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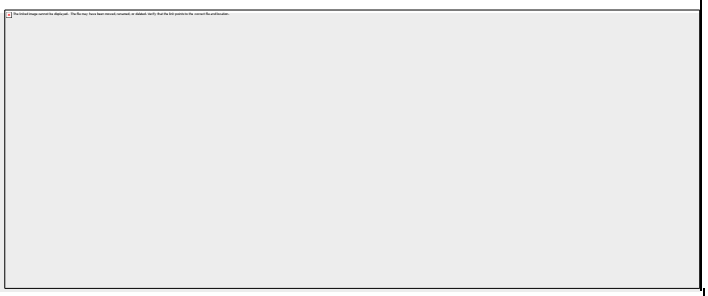
THE LONDON PMS AND MENOPAUSE CLINIC

December Newsletter



Dear

Testosterone:

As highlighted in my last newsletter there has been a manufacturing problem with hormone pellets. However we now we have both the oestradiol and testosterone pellets available. This is good news for those who have been using Testogel or Testim three times weekly. Although the gel works well it is easy to put on too much or too little over the months and very easy to forget.

It may interest you to know that the pharmaceutical company involved is producing 200 mg pellets for men, not the 75 mg or 100 mg pellets for women, as if male hypogonadism is more common than female androgen deficiency with associated symptoms. Perhaps men are more important! However, they have supplied pellets of 200 mgs which can easily be cut in half to achieve the correct female dose.

Testosterone therapy for men has a place. Many middle aged men have problems with tiredness, depression, irritability, loss of libido and difficulty in having or maintaining an erection. This so called “grumpy old man” syndrome is often the result of testosterone deficiency and with these symptoms they should have their testosterone measured and at the same time it is convenient to check on thyroid function, liver function, prostate antigens as well as anaemia. This is a simple blood test which can be done without consultation with the results phoned through the following day. For those men that have low testosterone, discussion is required whether transdermal testosterone in the form of gels or implants would help these problems. For both men and women it is better to use transdermal testosterone than oral testosterone products which are synthetic, less effective and potentially can cause liver damage as 95% of the medication will have a first pass passage through the liver producing changes in liver function and coagulation factors. The correct implant dose for men is between 600 and 800 mgs every 6 months using the 200 mg pellets that are now available and very suitable.

Depression:

I am still fighting with psychiatrists about the number of women with premenstrual depression, post natal depression and climacteric depression who are given antidepressants and mood stabilising drugs rather than oestrogens.Now 90% of my new patients have depression which has not responded to treatment from psychiatrists and in this large group of patients I probably see about 5 each week whose characteristic premenstrual depression have been misdiagnosed as bipolar disorder and treated with antidepressants and mood stabilisers such as Lithium. This is of no benefit whatsoever because the condition is an endocrine problem and not a psychiatric problem.

I have arranged a meeting with the Royal College of Psychiatrists and the Royal College of Obstetricians and Gynaecologists at the RCOG in London on 26th January and I enclose a programme which might interest you. **(1 - Click here to view the document)** The admission fee is quite expensive for doctors but I have arranged a cheap deal for the public who can attend the days meeting for a £100.00. If you are interested with a good story to tell the psychiatrists I will be very glad to see you there. I have just published a paper on a guide to treatment of depression in women by oestrogens which I sent out in the last newsletter but I think that many patients could not open it. **Best of luck with this one. (2- Click here to view the document)**

It is not possible to diagnose hormone responsive depression by measuring hormone levels. They will be normal in the premenopausal range but the clues are in the history.

There are 8 important questions to establish to diagnose PMS and to exclude bipolar disorder.

1. There is a history of PMS as a teenager
2. There is relief of depression during pregnancy
3. Depression started or occurred as post natal depression
4. Premenstrual depression recurred when menstruation recurred after delivery
5. Premenstrual depression becomes worse with age blending in to the menopause and transition about the age of 45, becoming less cyclical
6. There is often recurring symptoms of cyclical somatic symptoms such as menstrual migraine, bloating or mastalgia. These physical symptoms do not occur in bipolar disorder.
7. These patients usually have runs of 7-8 good days a month.
8. These patients have recurrent episodes of depression related to periods but rarely or never have “highs”

It is a tragedy when simple PMS is misdiagnosed as “bipolar disorder” and young woman can then have many years of inappropriate drug therapy and hospitalisation when the treatment of suppressing the menstrual cycle with transdermal hormones is very simple, very inexpensive and effective. The addition of electroconsvulsive therapy ECT is a further unnecessary assault on these patients who have in reality have a hormone responsive depression. There is a move to rename the syndrome of premenstrual depression, post natal depression and menopausal depression to “Reproductive Depression”. I think that makes a lot of sense but it will infuriate psychiatrists.

If any of you wish to come to the RCOG and debate this with psychiatrists, you will be very very welcome.

General Principles of HRT:

It is important to note that there is no evidence of serious harmful effects of HRT in women who start below the age of 60 or who start within 10 years of the menopause. This would include all of the premenopausal period related depressive patients.

There is little doubt now that transdermal oestrogens by implants, patch or gel is safer than oral therapy because oestradiol is not converted to a less active oestrogen, estrone and it avoids the first pass liver effect which would in oral therapy stimulate the many coagulation factors that are responsible for the small increase in deep vein thrombosis that occurs in the oral contraceptive and oral HRT.

It is also clear that women who are having oestrogen alone, i.e. without progestogen if they have had a

hysterectomy, have a much reduced incidence of breast cancer, heart attacks, strokes and even have fewer deaths within the 7 year study period. It is for this reason that women post hysterectomy should be very easy to treat with transdermal oestradiol, transdermal testosterone with no progestogen with no rush of progestogenic symptomatic side effects or increased risk of thrombosis. This is why I routinely use 7 days of progestogen a month in women with a uterus rather than the orthodox 14 days. It seems to make sense.**(3 - Click here to view the document)**

If any new patients want old newsletters, please let me know.

Until then may I wish you all good health and a Happy Christmas holiday.

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