

I meet women every week who carry a familiar mix of frustration and hope. They want sleep back. They want their concentration to return so meetings do not feel like wading through fog. They want hot flashes to stop hijacking the day and night. Many have heard that bioidentical hormone replacement therapy could be a gentler, more natural answer. Others were warned away from hormones entirely after a relative's scare two decades ago. Sorting myth from medicine takes time, a clear head, and respect for personal priorities.

From a naturopathic lens in London, Ontario, I see both sides of the hormone conversation. I use nutrition, sleep coaching, stress physiology, and targeted supplements as foundations. For many, those pillars do a lot. For some, they do not do enough. Hormone therapy remains the most effective tool we have for vasomotor symptoms like hot flashes and night sweats, and it can additionally support genitourinary symptoms such as vaginal dryness and painful intercourse. The question is not whether hormones work. It is how to choose the right form, route, and dose, and how to balance potential benefits against individual risks.

What people usually mean by “bioidentical”

The term bioidentical originally referred to hormones that are structurally identical to those produced by the ovaries, mainly estradiol and progesterone. Today, the word often gets used in two very different ways. In one sense, it describes Health Canada approved products that contain estradiol or micronized progesterone. These include transdermal patches and gels, oral estradiol tablets, and oral micronized progesterone capsules. They are regulated, come in standardized doses, and have safety data.

In another sense, bioidentical has become shorthand for compounded hormone creams, capsules, troches, or pellets that a compounding pharmacy mixes to a prescriber's specifications. Compounded products may include estradiol, combinations of estradiol, estrone and estradiol, or customized progesterone and testosterone doses. Compounding has a place in medicine when a person needs a form or dose not commercially available. The issue is that routine use of compounded formulations for menopausal symptoms is often marketed as safer or more natural, even though those claims are not supported by evidence. Dosing consistency, quality assurance, and long term outcome data lag behind what we have for standardized products.

When I discuss options in clinic, I clarify this distinction early. If someone wants bioidentical hormone replacement therapy in the strict biochemical sense, we can use approved estradiol and micronized progesterone. If someone is considering compounded BHRT therapy in London Ontario, I explain where that might fit and where it raises more questions than answers.

Conventional HRT, updated with nuance

Conventional hormone therapy is a broad label. It includes both bioidentical molecules, like estradiol and micronized progesterone, and non bioidentical ones, such as conjugated equine estrogens or medroxyprogesterone acetate. Two decades ago, the Women's Health Initiative trial cast a long shadow by associating combined therapy with higher breast cancer risk and cardiovascular events in older postmenopausal women, average age in their early 60s, many years past their final period. Later analyses taught us two key lessons. First, timing matters. Starting systemic hormone therapy before age 60 or within 10 years of menopause appears to carry a more favorable risk profile, particularly for

cardiovascular outcomes. Second, the choice of molecule and route matters. Transdermal estradiol is associated with a lower risk of blood clots than oral estrogen, and micronized progesterone seems to have a more favorable breast risk profile than medroxyprogesterone acetate in observational studies.

Medical societies in Canada, the United States, and Europe have converged on a similar position. For moderate to severe vasomotor symptoms, hormone therapy remains the most effective option. The Society of Obstetricians and Gynaecologists of Canada, the North American Menopause Society, and other groups recommend using the lowest effective dose for the shortest duration needed, favoring transdermal estradiol when clot risk is a concern, and using a progestogen to protect the uterus if the person has not had a hysterectomy. They prefer approved products over compounded because of quality control and safety data.

How I evaluate a person sitting in front of me

The first visit is part detective work, part education, and part shared decision making. Menopause is a life stage, not a disease, but severe symptoms are a health issue that deserves treatment. I take a careful history: timing of period changes, pattern and severity of hot flashes, sleep disruption, mood changes, libido, vaginal or urinary symptoms, migraines, family and personal history of cancer, clotting, stroke, heart disease, and bone density concerns. I ask about alcohol, smoking, activity, what a usual week of food looks like, and levels of work or caregiving stress. Lab testing is tailored. Routine hormone testing is rarely needed to diagnose perimenopause or menopause. [menopause treatment options](#)
[London ON](#) Follicle stimulating hormone can be helpful in certain scenarios, but readings swing during perimenopause. Thyroid screening can rule out a contributor to fatigue or mood changes. Iron status can matter if heavy bleeding has been a theme.

