ReadUnexpected.com](http://ReadUnexpected.com). There, you can also collect your free bonuses. So grab your copy today and begin your own transformational journey through functional medicine and finding resilience.

**Dr. Jill 17:27**

I was going to ask you about that because I feel clinically the same way. It's hard. I always say this is a little bit more difficult to change. So the niacin potentially. But do you find that's more genetic or is it more lifestyle-inflammatory that you see elevated?

**Dr. Howard Elkin 17:42**

LP(a), it's definitely genetic.

**Dr. Jill 17:43**

Okay, that's what I thought.

**Dr. Howard Elkin 17:45**

It is genetic. And again, you don't know you have it unless you do the test. And it's automatic in Boston and in Cleveland HeartLab. I think it's important to know because patients need to know the risk. And I tell them about it. Even if we can't get it down to optimal levels, I'm going to try to do everything else. In the best of all possible worlds, you want to lower everything, but you can't unless they respond well to niacin. And I would say over 50-60% of my patients do. But I really know niacin well, so I know how to dose it correctly and how to start people on it.

**Dr. Howard Elkin 18:25**



All right, so we've got the lipids. We've got the inflammatory profile. Then we have the metabolic profile, which is really important. So yes, they do a fasting blood sugar and they do a hemoglobin A1C, which gives you an idea of how well your blood sugar has been controlled in the previous three months. It's a marker on the red blood cells. And red blood cells live for 90 days. Other tests that I really think are important: Your fasting insulin level, which should be, I think, less than 8, certainly less than 10.

**Dr. Jill** 18:54

I'd say less than five.

**Dr. Howard Elkin** 18:58

That's right. The interesting thing about being a bodybuilder is that most strength athletes are very insulin-sensitive, so we tend to have really low levels of insulin. So we want to know what that is. And let me just digress for one second. We also do what's called a C-peptide. C-peptide tells me how hard your pancreas is working because you could have a normal A1C, an elevated insulin, and an elevated C-peptide. That's telling me that your pancreas is working really hard to not make you a full-fledged diabetic. But eventually, if the insulin level doesn't come down, the pancreas will poop out. It just can't keep on producing insulin for years on years. So everybody gets the insulin-inflammatory markers and the metabolic markers. Really, only about 5% of the country's population is metabolically healthy. We're not a healthy country, and I think it got worse in COVID.

**Dr. Howard Elkin** 19:58

The other one is genetic markers. And that's what I like. There are about five that I follow. One is KIF6. I like that because I spent some time at Berkeley HeartLab with Dr. Superko several years ago. KIF6 is associated with premature heart disease or coronary heart disease. MP21—they call it the heart attack gene. It's really common. And about 50% of them have at least one carrier. So it's rampant. Then there's 4q25. It's on the fourth chromosome. That lets you know that you could be predisposed to have atrial fibrillation, which is the most common arrhythmia that we see, especially in people over the age of 70. And then APOE. APOE is really important. If it's elevated, if you have one or more of the alleles, then that means you're at risk of coronary disease because that means these people tend to absorb more cholesterol from their diet.

**Dr. Howard Elkin** 21:14

It's also associated with Alzheimer's. I think it's good to know this because then I talk to people about brain health and what they can do to obviate problems down the line. And I'm in agreement with Dr. Bredesen and [inaudible]. I think we can put a damper on Alzheimer's disease. But it's an active process. It's like heart disease. It's not going to stop in its tracks unless we become proactive. So that's what you get from these tests. So you get the lipids, including LP(a). You get an inflammatory profile. You get a metabolic profile and you get a genetic profile. And then you've got a nice potpourri of information to discuss with the patients.

**Dr. Jill** 21:55

Yes. And then you can really look at: Where is the risk? Is it diet? Is it lifestyle? Is it genetics? Is it the oxidized cholesterol? And like I mentioned before, I always love saying this because we see, like celiac, a massively increased risk of heart disease. You would never associate those two things, but autoimmunity and inflammation are massive triggers in otherwise healthy women or people with maybe healthy weight or healthy body mass. That autoimmune component can be a huge trigger. And you might see that on some of these labs because MPO, plaque, or some of these would show up potentially.

**Dr. Howard Elkin** 22:26

Yes. And I have seen it. I tell people this: Inflammation of any cause that's persistent doesn't bode well for aging. So I don't care whether it's heart disease, cancer, autoimmunity, or Alzheimer's—all four have inflammation at their base. That's why in functional medicine we make a big deal about it and try to identify where it's coming from. We try our best. Traditional medicine: Symptoms, treatment.

