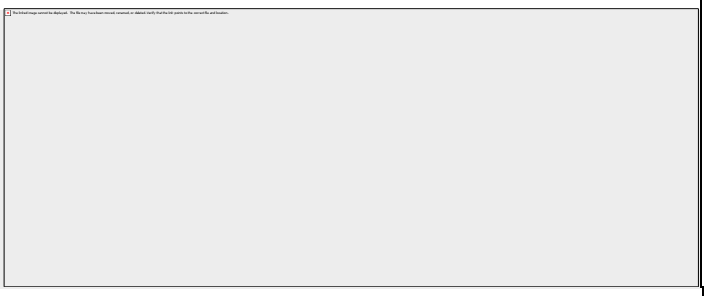
20th May, 2011

THE LONDON PMS AND MENOPAUSE CLINIC

June Newsletter



Dear

I hope you have found the February newsletter useful and informative. The plan was to write them each month but this one in June is a little delayed.

Testosterone and Libido

Last month I gave the annual Royal College of Obstetricians and Gynaecologists Founder's Oration on "19th century attitudes to female sexuality as portrayed in medicine, literature, art and music". This was a historical lecture reminding the audience of what brutal things psychiatrists and gynaecologists did to women in the last half of the 19th century in order to suppress their sexuality and treat "menstrual Madness". The evening was elevated by some wonderful examples from the music of Richard Strauss. A copy of an earlier version of the lecture, without the music, can be obtained by the following link. I hope you find it interesting and not too shocking.

Testosterone

How things have changed. In the 19th century there was a fashion for removing ovaries and even removing the clitoris in women who masturbated or were seen as suffering from nymphomania! These details can be seen in the attachment above. Female sexuality was suppressed during those days but now a healthy sexual life is regarded as normal and desirable. The problems of sexuality including lack of arousal and lack of orgasm are even regarded as a "disease" that should be treated. It

Hysterectomy

I have previously written about the great benefits of the much maligned total hysterectomy, that is removal of uterus and ovaries in women with cyclical symptoms of pain, heavy bleeding or PMS as they will not only be symptom free but can take their replacement hormones without progestogen. It should also be remembered that 4% of women die of cancer of the uterus, ovaries and cervix After this surgery in the premenopausal woman it is essential that the woman has replacement hormones because she would have lost her ovarian hormones. That is not only oestrogen but also the missing androgen testosterone should be given either by implant, gel or patch.

has an official label Human Sexual Deficiency Disorder (HSDD) that can be treated in many ways. The traditional method would be through discussion, counselling and psychotherapy of both partners or by sensate focusing, a technique pioneered by Masters and Johnson who did the original work on the physiology of female sexuality defining the four stages of 1) excitation, 2) plateau 3) orgasm 4) resolution. Now transdermal testosterone is licensed for both loss of libido and failure to achieve orgasm, which has the added benefit of improving energy, mood and general wellbeing. Many of us have been treating this by testosterone implants for 30 or more years with great effect. More recently the availability of testosterone patches or gels although less convenient for women give more control over dosage, response and any desire to discontinue treatment. It should be remembered that testosterone is not just a male hormone as it is present in the young woman at 10 times the level of oestradiol. Similarly, there are more androgen (testosterone) receptors in the brain than oestrogen receptors. It is a vital female hormone for mood, energy, libido and self-confidence and it is for this reason that perhaps 70% of my patients receiving HRT in various forms also are prescribed testosterone. It should be emphasised that this inclusion may be for reasons other than sexuality. There are certainly positive effects upon a woman's sexual response but even more interesting are the non sexual changes that occur in women who have a greater sense of well being, energy, self confidence and even communication skills. No effective

Traditionally a hysterectomy is performed for fibroids , bleeding , uterine prolapse or cancer but more recently I have become increasingly convinced that hysterectomy and removal of ovaries has a place for the severe cyclical symptoms of PMS if they are not controlled by medical means. Many postmenopausal women on oestrogen/progestogen HRT, and also younger ones with PMS are progestogen intolerant .Such women have monthly depression anxiety tiredness and headaches as well as possible coexistent heavy and painful periods as a result of their own cyclical progesterone or the synthetic progestogen given in medication . They will of course need replacement of oestrogens and testosterone after surgery. Such HRT is very straightforward—no uterus—no progestogen—no problems !!