I ask what the person most wants back in their life. Some want sweats down to a manageable level. Some want to sleep through the night. Some want their libido and comfortable sex life back. Knowing the main goal helps shape whether we reach for vaginal estrogen alone, systemic therapy, or nonhormonal tools first.



What bioidentical looks like in practice with approved options

If a person wants a bioidentical approach with the strongest evidence base, the combination that shows up most in my practice is transdermal estradiol plus oral micronized progesterone in those with a uterus. Patches or gels avoid first pass liver metabolism and have a steadier effect. Patches also provide a quiet convenience that many appreciate, especially for those with busy schedules or sensitive stomachs. Micronized progesterone at bedtime can improve sleep quality for some, a not so small bonus.

Doses are individualized. A typical starting patch dose might be 25 to 50 micrograms of estradiol twice weekly. Micronized progesterone is often 100 mg nightly in continuous regimens or 200 mg nightly for twelve to fourteen days per month if a cyclic pattern suits better. We adjust based on symptoms, bleeding patterns, and tolerability. The goal is not to chase a perfect lab number. It is to relieve the target symptoms with the least medicine that gets the job done.

For vaginal dryness, soreness with sex, recurrent urinary tract infections, or urgency, low dose vaginal estradiol rings, tablets, or creams are highly effective, and systemic absorption is minimal at usual maintenance doses. Many women who cannot or do not wish to use systemic therapy can still benefit from local treatment.

Where compounded BHRT may enter the conversation

Compounded BHRT is sometimes considered when someone needs a form that does not exist in approved products, such as a very specific low dose cream, or has a true allergy to a filler. Certain cases of vulvar conditions may benefit from a compounded estradiol cream, and there is some clinical tradition there, though robust head to head data are scarce.

For routine perimenopause treatment in London Ontario, I lean toward approved options. Reasons are practical. Compounded products vary more batch to batch, they rely on a pharmacy's quality systems, and they often come with higher out of pocket cost. Measuring saliva levels to tailor compounded dosing is a popular marketing hook, but salivary hormone testing does not reliably reflect tissue exposure or symptom relief, especially for estradiol in perimenopause. Blood levels can be useful in select contexts, for example when confirming absorption of a transdermal product, but I do not titrate to reach a number. I titrate to reach a life.

When someone insists on compounded hormones after a thorough review of pros and cons, I document the rationale, choose a reputable compounding pharmacy, and schedule closer follow up. For safety, any estrogen exposure still requires appropriate progesterone if a uterus is present, compounded or not. Irregular bleeding on any regimen warrants evaluation.

Testosterone, DHEA, and the desire for energy or libido

Questions about testosterone come up frequently. In Canada, there is no testosterone product approved specifically for menopausal women. Some clinicians prescribe off label for hypoactive sexual desire disorder after other causes are addressed. Small doses can help in carefully selected cases, with close monitoring for side effects like acne, hair changes, or voice effects. This is not a casual add on. I emphasize first the foundations that help libido, such as sleep, stress reduction, vaginal comfort with local estrogen, and relationship dynamics. DHEA appears in over the counter supplements and as a prescription vaginal insert in some jurisdictions. Oral DHEA can tilt hormones in unpredictable directions. I approach it with caution.

Safety considerations that matter more than the label

People often ask whether bioidentical hormones are safer than conventional hormones. The more honest answer is that safety tracks with the molecule, dose, route, and personal risk profile, not the marketing term.

