# The use of complementary medicine and therapies in women’s health – Webinar transcript

**Dr Elizabeth Farrell (00:00:07):**

Good evening everyone, and welcome to our lovely session tonight, looking at the use of complementary medicines and therapies in women's health. My name is Liz Farrell. I'm the Medical Director of Jean Hailes, and I will be the host for the evening, and we'll also conduct the question and answer session. Jean Hailes, earlier this year, conducted a survey of health professionals who are supporters of Jean Hailes, looking about their learning needs. And we received a response of over 1000 GPs, nurses and other disciplines. Natural therapies in women's health was one of the top five topics for skill development, and so tonight's webinar is a response to this. We can't of course provide natural therapies 101 tonight, with all available treatments for women's health conditions, but what we intend to cover are different approaches, the importance of communication, and some case study discussions.

**Dr Elizabeth Farrell (00:01:30):**

Jean Hailes is aware that complementary medicine and therapies is sometimes considered controversial amongst health professionals, but we know at Jean Hailes that women are interested in complementary options for managing their health. So we consider it an important area of discussion. What we do know is that women are the biggest users of complementary therapies in medicines, and we feel that our role is to assist women in their decision making by providing information without a commercial bias. We provide health information on a range of treatments and management options for women's health conditions, and this includes conventional medicine, allied health professions such as physiotherapy, psychology, as well as complementary medicines and therapies. We talk about the level of evidence in a consumer-friendly way, and we also highlight where more research is required for some therapies.

**Dr Elizabeth Farrell (00:02:36):**

It's now my pleasure to introduce our panellists for tonight, and we have first of all from Jean Hailes, Sandra Villella. Sandra Villella has been with us for many years. She is a herbalist and naturopath, and has worked in women's health for many, many years. In fact, Sandra is the one person in our team who always knows both the complementary medicines and therapies literature, as well as conventional literature. She's interested in women's health across the lifespan, particularly in management of the menopause. She's keen to bridge the gap between natural therapies and conventional medicines to achieve true complementary health. In other words, a more holistic approach.

**Dr Elizabeth Farrell (00:03:31):**

Also tonight we have joining us from Sydney, Dr Susan Arentz. Susan is a clinical naturopath with over 25 years of experience. She's also an adjunct research fellow at Western Sydney University, the editor of the Australian Journal of Herbal and Naturopathic Medicine, and a board member of the Australian Integrative Medicine Association, and a member of the editorial board of several other scientific journals.

**Dr Elizabeth Farrell (00:04:05):**

I will now hand over to Sandra who will commence the evening's presentations. Thank you. Sandra, if you could please switch your camera and your—

**Sandra Villella (00:04:19):**

Thank you Liz. Thank you for that introduction, and welcome everyone. It's really nice tonight to be here, and be amongst another naturopath presenting. So thank you, Susan, for joining me today. I'm just going to start our presentation. Okay. Alright. Okay. So what we do know, we're going to be talking about complementary medicines in women's health. Now the preferred term that we use these days, there have been a lot of different terms, natural therapies, complementary medicines, alternative therapies, but the preferred term now is 'complementary medicine and therapies', and we'll abbreviate that with 'CM&T'. And we do know there's a high prevalence of complementary medicine use.

**Sandra Villella (00:05:07):**

What we're predominantly going to be talking about is a complementary, looking at these complementary medicines and therapies in a collaborative healthcare model. And we're going to look at it with a patient-centred approach. Most importantly, it's going to be presented with the evidence in mind, but also the experience and expertise, I think there's about 50 years' experience between, over 50 years' experience between us, between Susan and I, using us, the practitioners who actually use these complementary medicines and use these therapies as they're intended to be used.

**Sandra Villella (00:05:43):**

We'll also look at case studies to exemplify how these patient-centred care of these conditions in this collaborative healthcare model will be looked at. There are lots of reasons we know why women want to choose to use these therapies, and often it is for the choice of wanting to have something more natural, having a choice over, control over their body, prevention of chronic diseases. It is also important where perhaps medical treatment is contraindicated, and my best example is where I see perimenopausal women after oestrogen receptor-positive breast cancer, and they will often seek help. Many women just want to seek a gap, filling the gap between these complementary medicines.

**Sandra Villella (00:06:27):**

And I think the other reason that women will particularly seek a therapist is they know that the naturopaths are qualified to inform the safe and effective use of complementary medicines and therapies. We understand the evidence of efficacy and safety, and that's the point of difference to seeing someone perhaps in the pharmacy, or perhaps reading in the local, the excerpt of the Sunday paper talking about natural therapies. We're often talking about the differences between, of these therapies and conventional medicine, but I wanted to show that the similarities also exist. Our principles of naturopathy start with 'first do no harm', and that's similar to the, in conventional medicine, the Hippocratic Oath that medical practitioners will abide by. We talk about the healing power of nature, and these days is 'ecopsychology', is part of our public health message. I can look at a billboard at the train station and it'll say 'get out into green space, it's good for your mental health'. So there's this recognition, and this crossing over, side by side.

**Sandra Villella (00:07:31):**

Treat the cause, certainly is not just unique to our medicine. Holistic healthcare is certainly part of the way that a lot of medical practitioners will practise, and treating the whole person as well. Disease prevention and health is similar to some of the messages that we also see in public health. And the wellness model, where we are looking at wellness as being more than just the absence of disease, is perhaps the point of distinction. As we talked about, there is a really big use of these therapies in women, and this lovely study in Australia, longitudinal study, looking at over 13,000 women, will show us that women are more likely to seek help from a natural therapist if they have heavy periods, if they have irregular periods, and this is, and also if they're suffering with PMS.

**Sandra Villella (00:08:27):**

And Susan will talk a little bit more about women seeking help for PCOS, and Susan is actually one of the leading researchers in the world on PCOS in this natural therapies arena. So we're very lucky to have her join us today. But what this is showing is that if women are having these conditions that are typically like PMS and heavy menstrual bleeding, they are more likely to seek help from either a naturopath, or it might be a massage therapist, acupuncturist. The therapies vary across the board. What I want to take home from this slide is that this is a study, an Australian study that looked at over 10,000 women at menopause. And we can see that at least, it's over 75% of these women used at least one self-prescribed complementary medicine and therapies. A very small percentage of these women actually consulted a therapist in this area. And just over 13,000 women used these medicines for the treatment of hot flushes, for the vasomotor symptoms.