Although I am an advocate of a well performed hysterectomy, performed skilfully for the correct indications preferably by laparoscopic key hole surgery, I would add that I have stopped doing all surgery, so this statement is not in any way a commercial!

PMS or BIPOLAR DISORDER

Bipolar Disorder has become a common , even fashionable diagnosis , which is often incorrect in women with the cyclical endocrine problem of Premenstrual syndrome .I am busy writing up 20 patients who have had many years of antidepressants mood stabilizing drugs and even electroconvulsive therapy only to be totally cured by the appropriate hormone treatment suppressing ovulation and the cyclical hormonal changes which produce the cyclical symptoms of PMS. More in the next newsletter. Until then visit the section on depression at **www.studd.co.uk**

treatment is without side effects and a few women on long-term testosterone therapy may achieve higher than normal testosterone levels with slight excess hair growth and even acne. This will stop if the testosterone is discontinued. Theoretically, testosterone can also cause slight clitoral enlargement and increased sensitivity but not surprisingly, women never complain of this any more than a man would complain if a certain treatment increased the size of his penis.

There have been reports in the Press that HSDD is a "disease" manufactured by the pharmaceutical industry to allow them to sell their products. The pharma industry is guilty of many things, encouraging doctors and patients to use expensive in patent treatment than older non profit treatments but a desire to treat poor sexuality in women is laudable. The alternative attitude takes us back to the 19th century and the attempts to suppress normal sexuality in women.

Breast Cancer

It is now generally accepted that there is a small increase in breast cancer in women taking HRT long term and in the attachment to the last newsletter I quoted an extra 1% life time risk of developing breast cancer. The fact that these breast cancers have a better prognosis is barely relevant compared with the desire to avoid such a problem in the first place.

However, this month there has been yet another article indicating that oestrogen alone is associated with a decrease in breast cancer. This was first reported in 2004 from the oestrogen only arm of the WHI study which also showed a 42% decrease in

Best Wishes

I hope you find this newsletter useful. If you have any requests for future topics please let me know. I plan to discuss the reduction of heart attacks with HRT and the possible but unlikely increase in strokes. It is the age of starting HRT which is critical as the side effects only occur in those starting over the age of sixty.

Please feel free to telephone or email me with any questions.

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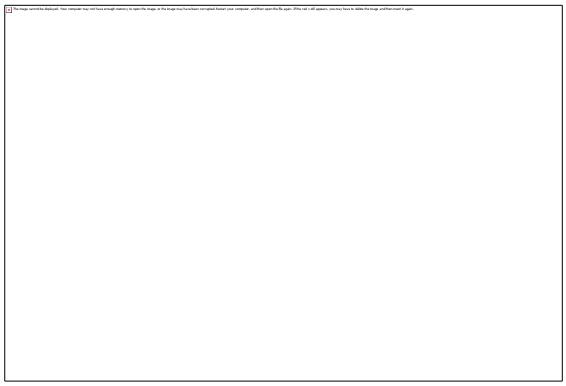
Link to my website



heart attacks 27% decrease in breast cancer, 42% decrease in colorectal cancer and a 28% decrease in deaths and a 30% decrease in deaths but the study was stopped too soon and these apparently large benefits were not significant. In the latest study, they mostly are.

Thus there is mounting evidence that it is the progestogen component of HRT, which is the risk factor, and therefore the women in the initial WHI study who were given continuous oestrogen and continuous, i.e. every day progestogen did show a slight increase in most side effects. It is for this reason that I do not use a continuous combined oestrogen/progestogen preparation although it gives the advantage of no bleeding (amenorrhoea), and for many years have even modified the orthodox 14 days of progestogen each month, first described by my research team almost 30 years ago, to 7 days each calendar month in women with a uterus. This duration of progestogen is long enough to protect the uterus and logically should reduce any risk of continuous progestogen.

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