**Dr. Jill** 22:59

And usually, pharmaceuticals or procedures—again, those are appropriate for the right case, but then there's more. There's so much more. Well, let's shift to men and women. There's a big difference, especially for women after menopause. Do you want to talk just briefly about men's and women's differences in heart disease and how they present or what you look at with a woman versus a man?

**Dr. Howard Elkin** 23:18

First of all, when you look at symptoms, they can be completely different. I have my

own little dictum in place: If it's a woman and it's anything above the belly button, it's the heart until proven otherwise, because it can masquerade as gallbladder pain. Women can have no chest pain at all. Very common are shortness of breath, fatigue, and dizziness. They don't usually have that pain that goes down the left arm—blah, blah, blah, crushing. You have to have a really high index of suspicion. So presentation is different because the symptoms tend to be different. Even the diagnostic criteria are different. I'm just sorting this out in the last couple of years.

**Dr. Howard Elkin** 24:00

The test that we look for, whether a person's had a myocardial infarction or a heart attack, is the troponin level. Yet troponin levels are lower in women than in men. Maybe it's higher. I forget which is which. They're different for the two genders. And that's really important because this is kind of a new finding. So now we have to know: What is the range for men and what is the range for women? You'll find out when you do the test. Even when you do the angiograms on these patients—women tend to have smaller hearts and they tend to have smaller arteries—you might not see anything major when you do an angiogram on these patients. I mean, you may, but you may not because they also have a higher what we call microvascular angina, which means the plaques in the tiny vessels that you can't see on an angiogram are very common in women. It's so totally different.

**Dr. Howard Elkin** 24:59

Now let's talk about the menopause. But one thing I want to just mention first is that I find this so... I can't believe it still exists, but about 52% of women in this country still think that their biggest issue is breast cancer or cancer in general. And just to refresh everybody's memory, there are about 250,000 women dying each year of heart disease and 80,000 of breast cancer. Through the kind of work that I try to do, women have to know that as many women die of heart disease as men. It just happens later in life, about 10 to 15 years later. And that's the estrogen connection.

**Dr. Jill** 25:41

Yes, excellent. So great. Thank you for that overview. So I want to go to medical advocacy because that's one of the things you stand for in your books. But before we do—

**Dr. Howard Elkin** 25:52

And you too!

**Dr. Jill** 25:53

Yes. We are. We're both medical advocates in a way. Diet—this is a big can of worms and I don't think there's one size fits all, but there are certainly principles. What principles do you find most helpful for your cardiology patients who are trying to improve their health?

**Dr. Howard Elkin** 26:09

First of all, I'm not going to say, "Don't eat eggs." That's so last century. I don't make a big deal about cholesterol because cholesterol in your food does not really equate to cholesterol in your blood. And I really differ with the American Heart Association on this. I give them credit where credit is due—they've been around since 1926—but when it comes to diet and risk factors, they're way behind the disease. I basically believe in the Mediterranean diet or a variation of [it]. I'm between Mediterranean and Paleo because—

**Dr. Jill** 26:45

I agree 100%. I just want to say it's right on. Even with my cancer and inflammation, I find this area is so powerful.

**Dr. Howard Elkin** 26:54

Yes, it really is. Patients are amazed—"Aren't you going to tell me about cholesterol and what I should avoid eating?" I say, "I'm going to try to avoid one thing, sugar, because eating sugar is like pouring gasoline over a fire." And that's what happens in arteries, right? And cancer, autoimmunity, and Alzheimer's—there's fire going on. We want to get rid of it. So that's where diet plays a big role. So I'm much into low starch, low-starchy carbs, and definitely very low sugar. It should be a treat. So it's Mediterranean, low carbs. Those are my basic principles. Because, again, if it doesn't run in the wild or grow in trees or bushes, it probably has no place on your plate. So I tell people: "If it's a box, bag, or can, forget it."

**Dr. Jill** 27:54

Oh, I love that because, really, processed foods contain more additives, sugar, chemicals, and glyphosate. And like you said, sugar [causes] inflammation. Before

we go into advocacy, one more thing I think is important is hormones. We're both in the realm; we have been at A4M. That's where we met first. And lots of anti-aging principles and hormones. I do believe—obviously, you mentioned this—that the major risk factor for women after menopause is their loss of estrogen. I have as listeners probably 50–80% women and the rest men. But let's talk a little bit about women and hormones. What are your thoughts on heart disease and estrogen replacement?