**Sandra Villella (00:09:33):**

But interestingly, the choices that they used, phytoestrogens, evening primrose oil and ginseng, are arguably not appropriate choices. While phytoestrogens in the diet can be useful, we know that the way that they behave in nature is quite, they have a nice affinity for the receptors, they behave themselves in a way that is quite balancing if you like, but they don't necessarily behave like that in a tablet formulation. Nor are they going to be effective for many women, because only about a third of the percentage, a third of the population actually have the bacteria in their gut that can convert the phytoestrogens in, say, soy to a more potent form. So only about a third of women will actually get benefit.

**Sandra Villella (00:10:19):**

Evening primrose oil was thrown around as the go-to of all conditions for women's health, but in fact for the management of hot flushes, it's been shown to be no better than a dummy pill, than a placebo. And ginseng, while it might have some indication, panax ginseng, for menopause or low libido, it's not the first choice that many of us would use as practitioners for the management of vasomotor symptoms. So what it's highlighting is that these women who are self-prescribing aren't actually making the right choices. And we also know that while, in our 2015 health survey, that over 70% of women didn't know very much about the efficacy and safety of natural therapies. And so we're going to touch on that tonight.

**Sandra Villella (00:11:03):**

This particular report that was done by the National Health and Medical Research Council reported on the conditions that many of the naturopaths in Australia are looking at. So you can see ranging from digestive symptoms, mental health issues, fatigue, irritable bowel, and 61% of these respondents were actually seeking natural therapies for menstrual disorders. In terms of safety with these complementary medicines and therapies, we need to separate product from practices. So, it's also, it's the practice of these particular therapies by the professionals, as well as the products that you can actually get in terms of the herbs, the nutrients.

**Sandra Villella (00:11:45):**

In the context of their use, ideally if they're professionally prescribed rather than self-prescribed, and practised within the scope of the professional practice, then they're generally considered safer than pharmaceuticals. There's relatively few adverse events, given the widespread use and availability, but probably these are also under-reported. There are predictable reactions. So for example, the ones that we typically look at with St John's wort, we know the pharmacological effects and how it can impact on that cytochrome P450, the liver enzymes, and therefore have an interaction with other medications. But there are reactions that are not predicted by pharmacology, such as the well-known idiosyncratic, or very rare condition, that can occur with black cohosh, that can cause rare liver damage. Now while we have to have a warning on the labels of black cohosh, this condition is very rare. And in fact in the reports that have been done with the European Medicines Council and the TGA, out the 69 cases that were looked at, one is probably associated with the use of black cohosh.

**Sandra Villella (00:12:51):**

GPs are often very concerned about the use of natural therapies, and more so their concern is not because of adverse events, but because of the possible delayed or misdiagnosis and treatment that comes with a patient seeking these therapies and medicines. There's also the subsequent fear that perhaps by using these medicines, the medical therapy, and it might be ceased, and the subsequent loss of benefit of that therapy. So what we're really trying to look at is fostering a collaborative relationship to work to ameliorate this situation. Susan and I both are lucky to be able to do that. We work within this collaborative health care, and we're really trying to encourage that as well.

**Sandra Villella (00:13:35):**

We are aware that it is an unregulated profession and that anyone can go out and start practising. Because of this, we do encourage you to seek out what the qualifications are of the particular practitioner, and being aware that most of the professional associations that these complementary medicine and therapists belong to impose qualifications and standards, and there is medical sciences and health sciences that are studied as part of the undergraduate.

**Sandra Villella (00:14:06):**

So this is a nice one to finish with as part of the introduction, the safety of ingestible complementary medicines and therapies, including herbal medicine and nutritional supplements, is within scope of naturopathic practice, and a large part of naturopathic degree programs. Building interprofessional communication networks, including qualified naturopaths, supports safe decision making of women, clients, patients who choose to use complementary medicine and therapies. So I'm going to hand over now to Susan, to talk a little bit about evidence.

**Dr Susan Arentz (00:14:43):**

Thank you, Sandra. Thank you for the kind introduction, and it is such a pleasure to be presenting on behalf of Jean Hailes. Let me just find my presentation. Always been such a fan of Jean Hailes, rely on them a lot in clinic to refer people, patients, to a transparent source of information, and I feel very privileged to be presenting here tonight. So thank you very much for the invitation. So first of all, I just wanted to touch on, I'm going to firstly talk a little bit about evidence in complementary medicine and therapies, and then we're going to go into talking about a case, and Sandra's going to come back in and follow on with another case. So evidence-based medicine, other than complementary medicine, is something that kind of developed in the late 20th century, around 1996 in England. It was in response to research being more applicable in a clinical setting and not so focused on mechanisms and in labs, essentially.

**Dr Susan Arentz (00:16:00):**

So it drove a movement towards providing research and clinical care that was based on research, but that also incorporated clinical experience and also the patient's values and preferences. So it is a model that has three pillars to it. As it has developed in the past 20 to 25 years, a significant change has been the refocus towards people at the centre, and in research this is highlighted in the evaluation of interventions on person-centred outcomes. And so there has been this establishment of the core initiative to enable transparent consensus development of person-centred outcomes for specific conditions. So for example, in polycystic ovary syndrome, consensus of experts and consumers, so that's women with PCOS. The core outcome set that's most important included three generic outcomes of the BMI, the quality of life, and treatment satisfaction, and 30 specific outcomes which were categorised into six specialist domains, some of which are listed here.

**Dr Susan Arentz (00:17:19):**

So what that actually means is that as a researcher, it's important to be investigating the effects and safety of interventions for the improvement of these outcomes that matter most to women who have the condition. Now I know that you all know about the evidence hierarchy. This one's actually from Wikipedia, and clinical practice guidelines are at the top here, but there are many that list systematic reviews and randomised control trials at the top. So these two. In evidence hierarchy, evidence is ranked according to its relative reliability based on the type of research methodology. So that's why systematic reviews of randomised control trials are at the top. But the problem with this approach is that it rates evidence on methodology only, and doesn't incorporate the results of the research. So whilst decision-making is very straightforward when using an evidence hierarchy, and the evidence is sufficient, such as when there is a systematic view that includes a large number of high quality randomised control trials, or a very large rigorous randomised control trial, decision-making is actually more ambiguous when the evidence is insufficient.

**Dr Susan Arentz (00:18:43):**

So there are plenty of cases where rigorous systematic review of randomised control trials finds low certainty or low-quality evidence. And another problem is the research methodology that's being used may not be the most appropriate to answer the research question. A key limitation to relying on the evidence hierarchy is that often clinical trials and evidence reviews may be unable to answer a critical clinical care question. So in particular, there is often insufficient evidence of the efficacy for interventions on improving patient-centred outcomes. For this reason, a couple of years ago, the NHMRC adopted the GRADE approach, and recommendations in clinical practice guidelines are no longer constrained by the quality or the certainty of the evidence base according to the hierarchy of evidence. In GRADE, when there is insufficient evidence, there are specific rules used to make recommendations in clinical practice guidelines, and these rules are often referred to as 'modifying factors'. So they modify, some factors modify the strength of a recommendation that is independent to the quality or the certainty of the evidence base.

