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THE LONDON PMS AND MENOPAUSE CLINIC

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Dear,

Thank heaven for the Danes

Depression

I must thank all of you who returned my depression questionnaire.

Of the 304 patients who replied and had a history of depression 200 said the depression had 'improved a little or a lot' after estrogen therapy, 92 said the depression was 'cured' and 11 women said that the hormones had "no effect" upon the depression.

95% said the treatment was 'life changing for the better', 5% claim that it was not life changing at all and no one claimed that it was life changing in a negative way. That is a good start!

It is interesting that of 185 patients who had been pregnant 110 had developed postnatal depression and 97 of these women who had been pregnant suffered both premenstrual depression and postnatal depression. There is still a lot of work to be done but it is overwhelmingly apparent that there is this hormonal link between premenstrual depression and postnatal depression and perimenopausal depression. It is probably variants of the same endocrine disorder due to variations in estrogen and progesterone levels and the correct treatment should be well-supervised hormone therapy to remove these fluctuations. Hence my advocacy of the term Reproductive Depression

The place of antidepressants, mood stabilising drugs and ECT should be questioned in these particular patients who have this"hormonal clue" in their history. In fact of 12 patients who had previously had ECT, 11 claimed to be 'cured' by hormone therapy. Similarly 48 patients had received Lithium or Quetiapine which indicates that a bipolar diagnosis had been made or suggested by psychiatrists or GP's and of those 28 claimed that they were 'cured' and were no longer having antidepressants or any other psychiatric drugs, 16 were 'much improved' and only 2 of these patients had not improved.

The residual problem is of course progestogen because these women with severe cyclical depression are usually progesterone intolerant.136 out of 233 women given oral progesterone or progestogen because they had a uterus developed severe PMS type symptoms .76 of these had a Mirena IUS inserted and 48 ultimately had a laparoscopic total hysterectomy. Some had both a Mirena followed by surgery. I don't yet have the depression cure rate after hysterectomy but I cannot remember any

whose depression has been not effectively cured. Perhaps my memory is selective but I will soon have the exact data for publication and for the next newsletter.

I would add that I stopped surgery 3 years ago so it not a commercial for my practice. My current obsession is to persuade psychiatrists that although there is certainly need for antidepressants for severe depression there is another more effective way to treat many (not all) women with severe cyclical, postnatal or perimenopausal depression and to stop them treating severe PMS, misdiagnosed as bipolar disorder, with powerful unnecessary mood stabilizing drugs with their frequent serious side effects.

Libido

Many of you have also received testosterone through the skin because this important hormone has a beneficial effect upon energy, mood and libido. Do not forget that this is a female hormone which is present in 10 times the quantity than oestrogens in healthy young women. Indeed, there are ten times more androgen receptor sites in the brain than oestrogen receptor sites. It is therefore a vital female hormone not a male hormone although hopefully men have rather more than it than women. Testosterone therapy is becoming more and more accepted as an important and effective way of treating a low libido in women and without doubt it is best given in a subcutaneous way by gels or implants. For ten years there have been testosterone patches (Intrinsa) but production of this has now ceased, no doubt because the patches were less effective and less popular than the gels.

This week a large article in the Daily Mail states that I support the use testosterone for loss of libido, as indeed I do, and that I am using a new low dose Testosterone skin patch. That is incorrect. Even the standard T patch dose has been discontinued as the response, on that dose, was inadequate and it produced too many skin reactions. Testosterone gels or implants are the answer as oral synthetic methyl testosterone was discontinued years ago for safety reasons.

I often make the point that libido is a complex mixture of Heart, Head and Hormones. We can do great things by manipulation of oestrogen and testosterone but if the woman doesn't like her partner or has serious mental hang ups about her sexuality there is not a lot that hormones can do about it.

Remember that antidepressants nearly always decrease libido as well as producing weight gain. That is yet another reason to avoid them if possible.

Safety from Denmark

However the best HRT news has come from Copenhagen. Gynaecologists and physicians in that city have already stressed that oestrogen should be first choice for the treatment of osteoporosis and they also successfully challenged the claim from the Million Women Study that the benefits of oestrogen on bone density 'rapidly' disappeared. That was not logical and certainly not the clinical experience although it has used by bone physicians to justify not using oestrogen therapy. This view was refuted by a large long-term study 5 years ago from Copenhagen, which clearly showed that the benefits on bone density lasted for at least up to seven years after discontinuing oestrogen therapy- as one would expect. More recently other Danish workers have published in the British Medical Journal a large 16 year study comparing women who have stopped oestrogen therapy with for those who continued .The evidence is quite clear that the women who continued HRT had 40% fewer deaths during the study period, 50% fewer heart attacks, no more strokes and even a small (statistically

insignificant), 20% reduction of breast cancer. This is in keeping with the many studies, which predated the clinically incompetent WHI study.

Thus we have had young women in the 40s and 50s denied the symptomatic relief and the long-term health benefits because of bad American epidemiology and even worse British epidemiology. Thank heavens for the Danes!

The WHI investigators have now retracted virtually all of the alleged side effects now that they have looked at their own data from women starting HRT below the age of 60 (95% of patients) particularly in women who have had a hysterectomy and do not need progestogen. It is now clear that it is progestogen, particularly if continuous, which is the risk factor.

Last month I was in Lisbon trying to persuade physicians that oestrogens are a more effective and safer treatment for low bone density for women under 60 years old than bisphosphonates or Strontium. The lecturer after me was one of the original WHI investigators, a physician, who acknowledged the mistakes made in the original publication which didn't separate women who started HRT before 60 (good results) and those who started over the age of 70 (bad results). Most of all he regretted that millions of women from the American baby boomer generation had been denied this preventative treatment due to the false interpretation of a bad $ 1 billion piece of epidemiology

I realise that many of you are my patients because you are unable to receive the correct treatment on the NHS because this misinformation about the dangers of HRT is now in the undergraduate textbooks.It will take a generation for it to be removed. ***Until then we have to persuade GPs that HRT is effective and safe particularly in women who start this treatment under the age of 60***. I know that many of you send these newsletters to your pals but also think about your GP and your friendly psychiatrist if you know any.

Keep well and best wishes for 2013
Yours sincerely

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