



MAGNOLIA FUNCTIONAL WELLNESS

Hormone Optimization & BHRT in DFW

How to Find the Right Provider — and the Right Questions to Ask

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TL;DR The women's hormone therapy market in DFW is dominated by NP-run medspa models with a physician on the compliance paperwork. Texas law requires a collaborating agreement — it does not require the physician to review a single chart or see a single patient. At Magnolia, Dr. Farhan Abdullah, DO sees the vast majority of patients personally; every NP-managed case is reviewed with him directly. Beyond oversight: testosterone is evaluated in every woman, the complete thyroid panel including reverse T3 is standard, WHI risk is applied to bioidentical compounds correctly, and perimenopausal fluctuation is assessed by symptom history — not dismissed with a single lab value. The timing of hormone initiation matters clinically. Waiting until symptoms are debilitating doesn't make therapy safer. It closes a protective window.

What I See as a Hospitalist That Most Hormone Providers Never Will

I work inpatient medicine at Methodist Dallas and Methodist Southlake alongside running Magnolia. That means I see the long game — the 62-year-old woman admitted for her second fragility fracture, osteoporosis that accelerated unchecked for fifteen years post-menopause because nobody initiated bone-protective hormone therapy at the right time. The 58-year-old with accelerating cognitive decline and a hormone history of 'we told her to manage it naturally.' The women in their late 50s with early cardiovascular disease whose perimenopausal window — the period when estrogen's cardioprotective effects are most recoverable — passed without anyone optimizing their hormonal status.

Most providers offering hormone therapy in DFW — certainly the medspa NP model that dominates this market — never see those patients. I do. It changes how I think about every hormone evaluation at Magnolia. When I tell a 46-year-old woman in perimenopause that the timing of hormone initiation matters clinically, I'm not repeating something I read in a continuing education module. I'm describing what I watch happen when that window gets missed.

The women's hormone therapy market in DFW has expanded dramatically. Access has improved. Quality has not kept pace. The gap between those two things is where most patients end up undertreated, incorrectly treated, or bounced between providers without ever getting a complete picture.

The Specific Ways DFW Hormone Clinics Are Failing Women Right Now

These are the specific clinical failures I see in patients who come to Magnolia after being managed — or dismissed — elsewhere.

Failure 1: Dismissing perimenopausal symptoms because a single lab looks 'normal'

Perimenopause is defined by hormonal fluctuation, not consistent decline. Estradiol can swing dramatically week to week — meaning a single draw can look completely normal while a woman is significantly symptomatic. Standard FSH and estradiol panels at a random cycle point tell you almost nothing useful about a perimenopausal woman's hormonal status. The clinical picture requires symptom assessment, cycle history, and often serial measurements. A provider who hands a perimenopausal woman a single estradiol result and says 'your levels are fine' has done an incomplete evaluation. This is one of the most common reasons women spend years symptomatic and dismissed before getting appropriate care.

Failure 2: Ignoring testosterone in women entirely

Testosterone is not a male hormone. Women produce it — in the ovaries and adrenal glands — and declining testosterone drives fatigue, reduced libido, muscle loss, cognitive dulling, and motivation loss frequently misattributed to depression or 'just aging.' The Endocrine Society's menopause guidelines address testosterone as a component of comprehensive hormonal evaluation, not an afterthought.¹ Most DFW clinics skip it in women entirely or treat it as an optional add-on. At Magnolia, it's on every female hormone panel.

Failure 3: Still applying WHI fear to bioidentical hormones

The WHI study used synthetic progestins — specifically medroxyprogesterone acetate — structurally different from the progesterone your ovaries produce. The cardiovascular and breast cancer risk signals do not translate directly to bioidentical progesterone.■ The Endocrine Society's menopause guidelines explicitly differentiate synthetic progestogens from bioidentical progesterone in their risk assessment.¹ Providers still counseling patients away from hormone therapy based on WHI are applying a study of synthetic compounds to a different class of molecules. The evidence has moved. Clinical practice should have moved with it decades ago.

Failure 4: Skipping the thyroid panel

Thyroid dysfunction and hormonal decline produce nearly identical symptoms. They're frequently comorbid. A hormone evaluation without a complete thyroid panel — TSH, free T3, free T4, reverse T3, and thyroid antibodies — isn't complete. TSH alone misses patients who convert T4 to reverse T3 instead of active T3, producing hypothyroid symptoms despite a normal TSH.■ I've had patients who spent years on hormone therapy with suboptimal results because a thyroid conversion problem was sitting in plain sight in labs nobody ordered. Most clinics don't run this panel. At Magnolia, it's standard.