**Dr Susan Arentz (00:20:05):**

So specifically, GRADE lists pragmatic situations in which a strong recommendation may be warranted despite low or very low confidence in the estimated effects. So here are five situations. So when you have low quality evidence that suggests a benefit in a life-threatening situation, the evidence can be graded higher or lower, or stronger or weaker, depending. Or when you have low-quality evidence that suggests a benefit and high-quality evidence that suggests the harm or a very high cost. Or when there's low-quality evidence that suggests equivalence of two alternatives, but high-quality evidence of less harm for one of the competing alternatives. Or when high-quality evidence suggests equivalence of two alternatives and low-quality evidence suggests harm in one alternative. Or when high-quality evidence suggests modest benefits and low to very low-quality evidence suggests a possibility of catastrophic harm. So it's these situations when a strong recommendation is made despite the presence of low-quality evidence, and it's not limited to complementary medicine at all.

**Dr Susan Arentz (00:21:22):**

For example, a strong recommendation to use folic acid to prevent spina bifida, based on the low risk of folic acid and the relative large impact of spina bifida. And then a weak recommendation for adjuvant chemotherapy in early stage breast cancer is based on the small possible benefit of survival compared to the serious side effects of chemotherapy. So you can see that in evidence-based medicine, when in clinical practice guidelines, evidence-based clinical practice guidelines, the recommendations are not only informed by the strength or the volume of the evidence base, they're also applied to the contextual circumstances of which the evidence is relevant.

**Dr Susan Arentz (00:22:10):**

So in the clinical practice guideline for polycystic ovary syndrome, there is a strong recommendation for lifestyle interventions as first line treatment, because it improves multiple outcomes valued by women with PCOS. However, the evidence for lifestyle intervention is limited by the adherence in clinical trials. So the evidence base isn't strong, or isn't certain, but the recommendation in the clinical practice guideline is strong despite that. So just to repeat that, the evidence base for lifestyle intervention is low quality and certainty, because many RCTs investigating different diets and exercises, women drop out before the end of the trial period. So it reflects a contextual situation [inaudible] encounter. The efficacy of lifestyle intervention relies a lot more on just knowing they work on important outcomes. It relies on women's internal and external resources, on their capacity and individual circumstances, not only for PCOS but in their social networks and in their environments.

**Dr Susan Arentz (00:23:36):**

And this showed up in a survey of women with PCOS in the community, where many cited using lifestyle interventions of dietary changes and exercises, but few felt that they'd actually achieved what they wanted with them. Interestingly, many were also using complementary medicine and therapies in this study. So what does naturopathic consultations for women with PCOS look like? So naturopaths can provide specialist knowledge about safe ingestible complementary medicines. They have knowledge about lifestyle interventions that extend beyond exercise, so for example, hydrotherapy and forest bathing as Sandra was just referring to previously, and mindfulness. They can provide collaborative care that may be led by the doctor. They can provide active support to acquire self-help skills and consolidate independence for future health maintenance, address individual needs in the context of an individual's resources and capacity. And they can help to facilitate personal agency and control through education and continuity of care. And they also have malpractice insurance.

**Dr Susan Arentz (00:25:00):**

So naturopathy is provided within a conventional medical care model, can be. In PCOS and in pregnancy, higher visits to complementary medicine practitioners correlated with increased use of conventional health providers, including more visits with GPs and specialists. So that particular research project found that instead of the impression that women will go and see a complementary therapist and not see their doctor, was actually contradicted by them actually spending more visits with their GP when they did see their complementary therapist. So respectful conversations with medical providers about patients' use of complementary medicine and therapies correlates with better medical care experiences. But there is still a high proportion of complementary medicine users that self-prescribed nutritional supplements and herbs, and as Sandra mentioned, this is an issue.

**Dr Susan Arentz (00:26:11):**

So the entire profession, however, should not be tarred with the same brush. So for example, a miracle weight loss product should not be lumped in with a standardised St John's wort formulation that has demonstrated efficacy for depression.

**Dr Susan Arentz (00:26:29):**

So now I'm going to present the first case study for the evening. It's a case study about a mother and daughter who came to see me about 18 months ago. It's an adolescent girl, she presented with her mum. Recently diagnosed with polycystic ovary syndrome by her GP. Her main concerns were acne on her back and chest, and her irregular periods. She also felt embarrassed about the acne, and they as a couple, the mother and daughter, they had a misunderstanding of what ovarian cysts were. The mother, I can distinctly remember the mum asking me to provide some detoxifying treatment to get rid of all of the debris that must be coming out from the cysts as they ruptured. And her current exercise behaviours or patterns met the lifestyle recommendations in the clinical practice guideline, which is 150 minutes a week with 90 minutes of vigorous exercise included.

**Dr Susan Arentz (00:27:39):**

Now this is just a sort of diagram of how naturopaths actually look at presenting cases in the clinic. So they have a complex model, rather than, a complex systems-based holistic model rather than a linear model. So they're not just thinking about individual biochemical pathways that you can intervene in and change the course of a disease. They're actually thinking about the person as a whole being, so right from a cellular level up to an organ level, to a systems level, and then to an external level as well. And up to the person being in a particular environment, including their social setting. And then drawing upon all of those as a resource and considering how they're actually interacting and influencing the person's state of health. So the consultation is typically much longer with the naturopath than it would be for a medical provider. I think the average length of time is about one and a half hours for the first consultation, and then 45 to 60 minutes for the follow-up consultation. In the first meeting there is, and in this case, there's a discussion about polycystic ovary syndrome, its prevalence, common experiences, the differences between adolescents' PCOS versus adults'.

**Dr Susan Arentz (00:29:15):**

And then I emphasise the genetic aspects, so the behavioural aspects. Because sometimes when the behaviour's focused on its own, it can lead to a emotional state that isn't conducive for engagement and adherence to healthy lifestyle patterns, so that people can start to feel guilty and start to blame themselves and things. So if you focus on the genetic aspects, then it avoids the behavioural, personal, judgmental kinds of conversations, which can easily come about when you're talking with people about their lifestyle behaviours, especially when they're so personal, involves personal choices and things.