**Dr. Howard Elkin** 28:29

Okay. Now, I'm biased. I admit it because I'm anti-aging. I do believe that whether you're a man or female, you look better, feel better, and think more clearly when on hormone replacement therapy. Does that mean I encourage every patient? No. It's an individual choice. But with women, it's very important. Women live on average [for about] 30 years post-menopause. They have a nice, long lifespan. So estrogen is very important.

**Dr. Howard Elkin** 28:59

First of all, I give hormones not just for symptoms. In the old days, you got it for hot flashes, insomnia, night sweats, and brain fog. And that's still an indication. That is usually what a lot of women have as they go through menopause. I look at the health benefits. Can it improve the longevity and quality of your life? Heart, no doubt about it because estrogen is very helpful in preserving the endothelium, and you lose that when you go into menopause. No more estrogen and the endothelium starts to have problems, and that's when you start seeing coronary disease. They could have cholesterol elevation their whole life, and I don't care about it until they hit menopause and if they're not being protected with estrogen. So the estrogen factor is important as far as the heart.

**Dr. Howard Elkin** 29:47

Bone health—no question about it. Also, brain health. Most gynecologists are not functional medicine [doctors] or really proactive. I treat a lot of women with bioidentical hormones, being that I'm anti-aging as well as cardiac. And they tell me that their OB-GYN says, "Well, you better get on and off as fast as possible, because it's really dangerous." Then they ask me, "How long should I be on it?" "Probably the rest of your life. Why would you want to stop?" But they're encouraged by their

gynecologists to stop it as soon as possible. And we're still quoting the Women's Health Initiative from 2001, I believe it was.

**Dr. Howard Elkin** 30:31

Well, first of all, the average age in that group was 61, which is pretty late in the game. We're not even looking at premenopausal or perimenopausal. We're looking at 61. The average age for menopause in this country is about that. So there were probably a lot of patients with heart disease who went undetected. So that was one thing. They also used oral estrogen, which we don't recommend because it goes straight to the liver and you can develop an inflammatory metabolite, which we don't want. We don't want inflammation. And also, come on, they use Premarin and Prempro.

**Dr. Jill** 31:09

I know, right? Not natural, not bioidentical.

**Dr. Howard Elkin** 31:15

Well, for example, if you look at mares, horses, they have 27 different estrogens. Women have three. We're not comparing apples to apples here. It's very good at controlling symptoms, but the long-term side effects... And I do believe the Women's Health Initiative did prove that. There are more heart attacks and more strokes. So all of that was true. It's just that they didn't give women any alternatives.

**Dr. Howard Elkin** 31:41

And this is how I got into it, I swear to God: After the Women's Health Initiative, gynecologists all over this country were abruptly stopping hormones. They didn't want to get sued. So all of a sudden, I had teachers and nurses come and say: "You've got to help us out here, because the gynecologists in this town know nothing." And I said, "Okay, I'm up for the challenge." And that's really how I got started, because I provided a need that wasn't being handled by the traditional doctors. Because I know how to follow hormones, I've never had anyone develop cancer while they were on bioidentical HRT. I'm sure it's happened, but I've never seen one. And I've been doing hormones since 2000, so 23 years.

**Dr. Jill** 32:26

I've said this before, but as a breast cancer survivor, I couldn't agree more with you—2001 was the year I got cancer at a very young age. And I am obviously

studying this for my own health. I really, really believe that the benefits far outweigh the risk. I wouldn't say within the first five years. You need to be a little tiny ways out from cancer to be safe in that sense. And obviously, we're not giving medical advice here; you need to talk to your doctor. But if you're not getting good information, find a functional or integrative-trained doctor, because there are ways to test. You and I, I'm sure, test metabolites. So we know where these are going. And like you said, the brain, the heart, the bones—there's so many organs that absolutely need...

**Dr. Jill** 33:06

Then the other thing I want to emphasize [is that] you mentioned oral versus transdermal. It's a really big difference in clot risk. The oral metabolites do potentially increase clot risk. So I rarely, if ever, use oral estrogens. Progesterone is different. Oral progesterone is safe—bioidentical. But transdermal—creams or patches—have a very different risk profile for women for clots, heart attacks, or stroke. So I love that you said that.

**Dr. Howard Elkin** 33:29

And it's really individualizing your treatment. Like I said, I don't recommend it to everyone, but—

**Dr. Jill** 33:38

Absolutely. It's a discussion because if someone is terrified, I never add to that fear. I give them the information and then let them choose what they feel best with because they know their own bodies better than me. And they get to choose. And I will just support [them] and give them all the information they need to make the best decision.