Failure 5: Pellet-first protocols that remove clinical flexibility

Pellets deliver a sustained hormone dose over three to six months once inserted. A newly initiated patient whose estradiol climbs too high, whose dose needs adjusting, or who develops a side effect at week six has no option for dose reduction — the pellet is already in. Pellets have a role for stable, established patients with known hormone response. Starting new patients on pellets before their pharmacokinetics are characterized is prioritizing the provider's convenience over the patient's clinical safety.

Failure 6: No physician actually involved in your care

This is the failure that matters most, and it's the least visible from the outside.

The women's hormone therapy market in DFW is dominated by medspa and wellness clinic models that are, in practice, NP-run operations. Texas is a restricted practice state — NPs cannot prescribe independently and are required by law to have a collaborating physician with a signed prescriptive authority agreement. That sounds like meaningful oversight. In practice, it often isn't.

Texas law requires the agreement to exist and specify how chart review will be handled. It does not require the physician to see any specific percentage of patients. It does not require real-time review. It does not require the physician to be on-site or regularly interact with the clinical operation. A physician can satisfy the full legal requirement by signing an agreement mandating quarterly review of a random chart sample — while an NP manages hundreds of hormone patients independently between those reviews. There is an active commercial marketplace where physicians sign these agreements for a monthly fee with minimal clinical involvement beyond the paperwork.

What 'physician-directed' actually means at most DFW hormone clinics: A physician signed a legal agreement. That physician may never review your chart, never interact with your care, and may not even be reachable if your NP has a clinical question about your case. You cannot tell from the website. The only way to know is to ask directly.

NPs are skilled clinicians within their training and scope. The issue isn't the NP. The issue is that hormone optimization — managing perimenopausal fluctuation, WHI risk stratification, estrogen timing windows, thyroid-hormone interactions, cardiovascular risk assessment, medication conflicts — requires physician-level clinical judgment beyond protocol-based care. When a case gets complicated, a protocol doesn't adapt. A physician does.

At Magnolia, Dr. Abdullah sees the vast majority of patients personally. For cases managed by our NP, every case is reviewed directly with Dr. Abdullah — not sampled, not batch-audited on a quarterly schedule. Reviewed. The physician oversight at Magnolia is a clinical standard, not a compliance checkbox.

What the Evidence Actually Says About BHRT Safety

The fear around hormone therapy in women has a specific origin and a specific misapplication problem.

The Women's Health Initiative trial enrolled women with a mean age of 63 — well past the perimenopausal window — and used synthetic conjugated equine estrogens combined with medroxyprogesterone acetate, not bioidentical compounds.■ The findings were real and important in their proper context. They were also applied far beyond that context for two decades.

The timing hypothesis: Hormone therapy initiated within ten years of menopause onset, or before age 60, carries a meaningfully different cardiovascular risk profile than therapy initiated later — supported by subsequent research and incorporated into the Endocrine Society's menopause guidelines.¹ A 47-year-old perimenopausal woman is in the optimal window. The WHI-driven hesitancy that delays that initiation doesn't make women safer. It closes a protective window that doesn't reopen.

What appropriate monitoring looks like: estradiol and progesterone at every follow-up, hematocrit surveillance in women on testosterone, breast cancer risk formally assessed before initiation, cardiovascular history reviewed as part of the workup, and a physician evaluating contraindications and adjusting protocols when the picture changes. That's the standard at Magnolia.

The Magnolia Evaluation: Specifically What We Do

These are attributable standards — not general descriptions of good hormone care, but the specific protocols Dr. Abdullah applies at Magnolia Functional Wellness.

Complete baseline panel — not a hormone snapshot. Total testosterone, free testosterone, SHBG, estradiol, progesterone, DHEA-S, LH, FSH, prolactin, TSH, free T3, free T4, reverse T3, thyroid antibodies, cortisol, insulin, fasting glucose, CBC, comprehensive metabolic panel, and lipid panel. Treating hormones without the metabolic and thyroid context produces incomplete results.

Symptom-led interpretation, not reference-range dismissal. Lab values are interpreted in the context of symptoms, age, cycle history, family history, and functional goals. A number that's 'within range' does not end the clinical conversation when the symptom picture is significant.

WHI risk stratification done correctly. Before initiating estrogen therapy, cardiovascular history, thrombophilia risk, and breast cancer history are formally assessed. The Endocrine Society timing hypothesis is applied to the individual patient — not a blanket protocol that ignores age and menopause onset timing.

Testosterone evaluated and treated in women when indicated. Not an optional add-on. Fatigue, cognitive dulling, flat libido, muscle loss with confirmed low testosterone — addressed as part of the protocol.

Bioidentical compounds through LegitScript-certified pharmacies only. Compounding quality varies enormously. Magnolia uses LegitScript-certified compounders exclusively — for potency accuracy, contamination standards, and regulatory accountability.