**Dr Susan Arentz (00:30:06):**

So in the first consultation, a detailed case history is taken in naturopathic consultation, and also a clinical history, menstrual history and family history. Narrative communication style is usually used, so you try to engage the two people in the consultation in a kind of conversation, to tell their story about how it came about. And then you talk about how individual issues are affecting them, including how their emotions are expressed and how they manage their emotions. And what sort of social support they've got, and their positive influences, what they perceive as positive influences in their life, their resources. So further information about this individual case was that this young woman was eating a vegetarian diet and she walked her dog regularly. She slept well, eight to nine hours per day, regular bowel motions, her immunity, she was getting two to three sore throats a year. She had a history of glandular fever, no allergies, but the mother had many. She had occasional recreational drug use. Very, very creatively expressive, this young girl was, young woman.

**Dr Susan Arentz (00:31:36):**

Her physical characteristics. So BP was 110/65. BMI, she was slightly overweight. And her hip-to-waist ratio, she had a kind of like a budding kind of apple shape. Her acne on her back was in the, more than half of the affected area was involved, and on the chest, it was easily recognisable, less than half was involved, and the same with the face. Her menstrual cycle, she was using an app, a phone app called Flow. Her previous 12 month average cycle length was 39 days. So she had a long cycle. Shortest was 33, longest was 49, period was for three to five days, and she had some dysmenorrhoea, which she managed through ibuprofen and a wheat pack. She had self-reported insulin resistance, which the doctor had identified, and she'd had a pelvic ultrasound showing that she had polycystic ovaries. Her androgens were elevated as well, so her testosterone. Sex hormone binding globulin was low, which is very typical.

**Dr Susan Arentz (00:33:02):**

So the naturopathic management, there were direct and indirect strategies for treating the presenting complaints. So for acne, there were, the mechanisms, the therapeutic mechanisms, included lowering androgens, normalising blood glucose, and general support of healthy skin. And to regulate the menstrual cycle, to normalise the LH:FSH ratio, shorten the pre-ovulation phase so that her menstrual cycle would overall lessen, and then to manage stress. So in this case, I'm going to go through some of the treatments that a naturopath would use for a case similar to this. And the highlighted remedies are what I did actually use in this case. So one of the first strategies is to increase liver metabolism of androgens. And so, herbal medicines that induce liver detoxification pathways include turmeric and globe artichoke, rosemary, and Schisandra, which is the herbal medicine that I used in this case, but also St Mary's thistle and dandelion root.

**Dr Susan Arentz (00:34:18):**

Then the next strategy is to increase sex hormone binding globulin, to bind with the androgens and lower the free androgen index. So those herbal medicines include paeony, Berberis and nettle, or Urtica. Nutritional supplements, inositol. So I know some people have asked about this in the questions, so I'm happy to talk about that. And then dietary phytoestrogens, which I've learned something from Sandra in the introduction, too, about those today. And the other, third strategy for lowering androgens is to support aromatisation of androgens to oestradiol in the ovaries, so ovarian aromatisation. So those herbal medicines are paeony and liquorice, or Glycyrrhiza, and dietary additions, grapes and berries. And the references are down here for these.

**Dr Susan Arentz (00:35:17):**

So another direct strategy for reducing acne is to normalise blood glucose. So exercise is a big one, and in this case we definitely used it, recommended more exercise, which I'll talk about in a sec. Herbal medicine, cinnamon, Trigonella and dong quai. Inositol, and a low-glycaemic index diet, which is an interesting challenge for some people who are eating a vegetarian diet. But also, in this case, I recommended to avoid dairy because it contains insulin-like growth factor. And some research has shown that it can increase acne in teenagers.

**Dr Susan Arentz (00:36:04):**

So indirect therapies. So from that more complex model that I was talking about earlier, regulate sleep to help regulate insulin or blood glucose or glycaemic control. Support elimination of waste products, so regulate bowel function and use saunas to induce a good sweat, from that point of view. And then dietary additions to include cruciferous vegetables, which are the ones from the broccoli family, leafy salads which contain a bit of flavour and can help induce the production and synthesis of bile into the digestive tract. Dandelion coffee, turmeric, spearmint tea, some of which have evidenced, randomised control trials and have been featured in systematic reviews, showing that they can lower androgens in PCOS, women with PCOS. And then insoluble fibre to regulate bowels and prevent reabsorption of oestrogen metabolites. And a slow and seasonal diet which is low glycaemic index. Again, avoid dairy.

**Dr Susan Arentz (00:37:23):**

So other indirect supportive therapies, in this case B complex and omega 3. B complex helps to regulate the nervous system. Omega 3 helps to minimise inflammation. And then herbal medicines that help with lymphatic movement and just detoxification of the lymph system. In this case I used echinacea. So the next presenting complaint was really to regulate menstruation. So normal, direct approaches include to normalise FSH and LH. So I can use these two herbal medicines, Actea racemosa, or black cohosh, or Tribulus terrestris. Tribulus I use often with people who are wanting to conceive, because it helps to raise FSH and bring on ovulation sooner, which can in turn shorten the cycle in women with PCOS.

**Dr Susan Arentz (00:38:31):**

Exercise, so resistance exercises. Other things are holy basil and again tribulus terrestris, which can help shorten the pre-ovulation phase. And then there's some evidence also for inositol in regulating menstruation, which I'll talk to you about later as well. So indirect support for regulating menstruation. So managing stress is very important. So you can use herbal medicine such as St John's wort. In this case I used magnesium and B6. And diet, there's indirect effects such as lentils and beans to help regulate body weight and also to help regulate the bowels. And some of these other things are really essentially about improving regular bowel evacuation and helping the digestive system work more efficiently, and to increase absorption and assimilation and general vitality and energy.

**Dr Susan Arentz (00:39:51):**

So the actual prescription included inositol, magnesium, omega 3 and B complex. And a herbal tonic containing Schisandra, liquorice, paeony, ginger, echinacea and sarsaparilla. And I recommended that she include some HIIT exercise in her routine, which meant walking up a hill after school each day, and she was using a trampoline with her mum. She had a low GI vegetarian diet, so we talked a lot about complete proteins. And we also talked about reliable sources of information, and this was an example when I actually referred her to the Jean Hailes resources for women with PCOS. So what happened was that at six weeks there were limited improvements to her acne. It had reduced a little bit, but not to the level where she was entirely satisfied. It possibly was because the time wasn't long enough. She had one menstrual cycle that was 31 days, which was the shortest she'd ever had.

**Dr Susan Arentz (00:41:08):**

Her waist circumference had reduced, and her BMI was slightly lower, and her LH level was lower as well. So that was on day three to four. But she now had become interested in using contraception. So she did actually start to, I recommended she see her GP, and they had a conversation about using the oral contraceptive pill, which would help to regulate her menstrual period, and also to help balance her hormones and reduce her acne too. But she, interestingly, she did continue to come and see me. So now I'm going to hand you over to Sandra. So there we go.

