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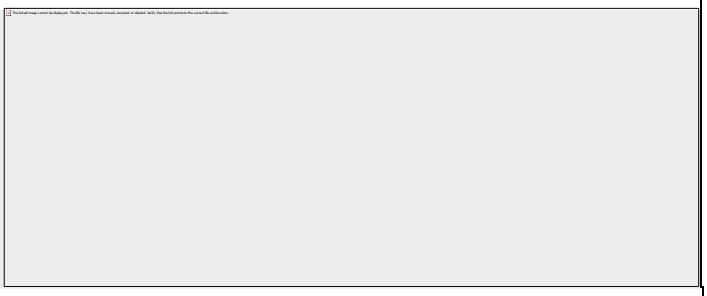
THE LONDON PMS AND MENOPAUSE CLINIC

September Newsletter



Dear

Testosterone is in the news again. We read that Jane Fonda at the age of 72 uses testosterone gels to improve her sex life. Good for her. Most doctors in the USA have always been a little uncertain about the value of testosterone in women but they seem to be learning fast with a huge increase in the use of testosterone pellets.

You will mostly be aware that in the UK there is a production problem with testosterone implants. The company MSD who have taken over Organon are not too keen to recommence manufacture because there is so little profit in it for them. The problem that these large pharma companies are now run by accountants who recognise that there is less profit in supplying two pellets per patient per year than one tablet per patient per day. Although there is a current shortage of testosterone pellets, I am sure we will put this right once that the American company Barton Pharmaceuticals that manufacture pellets is able to obtain an export license. This problem is with UK authorities, not the USA.

I have been using testosterone pellets for more than 30 years and in fact two thirds of my patients having HRT use testosterone either by implants, gels or patches. Gels are very convenient, patches work but they often produce a nasty skin reaction or discolouration. Oral testosterone like oral oestrogen is probably less safe because of its passage through the liver and the induction of liver coagulation factors. Therefore my implant patients at the moment are having oestradiol implants plus testosterone gel which they apply on alternate days. This works well but they lose the convenience of having the implant inserted and forgetting about it for 6 months.

Oestrogens and Depression

I have a long paper, "A guide to the treatment of depression in women by oestrogens" in press. I am enclosing a pre-publication galley which explains the use of oestrogens, testosterone and the problems with progestogen in patients with premenstrual depression, post natal depression and climacteric depression. These three hormone responsive depressions should be called "reproductive depression".

Please forward it to your pals so they can put it in front of their general practitioner, psychiatrist or gynaecologist who might prefer to use inappropriate antidepressants. I am very pleased with this paper and hope you enjoy reading it.

Bio-identical hormones

This has become a new fashionable description of hormone therapy emanating from the USA. At last our American colleagues are overcoming their love affair with the horse urine oestrogen in Premarin and are at last using normal human hormones such as oestradiol, testosterone and progestogen. We have been using these hormones in Europe for 20 years so it is hardly an American discovery but merely an American awakening for what we have been doing for decades. It is of course easy to prescribe transdermal oestrogens and transdermal testosterone but unfortunately the transdermal progesterone gel, in spite of many exaggerated claims is not effective. We have spent more than £100,000 in the last few years studying this preparation which not only is barely absorbed but has no effect upon hot flushes, libido, bone density or anything else. It can be obtained on the internet but I would caution patients about purchasing or using this worthless expensive preparation.

We therefore have to give a low dose of a progestogen (alas, not a natural progestogen) in the form of Norethisterone 2.5 mgs for 7 days a month. Some women certainly develop PMS type symptoms

Decrease in heart attacks

It has been known for 50 years that women who have a premature menopause have a higher incidence of heart attacks and strokes and part of the logic of giving oestrogens to post menopausal women of any age was to prevent this increase of heart attacks that do occur in women once their natural oestrogens are switched off. This was supported by more than 40 case controlled studies. However, the WHI placebo controlled study showed that there were a few more heart attacks and a few more strokes but (as we warned them before the study starting), they were using the wrong dose of the wrong hormone with continuous progestogens in the wrong age group. It does appear that there was also a slight increase in breast cancer. At the time of the initial 2002 paper it had cost more than $100 million and now that the conclusions have been unravelled showing considerable benefits including a decrease in osteoporotic fractures and colon cancer, the cost has now increased to $1 billion. Epidemiologists cannot resist spending money, no matter how imperfect their study.

The harmful affects of HRT are in the progestogen component not the oestrogen and it is clear that oestrogens are very safe and very beneficial if the transdermal route is used avoiding first pass liver metabolism. All the evidence now shows that oestrogen without progestogen is associated with fewer heart attacks, fewer strokes and even less breast cancer. Patients with a uterus have to have some progestogen and routinely I have cut down the duration to 7 days rather than the orthodox 14 days. Women who have had a hysterectomy are ideal for hormone therapy because no progestogen is needed. There is no bleeding, there are no progestogenic side effects and we now understand that there are fewer major complications.

on this hormone so it can be changed to Utrogestan a more natural progesterone which produces fewer psychological side effects but does not protect the endometrium from over stimulation as sufficiently as progestogen does.

Access to HRT

In spite of the overwhelming good news about HRT, many women are finding it very difficult to obtain this treatment from their general practitioners or even their gynaecologists. Psychiatrists are of course hopeless. General practitioners and even the Royal College of General practitioners are still stuck with the exaggerated fears from the 2002 WHI paper and have not modified their practice or their advice although many of the original researchers have accepted their former errors. Even if the patient has a whole range of distressing menopausal symptoms, it is easier for the GP to do nothing and if there is depression, their first choice is antidepressants. It is something we have to fight.

Best Wishes

I hope you find this newsletter helpful and I will as always be happy to answer any email enquires.

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