- Transdermal estradiol carries a lower risk of venous clots than oral estrogen, useful for those with higher baseline risk such as obesity, a strong family history of clotting, or migraine with aura.
- Micronized progesterone appears to have a more favorable breast profile than medroxyprogesterone acetate in observational research. That does not mean zero risk. It means relative differences that may influence choice.
- Starting therapy within 10 years of the final period or before age 60 has a more favorable cardiovascular risk pattern than starting late. The later start may still make sense for genitourinary symptoms with local therapy, but I am more cautious with systemic therapy long after menopause.
- Smoking, uncontrolled hypertension, recent stroke or heart attack, a personal history of estrogen sensitive breast cancer, active liver disease, or unexplained vaginal bleeding are red flags. Systemic therapy in these settings is either deferred, avoided, or coordinated closely with a specialist.

I also address breast screening, blood pressure, and, where appropriate, bone density. The net impact of hormone therapy on breast cancer risk depends on type and duration. Combined therapy may nudge risk up over time, while estrogen alone after hysterectomy had a neutral or even slightly favorable signal in some analyses. The absolute differences are small for most individuals, but they matter in counseling.

Perimenopause brings its own chaos

Perimenopause can outwit tidy protocols. Hormone levels swing week by week, and symptoms can feel erratic. Cyclic progesterone can help with sleep and premenstrual irritability. Low dose transdermal estradiol may even out vasomotor symptoms without overshooting. On the other hand, adding estrogen when bleeding is heavy calls for caution. I often stabilize iron stores, address inflammation and stress load, and bring in progesterone first to settle the lining and smooth mood. Nonhormonal tools help here as well. Cognitive behavioral therapy for insomnia, paced respiration, and cooling strategies can bridge the nights where everything feels amplified.

If you are looking for perimenopause treatment in London Ontario, expect a plan that shifts as your cycle shifts. We adjust, watch for patterns, and accept some imperfect weeks along the way. That honesty helps more than false promises.

Nonhormonal therapies deserve a real seat at the table

Some women cannot use systemic hormones. Others simply do not want to. Nonhormonal options can be effective for hot flashes, sleep, and mood. Certain antidepressants at low doses, such as venlafaxine or escitalopram, reduce hot flush frequency. Gabapentin can help with night sweats and sleep continuity. Oxybutynin has supportive evidence but can

cause dry mouth or constipation. Newer neurokinin 3 receptor antagonists have emerged in some countries as nonhormonal treatments for vasomotor symptoms. Availability and insurance coverage evolve, so I check current Canadian status before suggesting them.

For vaginal and urinary symptoms, vaginal moisturizers and lubricants remain useful. Local vaginal estrogen is often the most effective, but nonhormonal hyaluronic acid based products can support mucosal comfort. Pelvic floor physiotherapy changes lives more often than it gets credit for.

Nutrition, physical activity, and stress physiology are not side notes. Alcohol reliably worsens hot flashes for many. Protein intake that hits 1.0 to 1.2 g per kilogram of body weight supports muscle maintenance during the midlife transition, and resistance training at least twice per week helps preserve bone. Short evening screen breaks and a cooler bedroom are not glamorous prescriptions, yet they reduce the number of 3 a.m. Wake ups.

The money and access question in London, Ontario

Cost and coverage shape real decisions. Some estradiol patches and micronized progesterone are covered under the Ontario Drug Benefit for those 65 and older or on specific programs, and some employer plans reimburse a wide range of products. Compounded hormones are usually paid out of pocket. Vaginal estrogen varies by brand and form, with generics easing the burden. If cost is a barrier, I look for the least expensive approved options that still meet the medical need, and I help patients ask the right questions of their insurer or pharmacist.

Local access is strong. Pharmacies across London stock common patches, gels, and capsules, and there are reputable compounding pharmacies for the rare cases that need them. Wait times to see a menopause specialized gynecologist can stretch, so primary care and collaborative clinics often handle the first line.

Risk communication without scare tactics

I appreciate how numbers can be twisted to alarm or to reassure. A phrase like relative risk doubles can sound terrifying without context. If the baseline risk is low, even a doubling can still mean a small absolute change. I use ranges and plain language. For example, with long term combined therapy, the additional cases of breast cancer per thousand women over several years is small, and those numbers vary by age, duration, and regimen. That does not minimize anyone's experience. It keeps the math honest while we center the person's values.