**Dr. Howard Elkin** 33:56

I'm totally with you. I'm in the same school. When I started in 2000, before the Women's Health Initiative, I would find one sheets on biomedical hormones, which no one even knew about back then. I learned it from A4M and then I'd give it to the patients. Then, when Suzanne Somers came out with her book, *The Sexy Years*, I said: "You know what? Just read her book," because it's written from a late-person standpoint. And that really did help during the bandwagon as far as bioidentical hormones.



**Dr. Howard Elkin 34:29**

So yes, I am pro-hormone for the right patient. And I think discussion is really important. I tell them: "I want you to think about this. Let's meet each other in three or four weeks. Do your reading." And women are great about it. Women research things all the time. Because I have a population of patients who are bright and really concerned about their health, they do the research, and they come back. Like I said, I never had any problems. I'll have to adjust things. With men, it's one size fits all, but not with women.

**Dr. Jill 35:03**

Women are complicated, but we're more rewarding in a way. So let's shift in our last little bit here to medical advocacy and your book, which is *From Both Sides of the Table*. And we'll talk about where to get that later. But tell us a little bit about: How did you become a medical advocate? What does that mean? And why is it important for our listeners?

**Dr. Howard Elkin 35:22**

Well, one of the reasons I relate to you is because you have your own back story. If you're a medical provider, like we are, and you go through the hell that we went through, it changes you as a person. I was hospitalized twice in a span of 19 months. The first time, I had a very small heart attack. I have no risk factors. I'm not hypertensive. I always worked out. I've never been overweight. I've never smoked. Even when I went to Cedars, they said, "You don't look like the profile." But it doesn't matter because it can happen to anybody. So I had a stent and then, [inaudible] the cardiologist who did my procedure that discharged me said: "Well, Doctor, I don't know what to tell you. You are so buffed," and so forth, "you can create your own cardiac rehab program." I said, "Okay, I can do that."

**Dr. Howard Elkin 36:22**

Now, this guy was about 20 years younger than me and was about 60 pounds overweight, and it wasn't muscle weight. He said: "But you know what? Everything is going to be great because you have the stent in. You're going to do great." And he left. This is when I knew I was going to write a book. I said: "Okay, he said that everything's fine now because I have the stent. First of all, if I'm so healthy, why did this happen to begin with?—number one. Number two, what can I do to prevent it from happening again?" And those are the unanswered questions. Then my daughter came up a few minutes later with the writing tab. "Dad, it's time to write

your book." So that's how it happened. So, I did very well. I had a very small heart attack.

**Dr. Howard Elkin 37:03**

But then, 19 months later, I ended up in the hospital again, Cedars-Sinai. I needed emergency back surgery. I had this condition called spinal stenosis that I knew from 1996. At that time, I was doing triathlons. I wasn't a bodybuilder yet, but I knew about it. So I'd have a relapse every, let's say, two years or so. But this time it was so bad that I went through rehab and chiropractic. Nothing worked. I got worse. I woke up one night and was reading a book and I'm numb from the knees on down. I stood up and I just collapsed. I couldn't walk. I crawled until my best friend, Barry, came to pick me up and bring me to the hospital the next day. I ended up needing surgery.

But here's the thing about it that I'm sure you can relate to: I just didn't have surgery; I had a botched-up surgery and I have permanent nerve damage as a result of that surgery. Not only was it botched up and I had permanent nerve damage that I'm still dealing with today, 15 years later, but it was incomplete. So he didn't complete the job. So over a period of years, I've been bending over more and more with the waist because stenosis likes flexion; it does not like extension. And it got to be the point in which it was hard to walk mechanically—not because I was short of breath or anything, just mechanically. So I had a second back surgery this past January.

**Dr. Howard Elkin 38:28**

But when you have permanent nerve damage, it changes you, especially if you're an athlete. There are certain things I cannot do anymore, and it's not because of my age. It's because I have limitations. Those two hospitalizations really inspired me to write a book because I had to become a medical advocate. When he said, "You're going to be fine because you have a new stent," I said, "This BS is absurd."

**Dr. Howard Elkin 38:54**

Here's the other one I wanted you to hear about: When I was hospitalized at Cedars for back surgery, on the second day the discharge planner said: "Well, doctor, we tried everything we could to get you into rehab, but your insurance wants you to go to a nursing home." I said: "A nursing home? Are you freaking kidding me?" She said,

"We tried everything we could." So here I am in bed, bedridden with opiates, in pain. And I spent two hours on the phone with ETNA Insurance—determined. That's really what being your own medical advocate is, taking charge of, because the hospital was not going to go out of its way. And the next day, I was wheeled over to the rehab unit.

