THE LONDON PMS AND MENOPAUSE CLINIC

February Newsletter

John Studd, DSc, MD, FRCOG
Consultant Gynaecologist,
46 Wimpole Street
London W1G 8SD

February 2015 Newsletter:

I have been remiss keeping up-to-date with the newsletter so please accept my apologies. My excuse is that I am busy writing a book on hormones and depression which should have written years ago. Having just finished the draft on a chapter on libido and depression and thought I would send it along as my current newsletter.
I hope that you may find it interesting and if so please do send it to every friend and particularly to your friendly psychiatrist who needs this information about treatment of depression in women.

Depression and loss of libido

One may ask, what has a libido got to do with depression? The answer is quite a lot; because they are interrelated by the changes in hormones levels and changes in personal circumstances. I always ask about the libido. If it is fine or adequate for the couple no further questions are needed. If not there will probably follow some very personal questions about having orgasms or not, or easy orgasms. I would even ask whether orgasms occur with no partner around - the so called "solos". These questions are normally asked and answered without any embarrassment from either side as they appear relevant to the presenting problems and women are pleased to have a reason to discuss such private matters with a neutral practitioner.
Libido, I believe is a barometer of how well people feel. By "people" in this context I mean of course women. I have no interest in men unless they play rugby or sing at the opera. Libido is a measure of the physical, emotional, hormonal and relationship characteristics of the woman. Fortunately a loss of libido can be easily treated in conjunction with other menopausal problems including depression with the appropriate hormones.
I often make the point in lectures that libido is a complex coordination of Heart, Head and Hormones. If it is simply a hormonal problem they can be treated easily with the appropriate therapy – Hormones - usually estrogen and testosterone and always by the transdermal route by gels, patches or implants. Oral estrogens have side effect and are not used. If the woman does not like her partner because of his behavior or lack of attention/attraction that is a problem of the Heart that doctors cannot sort out. Similarly if the Head is cautious because of the woman's background and beliefs about the whole concept of sexuality and sexual pleasure that is a problem that may need appropriate counselling.
Depression certainly produces a loss of libido and a loss of all other emotional and physical pleasures in life. The wrong treatment does not help. If depressed women are given antidepressants there seems to be an immediate loss of libido as well as frequent weight gain, which is very difficult to correct while they are still having antidepressants. The danger is that if the antidepressants do not work because the woman has Reproductive Depression of hormonal origin. They will then be given another antidepressant and then another one

and the woman's sex life becomes a thing of the past producing sometimes further tensions in the marriage.

But it gets worse. Cyclical depression which has failed to respond to repeated psychiatric interventions will often be incorrectly labeled Bipolar Disorder. Now she is in real trouble with a new batch of personality and libido destroying drugs that will be prescribed for her as well as hospital admission for what should be an easily treatable condition.

Estrogens often improve the local menopausal problems of atrophy in the pelvis after the menopause. Collagen is lost from the vulva, clitoris and vagina as well as other pelvic organs, particularly the uterus and the bladder. A smaller uterus is of no consequence but atrophy of the bladder can cause problems.

Many women in this age group suffer from vaginal and vulva dryness which leads to discomfort during intercourse followed by a wish to avoid sexual intercourse at all costs. This is due to the vaginal atrophy of estrogen deficiency. Apart from causing discomfort and burning during intercourse it can also lead to bladder problems and recurrent cystitis after almost every episode of intercourse. These problems can strain the relationship and provide further indications to give estrogens.

If the loss of libido persists then she should have transdermal testosterone. It is very important to reassure women that testosterone is a normal female hormone that is present in ten times the concentration of estrogen. There are more androgen receptors in the brain than estrogen receptors and so we must conclude that testosterone is very normal and very valuable female hormone. We know of the importance of testosterone because women whose ovaries have been removed at hysterectomy lose their ovarian androgens and although estrogens will prevent hot flushes sweats and vaginal dryness they are left with debilitating problems of loss of libido, loss of energy, depression headaches and loss of concentration. This is called the Female Androgen Deficiency Syndrome (FADS) and is treatable with testosterone.

I have been looking through all of my records of patients with depression who have been given estrogens and I find that 93% of my patients also have testosterone. The 7% who escape testosterone do so if the patient has adequate libido for her needs and doesn't want to experience an unwanted increase in sexuality. Otherwise I am clearly a great enthusiast for this treatment for libido problems, depression and problems with energy such as chronic fatigue syndrome (M.E.).

There is only one slight problem with testosterone admiration and that is availability.

It has been known for decades that oral testosterone is not quite safe in women or men as it can produce liver damage because of the "first pass" effect of testosterone being absorbed from the gut and going straight to the liver. This risk is probably very small but there are now no licensed preparations for oral testosterone available.

We are therefore left with implants, gels or patches. Transdermal testosterone implants inserted through the skin into the fat of the abdomen or buttock and have been available for about forty years. These work well but currently there is a problem in that manufacture ceased for two years following a decision by the company's accountants, not doctors. However they are now slowly being drip-fed into the market at ten times the original cost. I have a supply of 200mg pellets that I have to cut in half but at the time of writing we expect to obtain next month testosterone pellets of the correct 100mg dose from a new supplier. However we have been promised this monthly over the last two years. We will have to wait and see.

My biggest academic regret in my career is that although I was the first in Europe to use testosterone pellets and I published a study of 150 patients 30 years ago, it was a very large but poor uncontrolled study that merely compared the changes in libido with estrogen implants alone and then testosterone implants were added to those with inadequate libido improvement. Of course the testosterone worked, but as it was an uncontrolled study

without a placebo arm. I have to confess that in retrospect it was a fairly worthless publication and many years later an Australian researcher visited my clinic and within six months had published an excellent paper comparing testosterone pellets with estrogen against placebo arm and this now is deservedly the definitive early paper on this subject. In my haste to publish I had blown the opportunity to write a scientifically sound paper twenty years previously.

Not everybody, particularly younger women want the minor surgical procedure of an implant so it was important to have some more acceptable method of administering this hormone through the skin. This was initially done with a patch, the Intrinsa preparation containing a low testosterone dose which improved sexuality creating two extra sexual episodes per month. The Food & Drugs Administration (FDA) did not think this was an adequate improvement but nevertheless gave the product a license. However, the public also seemed to think the modest improvement in libido was not adequate and as it did not produce an adequate profitable market share the company withdrew it October 2012. Fortunately estrogen patches are available in the appropriate doses and are quite popular, they work well but there is a problem of skin irritation and staining. The preparation Estradot with the smallest surface almost avoids this local problem.

The best preparation now without doubt is transdermal testosterone cream or gels. However at the time of writing these gels are only licensed for men. Therefore it is usual to use approximately one tenth of the male dose daily making a single tube (the daily male dose) last for about ten days. This works well but usually gives a concentration level slightly above the normal range. I am not at all concerned by this but no doubt this is way the gels are more effective than the Intrinsa patch. This Testim or Testogel will be given in combination with the oestradiol gel Oestrogel. This combination is my first choice hormonal therapy for virtually all patients who need HRT for their menopausal symptoms or their depression or their libido or their low bone density.

Thus the combination of transdermal oestradiol and transdermal testosterone is very effective treatment for loss of libido and the many types of depression that occur in women. They will also over the years correct and prevent osteoporosis if used long enough.

The treatment is also very safe and we must ask ourselves why is it not used more often for depression in women or for libido problems and also for the long term for the almost total avoidance of osteoporotic fractures.

Professor John Studd

46 Wimpole St
02074860497