I also keep a close eye on warning signs. Any postmenopausal vaginal bleeding needs assessment. New headaches with visual changes, calf swelling or pain, chest pain, or sudden neurologic changes are urgent reasons to stop hormones and seek care. Periodic blood pressure checks and routine screening continue as usual.

How decisions are actually made

Most women do not decide based on a single fact. They decide based on a hierarchy of needs. If night sweats have broken sleep for months and work performance and home life are wobbling, the quality of life argument carries heavy weight. If a mother and two aunts had breast cancer in their 40s, that family story matters, even if the person's own risk numbers look moderate. My role is to translate the data, frame the trade offs, and respect the final call.

Here is a simple way I help organize the decision without oversimplifying.

- If hot flashes and night sweats are the main problem, and no major contraindications exist, consider transdermal estradiol at the lowest effective dose. If you have a uterus, add micronized progesterone for uterine protection.
- If vaginal dryness or urinary symptoms lead, start with low dose vaginal estrogen or nonhormonal local options. Many will not need systemic therapy for this alone.
- If cycles are irregular with heavy bleeding and sleep is poor, consider cyclic micronized progesterone first, manage iron, and layer estrogen later if needed.
- If personal or strong family cancer history raises concern, weigh nonhormonal options first, involve oncology when appropriate, and consider local vaginal therapies that have minimal systemic absorption.
- If finances are tight, ask your pharmacist about generic estradiol patches or tablets and insurance coverage. Avoid compounded products unless there is a specific medical reason.

A brief case from clinic that illustrates the middle path

A 52 year old project manager from north London came in with 8 to 10 hot flashes a day, soaked night sweats, and brain fog that made presentations a chore. Periods had spaced to every two to three months. Blood pressure was normal, she exercised three times a week, and there was no personal or family history of venous clotting or estrogen sensitive cancer. She preferred a bioidentical approach and asked about BHRT therapy in London Ontario after seeing ads.

We discussed options and settled on a transdermal estradiol patch at 37.5 micrograms twice weekly, plus oral micronized progesterone 100 mg at bedtime. I suggested a 10 percent reduction in evening alcohol, a cooler bedroom, and a wind down routine to help sleep. We also started a vaginal moisturizer, with a plan to add local estrogen if dryness persisted.

Three weeks later, hot flashes were down to two or three daily. Sleep had improved, and the brain fog lifted enough that she felt more confident at work. At two months, we nudged the patch to 50 micrograms to clear the remaining daytime sweats. She did well, with no unscheduled bleeding. At six months we reviewed whether her goals were met and documented an annual reassessment plan. She appreciated that the therapy used estradiol and micronized progesterone, which matched her desire for bioidentical hormones without the uncertainty of compounded dosing.

This is not everyone's story, but it shows how steady, modest steps can change a life quickly.

What to expect from follow up

The first year of therapy usually includes visits or check ins at about 6 to 12 weeks, then at 6 months, then annually if stable. We watch for symptom control, side effects like breast tenderness or spotting, blood pressure, and whether the reasons to start are still present. If a person wants to stop, we can taper gradually over a few weeks or months to minimize rebound symptoms, or we can stop and see, then restart at a low dose if needed. There is no trophy for staying on or getting off. There is only what serves the person best.

Final thoughts from a naturopath in this city

Menopause symptoms can test even the most resilient person. The toolkit is bigger than it used to be, and it is more nuanced. Bioidentical hormone replacement therapy, in the sense of using estradiol and micronized progesterone, can be both effective and evidence based. Compounded BHRT has a narrower role than its marketing suggests. Conventional HRT is not a monolith and now includes many bioidentical options. Nonhormonal therapies remain valid, sometimes essential, especially when risk or preference points that way.