**Sandra Villella (00:42:03):**

Thank you, Susan. I'm going to have a case now, and I'm going to talk about a case with PMS/PMDD. Let's just get that started. Okay. Oops, going from the beginning, sorry about that. So I had a patient, this patient is 26. They use the pronoun 'they/them'. Presenting with three years of low mood and mood swings. At this stage we weren't sure whether it was just a premenstrual exacerbation of an underlying disorder, or whether it was just low mood, or indeed PMS. They presented with lack of motivation, high levels of anxiety, trouble focusing, lack of clarity, preoccupied and paranoid thoughts, poor sleep. They were also vegetarian. Not all patients that come to see a naturopath are vegetarian, it's just a coincidence we have two vegetarian patients today. They also had digestive symptoms, alternating constipation and diarrhoea. In terms of her menses, there was a history of dysmenorrhoea with some episodes of mid-cycle pain.

**Sandra Villella (00:43:13):**

There was extreme mood swings a week before, premenstrually. So as I mentioned, not sure at this stage because there hadn't been any tracking, as to whether it was a premenstrual exacerbation of an underlying mental health condition, or indeed PMDD or PMS, just a severe PMS. They had seen a naturopath three years prior, and when they were seeing the naturopath, they had responded to St John's wort, Hypericum perforatum. They had also been taking Vitex, Vitex agnus-castus, but currently the patient wasn't on any of these medications but was doing a bit of self-prescribing, as is often the case. they were taking a herbal anxiolytic, so kava are very popular and well-researched, in fact one of the most well-researched out of all of the herbal anxiolytics. We know a lot about how it works, including that you can operate heavy machinery and not be affected by taking kava.

**Sandra Villella (00:44:06):**

They were also, being vegetarian, took a DHA of fish oil, and this is important because it might come back to how it might've been impacting on her dysmenorrhoea, because you can manipulate the pain prostaglandins by loading up with the omega 3s. And because they are not having fish in their diet, it's important that there are other omega 3 resources, which I'll talk about shortly. This patient was also under the care of a psychiatrist, and had been seeing a psychiatrist for six months, and was having a particular type of therapy called EMDR therapy, and it included psychoanalysis, and it included sound and hand stimulus, particularly used for trauma because this patient did reveal at some time later that there was some trauma in past. The psychiatrist supported the patient's choice not to medicate, and was happy for the patient to be also having natural therapies.

**Sandra Villella (00:44:56):**

As some of you might be aware, a paper that came out in 2017 that really looked at the new understanding of PMS. And I'll talk a little bit about this new understanding shortly, but this treatment algorithm was presented as part of the paper. And as you can see as first line, exercise is part of that first line intervention, as is cognitive behavioural therapy and vitamin B6. As it progresses down, you can see that there's more and more intervention, but you can see that there are the new generation pills, particularly in embracing some of the newer progestins, and some specific SSRIs. Now you'll see from citalopram or escitalopram is the first line intervention, and that's relevant for when we talk about what happens with this patient. So my management was, I actually used a formula with some herbs that I'm going to call 'serotonin sparing'. So they are acting a little bit like an SSRI, but they do have this serotonin sparing impact, so therefore improves the mood.

**Sandra Villella (00:45:55):**

The herbs that fit into this are hypericum, and also crocus, which is saffron. There's a very small study that's done with saffron, and using it to look at premenstrual syndrome, and showed to be quite effective. So it was one of the reasons why I chose this. It also tended to have in this formula, as you can see, some B6, that first-line intervention being incorporated as part of this strategy. But it's only 20 milligrams there. So I added an additional B6, 50 milligrams, because I like to go around the 100 milligram mark, and the research certainly supports between 100 to 200, but you do need to be careful with high doses of up to around 200 because you can see patients develop an irreversible peripheral neuropathy. So it's important to avoid those really high doses, and if anything, perhaps having a higher dose just in that luteal phase.

**Sandra Villella (00:46:51):**

Naturopaths tend to use B6 in combination with a B complex, so not necessarily on its own. And this patient was also prescribed magnesium. Because what the magnesium and the B6 and some of these other nutrients are doing is targeting the neurotransmitters, because the new understanding of PMS is that there is this interaction that occurs with the hormonal changes from ovulation. So the oestrogen and the progesterone and the metabolite of progesterone have this conversation, this interaction with these neurotransmitters, particularly GABA and dopamine and oestrogen, sorry, and oestrogen, yes, and oestrogen has an impact with serotonin particularly.

**Sandra Villella (00:47:33):**

So what we are tending to look at is, rather than this idea that balancing hormones, you're targeting where the actual hormones are having that conversation with. So targeting where the hormones are having the interaction with. I made sure that her diet was focusing on adequate protein, as again these amino acids are the building blocks to these neurotransmitters. Ensured that she was having a diet that was high in these plant-based omega 3s. So particularly linseeds, one of my favourites. Also hemp and chia and walnuts. And this could particularly continue to improve her dysmenorrhoea management.

**Sandra Villella (00:48:13):**

Soluble fibres was really talked about there in terms of managing some of those IBS type of symptoms. And it was suggested to reduce her alcohol consumption, because what we do know from the research is that high intake of alcohol, and high intake was actually considered any more than one alcoholic beverage a day, is very strongly associated with an increase in PMS. So that was discussed in the context of her management. Keeping away from having her coffee and tea in the evenings, and we actually talked about using some herbal teas a little bit later on.

**Sandra Villella (00:48:44):**

At her second consultation four weeks later, she actually presented with worsening sleep and anxiety. This also corresponded with another lockdown in Melbourne, and certainly that lockdown was having an impact on her mental health. She hadn't had any change with her menses, and her psychiatrist had also suggested that she track her symptoms, really to see if there was a PMS/PMDD or to make this distinction as to whether it was an underlying anxiety and mental health condition. They also discussed the option of a pharmaceutical antidepressant, and there was a conversation with the GP who suggested escitalopram as in line with those interventions. But the actual prospect of that being prescribed actually made the patient quite anxious. So we continued with that previous management as from the first visit, but because of the presentation of the anxiety, we improved on the anxiety medication of the kava, and I added in a formulation that not only had kava but some of these other anxiolytic herbs. And we also discussed the use of using some of these herbal teas such as Melissa, which she found actually quite useful.