Delivery method chosen for clinical fit, not clinic convenience. Subcutaneous pellets, topical creams and gels, injections, oral or sublingual tablets — all available. New patients start on adjustable delivery methods. Pellets are an option once hormone response is established.

Follow-up labs at 4–6 weeks post-initiation, then every 3–6 months stable. Full panel evaluated each time — not just the primary hormone. Symptom response assessed at every visit alongside the numbers.

Every NP-managed case reviewed directly with Dr. Abdullah. Not sampled. Not retrospectively audited. Reviewed. If you're seen by our NP, Dr. Abdullah knows your case before your next visit.

The Question I Get Most Often

'I've been told my labs are normal for years. How do I know if I actually need hormone therapy?'

'Normal' means your values fall within a range derived from population averages that include women across all age groups and health statuses. It doesn't mean your levels are optimal for a 44-year-old who needs to sleep, think, and function at full capacity. It especially doesn't account for perimenopausal fluctuation, where a single draw can look normal on a day when you feel normal — and your estradiol was 40 points lower three days ago.

The clinical question isn't 'are your labs normal?' It's 'are your hormone levels appropriate for your age, your symptoms, your history, and where you are in your reproductive life?' Most providers who've told you your labs are fine were answering the first question. At Magnolia, we answer the second.

At Magnolia: The evaluation doesn't end at a single number. It ends when we have a complete clinical picture — full hormonal and metabolic panel, symptom burden, cycle history, thyroid status, and contributing factors all accounted for.

Frequently Asked Questions

What does the full initial workup look like at Magnolia, specifically?

Total testosterone, free testosterone, SHBG, estradiol, progesterone, DHEA-S, LH, FSH, prolactin, TSH, free T3, free T4, reverse T3, thyroid antibodies, cortisol, insulin, fasting glucose, CBC with differential, comprehensive metabolic panel, and lipid panel. Results reviewed directly with Dr. Abdullah — not sent through a portal message that says 'within normal limits.' Every value, in context, in plain language, at the same visit.

I'm still having periods. Can I benefit from a hormonal evaluation?

Yes — and this is more important than most people realize. Perimenopause frequently begins in the late 30s, years before cycles stop. You can be 39, cycling regularly, and experiencing significant hormonal disruption from fluctuating estradiol. Sleep disruption, mood instability, brain fog, irregular cycles, anxiety — these are perimenopausal symptoms. You don't have to be postmenopausal to benefit from evaluation and targeted support.

I've heard pellets are the best delivery method. Is that true?

Pellets work well for stable patients with established hormone response. 'Best' is the wrong frame — the right delivery method depends on your individual clinical picture, dose stability, lifestyle, and whether your pharmacokinetic response has been characterized. A well-managed injection or cream protocol beats a carelessly dosed pellet every time. New patients at Magnolia start on adjustable delivery methods first.

What's the real story on breast cancer risk and hormone therapy?

The elevated breast cancer risk in WHI applied to synthetic progestins — medroxyprogesterone acetate — not bioidentical progesterone. The evidence on bioidentical progesterone does not show the same risk signal.¹ Breast cancer history and family history are assessed before initiation at Magnolia, and patients with significant risk factors receive a formal risk-benefit discussion. This is a physician-level conversation, not a protocol checkbox.

How is Magnolia different from the hormone clinics I keep seeing advertised?

Most of what's advertised in DFW is an NP-operated medspa with a physician on the compliance paperwork. Texas law requires a collaborating agreement — it doesn't require that physician to see your chart. At Magnolia, Dr. Abdullah sees the vast majority of patients personally, and every NP-managed case is reviewed with him directly. Beyond oversight: the full thyroid panel is standard, testosterone in women is treated as a legitimate clinical finding, WHI risk is applied correctly, and monitoring is structured — not optional.

How do I know if a clinic actually has a physician involved in my care?

Ask directly: 'Will I see the physician at my initial evaluation, or an NP?' and 'If I'm managed by your NP, how often does the physician review my case?' A clinic with genuine physician involvement answers both questions specifically. A clinic running a compliance structure will be vague. In Texas, the law requires the agreement — not the physician's presence in your care. The gap between those two things is where most of the quality variation in DFW hormone therapy actually lives.

Do you see patients outside of Southlake?

Yes. Telehealth consultations are available for patients across Texas. Initial labs can be ordered to a draw site near you; ongoing management is handled remotely for established patients. The evaluation is identical whether in-person in Southlake or via telehealth — same panel, same protocol standards, same follow-up schedule.

References & Further Reading

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Ready to get a complete picture?

Book a comprehensive hormone evaluation at Magnolia Functional Wellness in Southlake, TX.
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