**Dr. Howard Elkin 39:40**

And people say: "Okay, well, you're a doctor. Of course, you figured it out." It's not true. Not necessarily true at all. In fact, that's why one of the chapters in my book is entitled "Heroes", because I interviewed about seven or eight people, both men and women, who had no medical background, yet they became their own medical advocates and made some important decisions that affected their lives in a positive way.

**Dr. Howard Elkin 40:02**

I want people to know you don't have to be a doctor or a nurse; you just have to have the desire. It's work. And I'm still doing it. I'm still doing it today. So that's how I got into it. I was inspired to write the book. And although the book starts off with my story, most of the book is really about how you can become your own medical advocate. So we talk about nutrition and supplementation, exercise stress management, and how to not age ungracefully ever after.

**Dr. Jill 40:33**

What a great message. And I could not agree more. I know we have this in common, because the truth is, whether it's the insurance denial, which happens as a matter of fact... I just think maybe older people who don't have advocates... Anyone can be an advocate, but it's so common for those denials or standards to be like, "Oh, you can't do this" or "You can't do this." Even for me, I'll look back with my own chemo. I literally requested a completely different drug and a completely different protocol. I did a completely different type of radiation.

**Dr. Jill 41:03**

I basically created my own plan that fit for me. And thank goodness I had doctors that went along with it, but it was completely not the standard. I said, "I want to do this and not this. I want to have my chemo in two days instead of one day. I want to do this to mitigate side effects." And "I'm going to take some antioxidants during

chemotherapy, even though it's not recommended." And again, talk to your doctor. I'm not advocating that without your doctor's permission. But I did a lot of things that weren't advocated, because I knew that it mattered to my own personal journey and health.

**Dr. Jill** 41:27

And I agree with you; I love empowering patients. Even when you and I sit with them, part of it is—whether it's bioidentical hormones or whether it's diet or lifestyle—I give them as much information as I can. And then they still get to make the decision. But I'm there helping them and saying: "Do you have questions? Is there any way I can help?"—because the truth is, we all know our bodies best. And even if I believe this supplement or this intervention is going to be best for the patient, if they don't believe it or they're afraid of it, it's not going to do them any good, right?

**Dr. Howard Elkin** 41:55

And that's why I related to you so much in your writings, your postings, and so forth, because you're about patient advocacy. Not many people are. You know, they pontificate about what they know. And I get into some of these arguments with... Not arguments, but I disagree with people on social media, because it's really not backed by science, some of the things they're saying. And I will interrupt and say: "You know what? I understand what you're saying, but your readers need to know this." I mean, if it's really against my grain, I will intervene.

**Dr. Howard Elkin** 42:24

But you're absolutely right. I did the same. When I had my back surgery recovering in rehab, I had a friend of mine bring my supplements that they had: CoQ10, fish oil, and vitamin D. They'd make their rounds—the doctors, the interns, the residents, the fellows, and the attendings. They said, "What's this?" I had everything in a shoebox. And they looked at me like I was from Mars. And I said, "Do you guys not know about this stuff?" Some of the people are like 20 years younger than me. "Oh, no, no, all we do here is rehab and pain medicine."

**Dr. Jill** 42:59

Unbelievable. Yes, exactly. Like you said, Coq10—you can't imagine someone doesn't know the science on Coq10, but the truth is, a lot of doctors still don't. Well, I love

the pathway you've taken. You've given us some really, really valuable information about the heart, about aging, about bioidentical hormones, and especially about patient advocacy. So obviously, here's your book. Where can people find you and get a copy of *From Both Sides of the Table*?

**Dr. Howard Elkin** 43:24

Actually, I have two websites. One is HeartWise.com. For the book, I have my own website for that; it's called BeYourOwnMedicalAdvocate.com. So although it's my story, *From Both Sides of the Table*, it's really about patient advocacy. So BeYourOwnMedicalAdvocate.com. Specifically about the book, there's a praise page of people who read the book before it was published. And also, it goes straight to my Amazon page, where you can buy it. I think it's like \$9.95 for the...

**Dr. Jill** 43:59

Electronic or...

**Dr. Howard Elkin** 44:01

Thank you. That's all I need—more screen time so that [inaudible]. For the book, I like turning pages. I'm old-school.

**Dr. Jill** 44:07

Me too. Me too. I have a copy there. Again, thank you for your time today. Thank you for your information. Thank you for the great work you're doing. If you're listening out there, wherever this podcast is being shown, heard, or watched, you'll see the links to the websites Dr. Elkin mentioned. And thank you again, Dr. Elkin, for your work in the world.

**Dr. Howard Elkin** 44:25

It's a joy to be here with you. Thank you.