

Commonly Asked Questions about pellet therapy – Female Patients

Q. What is pellet therapy?

A. Pellets are simply a delivery system for the administration of bio-identical estrogen and testosterone. Pellets are suitable for most patients suffering from the effects of hormone deficiency and imbalance. This type of therapy has been utilized in Europe since the 1930's and in the US for more than 30 years. Other options for hormone delivery prescribed here include capsules, troches and topical creams.

Q. I've been taking estrogen for years since menopause. How is this different?

A. Estrogen helps hot flashes, but many women still don't feel "right" on estrogen alone. Some are prescribed sleeping pills and antidepressants for sleeplessness, moodiness, anxiety, and depressive symptoms. This is especially seen in patients who have had their ovaries removed. One cause of these symptoms is testosterone deficiency. Testosterone is a very important hormone for women as well as men. Traditional providers don't pay attention to testosterone deficiency because there is no effective FDA-approved testosterone product for use in women. Most patients report that testosterone therapy makes them feel "whole" again. It is our goal to balance estrogen, testosterone, and thyroid levels to increase well-being.

Q. How do I know if I'm a candidate for this therapy?

A. A panel of blood tests will be done to determine your hormone levels as well as other parameters of health. Then, during your consultation appointment, we will discuss your symptoms, history, and lifestyle in the context of your lab results. Once your results are reviewed and it is determined if pellet therapy is appropriate for you, we will schedule an appointment for administration.

Q. Do I have blood work done before each treatment?

A. No, only initially and 6-8 weeks later to determine your peak levels for dosage verification. You will have levels checked again if there are significant changes or persistent symptoms, otherwise, labs will be repeated yearly.

Q. What are the pellets made from?

A. Estrogen and testosterone in the pellets are made from wild yams and soy because of their chemical similarity to our hormones. Once altered through a chemical process, the estradiol and testosterone that is produced is identical to your own hormones. The pellets are made in a federally-certified compounding regional pharmacy, where they are checked for potency, purity, and sterility.

Q. How long will the pellet dose last?

A. The typical dose interval is 16-18 weeks, but ranges from 13-26 weeks. The dose given varies depending on an age- and weight-influenced calculation. Individual physiology influences the timing of re-dosing, and high levels of stress or physical activity may speed absorption. When symptoms begin to recur, it is time to re-dose.

Q. Is the therapy FDA approved?

A. Estradiol and testosterone are FDA approved and regulated, the process of making pellets is regulated by the State Pharmacy Board, and the distribution is regulated by the DEA and respective State Pharmacy Boards. The use of compounded pellets and their subcutaneous administration in this manner is not FDA approved. It is considered "off-label" use of the hormones.

Q. How are they administered?

A. After a local anesthetic is given, the pellets are implanted in the subcutaneous fat of the posterior hip area. A small incision is made and the pellets are pushed into place with a hollow cannula. No stitch is required.

Q. Are there any side effects?

A. The most common issues are acne, increased hair growth, some fluid retention, and/or a few pounds of weight gain. All are either self-limited or treatable. Sometimes vaginal bleeding occurs, requiring a dose adjustment and/or evaluation by your gynecologist. Pellet therapy does not increase the risk of blood clots (DVT) as oral hormones might do.

Q. What if I'm already on HRT of some sort like creams, patches, pills?

A. You will be able to stop other hormone therapies within 4-5 days in most cases.

Q. What if I've had breast cancer?

A. Those with a history of breast cancer may still be a candidate for testosterone-only therapy, in most cases with an estrogen blocker added.