Newsletter January 2018

It has been a good year for HRT

NICE has at last recognised that oestrogen therapy is beneficial and safe and several of the WHI authors are publishing their views on the errors of medication in the study, the selection of patients, the collection of data and the shameless premature presentation of unjustified conclusions to the press 4 days before it was presented to the profession. The press you will remember had a field day but the authors are now queuing up to apologise for the harm that they have done to millions of women who have been denied treatment for symptoms and for the prevention of osteoporosis, heart attacks and severe depression.

Unfortunately, the inaccurate bad news is now in the undergraduate textbooks and it will take a generation to get rid of it. Many GPs are up to date but there remains a resistance in the majority who prefer to prescribe antidepressants or nothing at all. One can only hope that they see the light when their longstanding suffering patients return cured with the appropriate oestrogen therapy. However, there is no such hope to be had from psychiatrists who are trapped in their ignorance of the effect that female hormones have upon mood. How else can we explain premenstrual depression, postnatal depression, menopausal depression, or depression following hysterectomy and removal of ovaries without an understanding of the effects of oestrogen, progesterone and testosterone on mood? There are good scientific papers in prestigious journals such as the

Lancet (sorry many are mine) to support the value of transdermal hormones in the treatment of depression in women.

Happily, there is no dispute about the value of HRT for hot flushes / insomnia or vaginal dryness / painful intercourse/ loss of libido but depression remains a problem for women who are denied hormones. I have been in contact with an old friend a former President of the Royal College of Psychiatrists with this problem only to be told, “Nobody at the college is interested in hearing about hormones and depression”. There will be no help from psychiatrists but it is coming from unexpected sources – Celebrities. The latest to break cover and go public is a patient who, in a series of TV appearances and newspaper articles, has told of the debilitating effect of the post-menopausal state leading to profound depression and extreme suicidal thoughts. This debilitating problem was cured within weeks of starting the appropriate therapy and she remains well 2 years later. But what is the “appropriate therapy”?

The correct HRT

The most obvious fact is that we should avoid any oral therapy whether it is the logical oestradiol, which is the hormone produced by women naturally, or the ridiculous collection of preparations containing horse-oestrogens such as Premarin Premique Prempro etc. Oestradiol should be given transdermally as this route avoids the first pass liver stimulation of clotting factors with oral oestrogens which lead to the probable increase in deep vein thrombosis, heart

attacks and stroke with oral oestrogens whether it is the oral contraceptive pill or HRT.

Testosterone is often thought of as male hormone but the ovaries in young women produce very large amounts of this, naturally and it is very useful for problems of mood, energy and libido. 93% of my HRT patients also have testosterone as well as transdermal oestradiol with excellent results.

Women with a uterus need endometrial protection with progesterone either tablets or a Mirena coil but continuous progestogens should be avoided because if there is a risk of breast cancer with HRT as it is probably due to continuous synthetic progestogens and NOT oestrogens. All studies looking at oestrogen alone reveal a decreased or a no change incidence of breast cancer.

The types of transdermal oestradiol are
Gels - Oestrogel My first choice or Sandrena sachets (for hand luggage)

Patches - Estradot Evorel

For Testosterone there are gels Testim or Testogel both only licensed for men but are used in women using a smaller dose. There was a patch licensed for women called Intrinsa but the manufacturer discontinued it on commercial grounds. It wasn't selling enough because the manufacturers recommended too low a dose. One of the lessons of HRT is

that one has to use a dose that works. This will be assessed by the history of response rather than repeated blood tests.

Another brilliant means of delivering oestrogen and testosterone is by a hormone implant, which is convenient, painless and lasts about 6 months. It is ideal for women post-hysterectomy but is rarely available on the NHS and it is more expensive than gels or patches.

Bio identical Hormones

The therapy outlined above is all “bioidentical” and has been used by many of us in Europe for 20 years. No, it is not a clever American invention as they are still stuck with oral oestrogens particularly the ghastly Premarin. The hormones I use can all be obtained on the NHS if your GP is willing, although he/she will probably decline to prescribe testosterone, as it is not licensed for women now that the patches have been withdrawn.

This treatment should not be confused with the many purveyors of bioidentical hormones on the Internet who use oestradiol and testosterone (so far so good) orally (not so good) with oestrone and estriol (2 weak and unnecessary oestrogens), DHEA that only works when converted to testosterone and daily progesterone either orally or by cream, which is not even absorbed. These oral tablets or lozenges are manufactured by compounding pharmacies, which are unregulated for safety and efficiency. There is a move in the UK and USA to have them banned as a health hazard. Indeed, last year the Advertising Standard Authority

has ruled that the claims made in promoting bio-identical hormone treatment are misleading, with no evidence to the claims that such treatment is more effective or safer to the HRT I describe above. Another warning - if any of these practitioners invite you to measure your salivary hormones in order to have a bespoke made to measure HRT you should head for the hills and take your wallet with you!

The Future

I have no doubt that future research into the efficacy and safety of HRT will continue to be supportive and accepted by all. The exception are psychiatrists who will continue with their misdiagnoses labelling severe PMS as bipolar disorder and treating with antidepressants and mood stabilizers, which not only do not work but produce weight gain, loss of libido and increasing anxiety and depression. And then of course there is always ECT - shock therapy!

My personal commitment is clear. I opened the first menopause clinic in Europe, in Birmingham when I was a trainee in 1969 and have opened clinics in Nottingham, Kings London and Chelsea and Westminster Hospital, which are all still thriving. I have witnessed the changing often-hostile attitudes to HRT over the years. After compulsory retirement from the NHS and the University at 65 I am in full time private practice but I am still involved with research, lecturing and providing the best service for women with hormonal problems including osteoporosis. I am not stepping down but increasingly my two colleagues Michael

Savvas (Senior Consultant at Kings) and Neale Watson (Senior Consultant at Hillingdon) are doing sessions – currently one per week. They were both research fellows and trainees of mine at Kings and they were involved with the original research on hormones for the menopause and depression in women. I will still be doing three sessions a week until my two colleagues become too popular.

Happy New Year and a healthy 2018 to you all.