**Sandra Villella (00:49:58):**

The third consultation, which was eight weeks later, she had reported that she was starting to feel a lot better. She was exercising, more focused, she ticked off the day's list and was able to focus. And I think the mix of the herbs are great, and I like the tea. What was really apparent about this case is this patient did a lot of self-help, in terms of making sure she was exercising, journaling, meditating, and when she did that there was certainly an improvement. When they didn't do that, what would happen would be that when the mood was low, that of course made it very difficult for them to be able to be compliant. This patient was also very non-compliant and up and down with taking her medication. So certainly when they stopped the serotonin sparing herbs, her mood, the mood actually declined. So when there was less compliance, there was mood decline and they also experienced a fogginess.

**Sandra Villella (00:50:51):**

This consultation, there was also a presentation more of the dysmenorrhoea and the mid-cycle pain, which actually led to her having a hospital administration because she was concerned about the pain and went to AE. The PMS at this time was low, and she was experiencing these mood changes about once a month. We looked at in continuing the initial prescription, the sleep herbs when required, and I changed the formulation, the magnesium, to a formulation with magnesium and calcium that also had some B6in it. What we do know from the research, and one of the greatest levels of evidence actually when we come to look at PMS management, is calcium is quite effective for managing PMS. Initially it was calcium carbonate, and as a naturopath we would often look at other forms of calcium such as calcium citrate, which are a little better absorbed. But initially the research was done on 600 milligrams twice a day, and more recently, the evidence shows that 600 milligrams per day, which is probably a more manageable dose, was effective in reducing a lot of the PMS symptoms, including low mood.

**Sandra Villella (00:52:01):**

We also talked about, at this consultation, the introduction of Vitex agnus-castus, or chaste tree. It has the most convincing clinical data out of all of the botanicals for the efficacy of PMS, and this ranges from symptom management of mood changes and to cyclical mastalgia. The German Commission E, which is the equivalent to the FDA if you like, has approved it for the PMS management, and its efficacy in relieving PMS is supported by multiple clinical trials. It's considered safe and arguably better tolerated than conventional hormones or SSRIs. The other reason I wanted to use this is because it can be useful for the management of dysmenorrhoea. It's not the first line of intervention for dysmenorrhoea and it doesn't always work, and we're not quite sure on the mechanism of why it does, but I thought it might also be useful to incorporate, and certainly to help address that PMS.

**Sandra Villella (00:52:58):**

One month later, the patient returned, and they had decided to commence the escitalopram. The mood was continuing to be daily and not just in that premenstrual phase, and they had decided that it was the best thing to do. So because the patient was on hypericum and to reduce the risk of serotonin syndrome, there has to be a flush-out time. So for three days, the patient stopped taking the hypericum, that serotonin sparing formula, and then commenced on the escitalopram. Two months after, there was a text message that was sent that said, 'I'm doing really well on a mix of the Vitex and the Lexapro.' No PMS or dysmenorrhoea in the past two weeks.

**Sandra Villella (00:53:36):**

Now remember this patient was having dysmenorrhoea all the time. Now I'm not sure if there is evidence as to whether the escitalopram can work on dysmenorrhoea, but we would account that, we would put the Vitex and some of the dietary changes, and perhaps the magnesium, down to the management. So two very different mechanisms of action that are working between the Lexapro, the escitalopram, and the Vitex, being used together collaboratively to have a very nice management. I also feel that this was actually a good choice for this patient, because they are more likely to be more compliant with the Lexapro, perhaps taking it more seriously as a medication rather than doing the stopping or starting. The patient also reported that they had stopped alcohol for three months, and certainly we contributed this as a contributing factor in the improvement of the PMS.

**Sandra Villella (00:54:27):**

So we've got a couple of take-home messages that we will look at before we have time for questions. We do know that, and there's evidence, and particularly Australian evidence, that shows that women in Australia are the biggest users of complementary medicines. You know that, that's why you're attending this, we know that because we are actually in the profession. And we need to support them in their choices, and assist them to make informed decisions about their health, by providing information on the right sort of information on a range of treatments and management options, and to keep it really open and transparent so that they are truthful about their use of both medications. Susan, would you like to turn on your slide on your screen and have a message? You are muted.

**Dr Susan Arentz (00:55:20):**

Take-home messages from my case study and presentation are that evidence-based healthcare is informed by risk-benefit analysis, as well as the quality and certainty of the scientific evidence base. And including complementary medicine and therapies in a collaborative healthcare team can improve patient's experiences of medicine.

**Dr Elizabeth Farrell (00:55:53):**

Thank you both very much for your wonderful presentations. And I would now like to now continue with the question time. A couple of the questions that have just come up is in relation to your PCOS case, Susan, and one of the questions was, with the remedies that you prescribed to lower the androgens and to improve fertility, are they actually safe in pregnancy? If the woman were to become pregnant, what would happen then?

**Dr Susan Arentz (00:56:35):**

Well, the one that I usually use, that we talked about in that case, is tribulus terrestris. And that is a herbal medicine that raises FSH, so it increases FSH, and it's only used in the pre-ovulation phase of the menstrual cycle, so between days five to 14. So if a woman becomes pregnant, it's after ovulation, so they wouldn't be using it, because of the time when you use it. But to extend that, there is very limited evidence of the safety of tribulus in pregnancy, and I wouldn't recommend it at all.

**Dr Elizabeth Farrell (00:57:21):**

Thank you. Also from that, this young case of yours, she went off and took the Pill. Did she continue with her herbal remedies, and if so, is there any interaction between the two?

**Dr Susan Arentz (00:57:37):**

She didn't continue with the herbal remedy, she just took the Pill, but she continued with the supplements, so the inositol, and she continued with the other recommendations.

**Dr Elizabeth Farrell (00:57:50):**

So that leads us into the next question, and that is about the current scientific evidence of inositol in PCOS, and any recommendations in clinical practice for women using it or wanting to use it, given that the international guidelines state that it's currently only experimental.

**Dr Susan Arentz (00:58:11):**

I think it's in the PCOS clinical practice guideline as being having very low-quality, insufficient evidence, and that's based on a systematic review that I've cited in the presentation by Unfer, I think. And the other thing is that the clinical outcome that it has been investigated for is for glycaemic control mostly. But I also published a systematic review that looked at randomised control trials with investigating inositol for several different aspects of PCOS, and found evidence that it was effective for lowering androgens and improving menstrual cyclicity, and also improving pregnancy rates. But the quality of the randomised control trials was very low, so there was a fairly high risk of bias in a lot of them. And so again, it's an insufficient evidence base. But if you do think about it in the context of a clinical practice guideline where recommendations are made and these modifying factors are considered, inositol is a vitamin B, it's a water-soluble vitamin. It's a component of a compound called lecithin, and lecithin is in eggs. And lecithin is a very widely used additive in food production because it's an emulsifier. So it's had a very broad application and very high low-risk profile, safety profile. So if you think about that, that it's got low-quality evidence of efficacy, but it also has fairly reasonable evidence of safety, then you could understand why it might be an option for some women, or why they might want to use it. Okay.

