JANUARY 2016 NEWSLETTER

Dear patient

I mentioned my chemotherapy and radiotherapy in my last newsletter, perhaps unwisely because several patients have expressed some anxiety on my behalf in case I am ill. This treatment was seven years ago when I had my throat cancer and I am now clear and the therapy is now a thing of the past. I am totally recovered. I thought that I would reassure that I do not plan to drop off the perch anytime soon.

TESTOSTERONE FOR MEN

As I am compelled to write another newsletter as an addendum I thought that I would also inform you about the problems of testosterone deficiency in men often called 'the Grumpy Old Man Syndrome' by the press. The obvious symptoms of this are loss of energy, irritability, loss of libido, poor erections and depression which if testosterone deficiency is proven in blood tests can be helped by the appropriate testosterone gels or injections. But there is another related problem - osteoporosis. We are all aware that one in three women will suffer an osteoporotic fracture sometime in their lives which should be preventable by having long term transdermal oestrogens. That is part of my philosophy of the long term treatment of patients. However we forget that one in twelve men have an osteoporotic fracture sometime in their lives and it may be related to steroid therapy, family history or testosterone deficiency. It is surprising how many patients come with erectile, loss of libido and tiredness problems who have low testosterone also have very low bone density. Fortunately this can be corrected by the same testosterone therapy but it can only be treated of course if we can diagnosed the presence of low bone density by doing the appropriate scans. Just a thought for my patients to pass on to their husbands. I cannot stress enough how important is this early diagnosis and appropriate treatment. They can come here for the usual male profile (no consultation charge) or they can ask their GP's to measure testosterone and also the PSA. They can then come here for a bone density scan if the T levels are low.

NICE

The really good news over the last few months is that NICE at last have published their first report on HRT. It has been recommended that HRT is prescribed more frequently by GPs because the benefits clearly outweigh the risks. They stress the importance of transdermal oestrogens over oral. I have not used oral therapy for about twenty years because transdermal therapy by gels, patches or implants do not induce coagulation factors in the liver and there is no increased risk of deep-vein thrombosis, heart attacks or strokes. In fact the incidence of heart attacks is almost certainly lower with oestrogen therapy in general and particularly by the transdermal route.

It is recommended that general practitioners prescribe HRT more often for hot flushes and night sweats and also consider HRT 'to ease low mood that arises as a result of the menopause'. At last! NICE also states that oestrogen only HRT has little or no increase in the risk of breast cancer (in fact it is a lower risk) while HRT with continuous progestogen can be associated with an increased risk of breast cancer. But any increased risk disappears after stopping HRT. This will explain why I am so keen on transdermal hormones and even in women with a uterus I prescribe the minimum duration of natural progesterone rather than continuous or 12 day addition of synthetic progestogen for endometrial protection.

I am still having trouble persuading psychiatrists that the first line treatment for depression in perimenopausal women is oestrogens but I have taken part in a debate with psychiatrists that will soon be published in the British Journal of Obstetrics and Gynaecology. I am enclosing my summary which stresses my support for this treatment and also my anger at arrogant and bone headed psychiatrists for deliberately ignoring thirty years of literature demonstrating that oestrogens help menopausal depression, postnatal depression and premenstrual depression. It is easier for them to prescribe their familiar antidepressants. The problem is that they don't work ! The battle continues.

DEBATE

ESTROGENS ARE FIRST LINE TREATMENT FOR DEPRESSION IN PERIMENOPAUSAL WOMEN

Perimenopausal women with depression (PMD) suffer the many symptoms of the menopausal transition before the cessation of periods together with anxiety, poor concentration and loss of libido. These women often have a continuum of depression from an early age with a history of hormone related depression of premenstrual depression (PMS) and a history of post-natal depression (PND). The PND then becomes cyclical with the return of periods, becoming worse with age until the mid-forties. They are then denied hormone therapy because they are not post-menopausal. This pattern of depression in women is best called Reproductive Depression (RD) and cannot be diagnosed or excluded by blood tests because the hormone levels will usually be in the premenopausal range Studd J Nappi R Gynec Endocrinol 2012 28 42-45.

Transdermal oestrogens are safer than oral oestrogens in that they do not carry any extra risk of thrombosis and also have been reported as more effective in the treatment of depression. This should be by patches or gels giving a reasonably high dose using oestrogen patches of 100ug twice weekly. Soares CN et al 2001 Arch Gen Psychiatry 58 529-34 A similar dose of gels should be used. There is often a loss of libido and loss of energy at the same time and these women will benefit from transdermal testosterone although it is unlicensed in women it can be achieved by testosterone gel, Testim or Testogel using approximately on tenth of the licensed male dose. Studd J 2011 Climacteric 14 637-642. Those women with a uterus have to have cyclical progestogen but as these women are progesterone intolerant it is justifiable to use a shortened course of Norethisterone, Provera or Utrogestan for seven to ten days each month.

Not all women will have the depression removed by hormone therapy and there will be a case for the use of antidepressants in a few women but I believe this is second line treatment for these patients who do not respond to the more logical transdermal oestrogens. I have tried to arrange a lecture for years at the RCPsych but I am informed that there is no interest in this treatment among senior psychiatrists. Is it a territorial issue? Possibly. Is it a safety objection? This is unlikely as transdermal oestradiol is safer than long term antidepressants. Smoller et al 2009 Arch Int Med 2009 169 2128 -39. Essentially the problem is the failure to recognise the hormonal component of perimenopausal depression. This failure leads to an interesting catalogue of explanations. 1 Treatment resistant depression (wrong treatment) 2 Borderline personality disorder (a familiar DSM V diagnosis) 3 Bipolar Disorder (It is cyclical! After all) 4 Premorbid history of depression (depression also occurred before the current PMD. It was PMS or PND - usually both.)

Most psychiatrists are not effective when treating depression in women. I hope the few interested psychiatrists will be able to instruct them .I have failed.

Please pass on the newsletter to your pals and your friendly psychiatrist

With best wishes and happy new year

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