If you are exploring menopause treatment in London Ontario or seeking thoughtful perimenopause treatment in London Ontario, look for a clinician who can hold space for lifestyle, hormones, and personal context at the same time. The best care plan is the one you understand, can afford, and are willing to follow. The right therapy is the one that gives you back your days, your sleep, and your sense that your body is not arguing with you every hour. I have seen that happen many times, and it is worth pursuing.

Business Information (NAP)

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Hours

Monday: 11:30 a.m. - 5:30 p.m.

Tuesday: 8:30 a.m. - 3:00 p.m.

Wednesday: 9:30 a.m. - 3:00 p.m.

Thursday: 11:30 a.m. - 5:30 p.m.

Friday: 8:30 a.m. - 3:00 p.m.

Saturday: Closed

Sunday: Closed

Plus Code: XPWW+HM London, Ontario

Google Maps URL: <https://maps.app.goo.gl/pzSdRYMMcAeRU32PA>

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Social Profiles

Facebook: <https://www.facebook.com/totalhealthnd>

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Total Health Naturopathy & Acupuncture is a customer-focused naturopathic and acupuncture clinic in London ON.

Total Health Naturopathy & Acupuncture offers whole-person approaches for insomnia support.

Call (226) 213-7115 to contact Total Health Naturopathy & Acupuncture in London, Ontario.

Email Total Health Naturopathy & Acupuncture at info@totalhealthnd.com for inquiries.

Visit the official website for services and resources: <https://totalhealthnd.com/>.

Find directions on Google Maps: <https://maps.app.goo.gl/pzSdRYMMcAeRU32PA> .

Popular Questions About Total Health Naturopathy & Acupuncture

What does Total Health Naturopathy & Acupuncture help with?

The clinic provides natural, holistic solutions for Weight Loss, Pre- & Post-Natal Care, Insomnia, Chronic Illnesses and more. Learn more at <https://totalhealthnd.com/>.

Where is Total Health Naturopathy & Acupuncture located?

784 Richmond Street, London, ON N6A 3H5, Canada.

What phone number can I call to book or ask questions?

Call [\(226\) 213-7115](tel:(226)213-7115).

What email can I use to contact the clinic?

Email info@totalhealthnd.com.

Do you offer acupuncture as well as naturopathic care?

Yes—acupuncture is offered alongside naturopathic services. For details on available options, visit <https://totalhealthnd.com/> or inquire by phone at (226) 213-7115.

Do you support pre-conception, pregnancy, and post-natal care?

Yes—pre- & post-natal care is one of the clinic's listed focus areas. Visit <https://totalhealthnd.com/> for related resources or call (226) 213-7115.

Can you help with insomnia or sleep concerns?

Insomnia support is listed among the clinic's areas of care. Visit <https://totalhealthnd.com/> or call (226) 213-7115 to discuss your goals.

How do I get started?

Landmarks Near London, Ontario

- 1) [Victoria Park](#) — Visiting downtown? Keep Total Health Naturopathy & Acupuncture in mind for trusted holistic support.
- 2) [Covent Garden Market](#) — Explore the market, then reach out to Total Health Naturopathy & Acupuncture at (226) 213-7115 if you need care.
- 3) [Budweiser Gardens](#) — In the core for an event? Contact Total Health Naturopathy & Acupuncture: <https://totalhealthnd.com/>.
- 4) [Museum London](#) — Proud to serve London-area clients with natural care options.
- 5) [Harris Park](#) — If you're nearby and want to support your wellness goals, call (226) 213-7115.
- 6) [Canada Life Place](#) — Local care in London, Ontario: <https://totalhealthnd.com/>.
- 7) [Springbank Park](#) — For pre- & post-natal care goals, contact the clinic at info@totalhealthnd.com.
- 8) [Grand Theatre](#) — Need a local clinic? Call Total Health Naturopathy & Acupuncture at (226) 213-7115.
- 9) [Western University](#) — Serving the London community with quality-driven holistic care.
- 10) [Fanshawe Pioneer Village](#) — If you're visiting the area, learn more about services at <https://totalhealthnd.com/>.