**Dr Elizabeth Farrell (01:00:14):**

Thank you for that. And another question from tonight is, what therapies would you use to increase the luteal phase, and what would be the indications to do that?

**Sandra Villella (01:00:29):**

It's interesting. I want to make two points. One is, the most common herb that we would often use would be Vitex agnus-castus. But I also think Vitex agnus-castus, or chaste tree, has such a real action that it really does belong in the hands of a practitioner who knows how to use it. So often I see this inappropriately prescribed, being taken two, three times a day, taken in the luteal phase only. There's so much misinformation about, and it really should be something that is prescribed by practitioners who know about how to use it. And the other aspect, in terms of, with the follicular phase, and often if there is that luteal phase, there's that aspect, but with lengthening the follicular phase, I just wanted to make a point that there was a small bit of research, and you know how much I love linseeds, Liz, where two dessertspoons of linseeds, not only for the vaginal dryness, but it also uses it for, in this research it was for lengthening that follicular phase.

**Sandra Villella (01:01:25):**

And in the lay media there's this now belief about seed cycling. I don't know whether you've seen it, Susan, but it does my head in that people are recommending these different seeds for seed cycling, for regulating the cycle. And I think it's this gross extrapolation of that one small bit of research on linseeds for lengthening the follicular phase, and these pop kind of channels on YouTube or pop sort of Instagrams are saying have sesame seeds one day and then different seeds the other day to try and lengthen the cycle. And it's a really good example of where natural therapies has gone popular and wrong. I'll get off my soapbox now.

**Dr Elizabeth Farrell (01:02:06):**

Well, I'll get you to come back on your soapbox please, because the next question is, you've already alluded to it, natural therapies for menopausal vaginal dryness.

**Sandra Villella (01:02:17):**

Yes. So in the late nineties, some of the practitioners, at Jean Hailes actually, did a small research on different foods that had an impact, that could have an impact on the vaginal cytology, and one of them was linseeds, these 25 grams, two dessertspoons of linseeds, and they tended to plump up the vaginal cells. Now I've been prescribing that for about 25 years, and I can tell you, I can report back from the clinical practice, that people do, that women do often say that that's improved. And I actually created a muffin on our website. Part of my job is I create recipes with the health focus, which in-house we call our 'juicy vagina muffins', but if you look that up, you'll probably find something else. So don't look that up. But it's our linseed and banana muffins, and in the nutritional information it talks a little bit about that. So the linseeds, there is some evidence about eating phytoestrogens as soy, again, about a third of the percentage of the population will have the benefit from that. There is some German research on the black cohosh. Susan, you're nodding your head. Is there anything else you want to add?

**Dr Susan Arentz (01:03:23):**

No, I was being reminded of some research that was at the Royal Women's Hospital about 20 years ago, where they had a look at soy milk for improving menopausal symptoms, including vaginal dryness. And they did find that there was some efficacy in, and I don't even know the design of the trial to be honest, but they did find some efficacy, but the women were having to have 500 millilitres of soy milk per day, which I think was very difficult for many of them.

**Dr Elizabeth Farrell (01:03:58):**

The next question, Sandra, to you, is herbal remedies in menopause for libido, weight gain, hot flushes and sleeplessness.

**Sandra Villella (01:04:09):**

Okay, so that's a lot. Can I just perhaps draw your attention to our website where there is a lovely section that has just been updated, and it's all evidence-based, but of course the language is designed for the consumer, which lists all the different herbs for menopause under the different conditions. So I think that's probably the best way to address that, and we'll send out a link to that as part, after the presentation.

**Dr Elizabeth Farrell (01:04:36):**

Okay, thank you. That's great. Now the next question is, Susan, what complementary therapies for women's health – this is a really tough one, I think, it's so broad – have a reasonable evidence base that is the gold standard? I think you've answered the question really. And how much research is being done?

**Dr Susan Arentz (01:05:00):**

Look, I think there's a very thriving international community in the area of complementary medicine and therapies in women's health. At the research centre that I'm part of, we have a women's health group, which is doing quite a lot of work around endometriosis, chronic pelvic pain, menopause and polycystic ovary syndrome. There's quite a lot. We've got a project that's going on at the moment for diminished ovarian reserve. There's also research groups that are located at UTS that are focusing on women's health and complementary therapies, more from a public health perspective.

**Dr Susan Arentz (01:05:47):**

There's also some really innovative groups overseas. There's Southampton University in England, has in their part of their primary healthcare discipline, or, what do you call it, syllabus. They have a whole section on women's health and complementary medicine and therapies, and that includes research. And it would be the same in the US, in the naturopathic colleges. There's a number of them in America and in Canada, and there's a World Naturopathic Federation that lists some of the research that is going on at the moment and has been published. But I do think that it has increased in volume. There is an increased interest, especially from an international perspective. I think sometimes in Australia we tend to be a little bit insulated from some of these international issues going on. So whoever asked that question, I'd encourage you to have a look at some of the international initiatives, as well as what's going on here in Australia.

**Dr Elizabeth Farrell (01:07:02):**

Do you find it hard to recruit women to your studies?

**Dr Susan Arentz (01:07:09):**

Well, when I did my PhD, I did a randomised control trial on women with polycystic ovary syndrome. And relatively speaking, I think I found it very easy to recruit, because a lot of women want the information, so it's not that difficult to explain that the reason and the purpose for the research is really to inform their decisions, and to find out if it does, or even if it doesn't work. I think the really important emphasis on research in this space is the lack of commercial agenda. So it's just as important to know that it doesn't work as to know that it does work. Obviously, if you're any individual looking for some kind of treatment for yourself, you do need to know, you can appreciate, you need to know if something doesn't work just as much as you need to know if it does. And so, no, we didn't find it that difficult to recruit women into the research. And the other thing that was really interesting was that the attrition of women in the randomised control trial was very low compared to other studies of overweight women with polycystic ovary syndrome. And some of my colleagues have found the same. And one of the clinicians that I work with does quite a bit of research with women who have endometriosis, and I think when there's a complementary medicine aspect to it, they find that, again, they're easier to recruit, and better adherence.

**Dr Elizabeth Farrell (01:08:55):**

Right. That's interesting because some years ago we were involved with supporting a study of Japanese kampo medicine in menopause, and the researcher had great difficulty in getting women to be part of the research, because when they saw that it involved having, there was a protocol and they had to fill out, have to have a history taken, had to have a general medical examination, they didn't like the fact that it was scientific, and so therefore they refused to be part of it, which was an interesting—

**Dr Susan Arentz (01:09:38):**

Yeah, I think, maybe if there's a way of presenting it to women as well, I think that it's just emphasising that it is for them, it's about them and it's for them.

**Dr Elizabeth Farrell (01:09:52):**

One of the other questions, both of you can answer this, how would you manage heavy periods? And you've talked a little bit about, in your case study, but are there specific, and you also have Sandra, but are there specific directions that you would go along, and does it depend on the history of how the periods present themselves? Because I think one of the things in conventional medicine is that we take a history and we talk about the symptoms and how heavy it is and et cetera, et cetera, but I think you actually have a slightly different take on how you look at symptoms, and what other associated symptoms that you might look for. Can you explain that to us?

**Sandra Villella (01:10:42):**

I think Vitex is an interesting one, and certainly there's a little bit of literature that looks at it with heavy menstrual bleeding, and you would certainly use it where there's unopposed oestrogen. So particularly in that perimenopausal phase where there might be anovulatory cycles. Interestingly, when the other end of the spectrum, where teenage girls and adolescent girls are having anovulatory cycles, we wouldn't necessarily use that. We try and just sort of perhaps, unless they're having very heavy menstrual bleeding and it's impacting their quality of life, we would sort of just wait and let that establish. But it does also depend on the cause. So if there's fibroids, we might need to manage that. So I actually find heavy menstrual bleeding rather challenging. It's not one of the easiest things to manage. And it certainly depends on the case, what it's associated with, if there's adenomyosis, if there's fibroids, and we would just treat that cause, Liz.

**Dr Elizabeth Farrell (01:11:41):**

Okay. So I mean if we've got—

**Dr Susan Arentz (01:11:42):**

You'd definitely refer on, Liz.

**Dr Elizabeth Farrell (01:11:45):**

Sorry?

**Dr Susan Arentz (01:11:47):**

You would definitely take a collaborative approach.

**Sandra Villella (01:11:50):**

Yes.

**Dr Susan Arentz (01:11:51):**

Yeah. So there'd be lots of other involvement, not just a naturopath managing it.

**Dr Elizabeth Farrell (01:11:58):**

That sounds great. One question that has just come up, and I just had the menopausal moment. Yes. The question is about phytoestrogens in your diet in a woman with breast cancer.

**Sandra Villella (01:12:17):**

Yes.

**Dr Elizabeth Farrell (01:12:17):**

This is really, really important and I know that you love this.

**Sandra Villella (01:12:21):**

I love this. My favourite story is when I order my soy cappuccino and the barista says that they're not going to give me soy because it's an endocrine disruptor. And so my standard retort now is actually, it's a selective oestrogen receptor modulator, and that usually shuts them up. There is a lot of misinformation about soy, and the way that soy in the diet actually acts in the body is quite well behaved, if I can use that. The soy isoflavones, the phytoestrogens, they have a similar structure to the way our endogenous, our own body's oestrogen looks. So if you think about the lock and key, we've got these receptors and oestrogen comes in and hooks onto those receptors like a lock and key. The soy phytoestrogens also can do that, but they have a higher affinity for the beta receptors, and the beta receptors, the oestrogen receptors, are more of a dampening down effect, so they don't have that stimulating effect.

**Sandra Villella (01:13:20):**

So when I say they behave like that, in food. And it also depends where the woman is in her reproductive cycle. So in a woman who is still menstruating and has an overall higher oestrogen level, perhaps they can actually act competitively and overall dampen down the oestrogen, the overall oestrogen. And in a postmenopausal woman where there are low oestrogens, they may actually have a plumping up effect if you like, increasing that overall low oestrogen. But there are several systematic reviews that look at the phytoestrogens, and the take home message with breast cancer is that if women have a diet high in phytoestrogens, particularly consistent with the doses that are used in an Asian diet, there is an overall decreased risk, particularly if the woman has that, has a diet high in phytoestrogens, before puberty. And for women who are breast cancer survivors who continue to eat a diet high in soy, they will have a better prognosis. So as long as it's real, the take home message also from those research is, that's in food, but we don't know how isolated soy, soy compounds or highly processed soy or highly processed soy supplements behave.

**Dr Elizabeth Farrell (01:14:37):**

Just one last question before we wrap up. I would like both of you to answer this. What type of information should be included in a referral to a complementary medicine practitioner?

**Sandra Villella (01:14:50):**

Susan?

**Dr Elizabeth Farrell (01:14:55):**

What would you like to see in your referral?

**Dr Susan Arentz (01:14:59):**

I think just the standard SBAR structure is fine. So the situation, the background and just asking for what recommendation would be for that individual. So what sort of information you are expecting as the other practitioner, and then sort of invites, so it needs to be concise, it needs to be purposeful information. And then it's very important, in my opinion, that the complementary medicine practitioner responds.

**Dr Elizabeth Farrell (01:15:43):**

I think that's very important, and Sandra always writes back, and I think also if you become one of a team of people looking after a patient, so such as somebody who's got breast cancer, I think it's very important for each practitioner to include you in a copy of the letter you're sending to the referring doctor. And I think that being part of that team is just so important.

**Sandra Villella (01:16:17):**

Yes, and I understand that GPs are often time poor, so I'm actually quite happy just to be CC'd in at the bottom, if there's already a referral letter that's going out to the gynaecologist or to the endocrinologist. And a CC at the bottom also provides all the information that I need.

**Dr Elizabeth Farrell (01:16:33):**

It's now wrap-up time. I would like to thank the two of you very much for your wonderful presentations, for your insight into complementary medicines and therapies, and that to keep up the good work. And I think to keep publishing research on complementary medicines and therapies is just so important. And I think this will help us all to really incorporate you in particular, the two of you, because you're so gifted and so knowledgeable. So thank you for your time and your energy.

**Sandra Villella (01:17:15):**

Thank you.

**Dr Susan Arentz (01:17:18):**

That's very kind of you.

**Dr Elizabeth Farrell (01:17:18):**

I want to thank our audience for participating in tonight. If your questions haven't been answered, then they will be answered, and they will be up on the website once the webinar is put up there. I would like to remind you that in the presentation handout, you'll find links to all of the resources that we've mentioned tonight. You'll receive an email once the recording is available, to view in the webinar library. And please don't forget to complete your evaluation tonight. And if you need CPD points or a certificate, a link will pop up on the screen shortly. So thank you once again to the two of you, and we look forward to seeing you again, hopefully, on another webinar. So thank you both very much. And goodbye to you all.

**End of transcript**

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