# Newsletter July 2016

For my current newsletter I am sending information about the correct treatment for Premenstrual Syndrome because I see so many patients who have been mucked up by the wrong treatment whether it be antidepressants, progesterone or in-patient visits to psychiatric clinics. This is a summary of my views of the treatment for PMS and perhaps if you could give a copy to your general practitioner or even your psychiatrist that might help a lot of women in the future.

## Effective treatment of PMS/PMDD

First of all we have to make the correct diagnosis and the major obstacle to this is using the term Premenstrual Dysphoric Disorder (PMDD) preferred by the American Psychiatric Association. By labelling the condition Dysphoric it clearly labels the condition psychiatric. None of us use the term Dysphoric in conversation and patients never tell me that they are feeling a little Dysphoric today! Such women in the hands of psychiatrists will be treated with antidepressants and when these are ineffective, as they usually are, they will have added drugs including mood stabilizers if the mood swings are severe enough to misdiagnosed as Bipolar Disorder (BPD) The condition has an endocrine aetiology essentially due to intolerance to the cyclical progesterone which is released by the ovary after ovulation. This causes the mood, energy and libido changes that occur in the days before ovulation together with the cyclical somatic changes, headache, migraine, and bloating and breast pain. This group of regular recurrent symptoms is best called Premenstrual Syndrome (PMS)

Depression is not only more common in women but it different from depression in men because of the contribution of the hormonal changes of the menstrual cycle, pregnancy and the perimenopause. This results in PMS, postnatal depression (PND) and menopausal depression (MenD). These frequently occur over time in the same woman and is collectively recognised as Reproductive Depression. (RD)

Hormone responsive depression cannot be diagnosed by blood tests, nor excluded in this way. The diagnosis is made entirely on the history. It is commonplace for women to recognise that they have hormonal depression and visit their doctor who will check the hormone levels. As the oestradiol and FSH levels will always be normal in this group of premenopausal women, they are then brushed off and given antidepressants. When these invariably fail, they will be given a second antidepressant, a higher dose, and ultimately when the misdiagnosis of bipolar disorder (BPD) is made they will be given mood stabilising drugs. This sad history may last more than twenty years with the woman's life blighted by the misdiagnosis and inappropriate treatment. During this time she will be labelled Recurrent Depressive Disorder, generalised anxiety disorder Borderline Personality Disorder, Treatment Resistant Depression as well as BPD but there will be no understanding of the effect of hormonal changes on mood.

Middle aged women with hormone related depression have the following items in their history. They usually have PMS as a teenager becoming worse with age-they are

in good mood during pregnancy in spite of nausea and vomiting but then frequently have PND with cyclical depression occurring as the periods return. As the menopause approaches the depression becomes worse and less cyclical. This is the menopausal transition in the 3 to 4 years before the periods stop when the climacteric symptoms of depression, panic attacks, brain fog, loss of energy and libido are at their worst. This is another time when women are denied the appropriate treatment with hormones because they are “not menopausal”

This history is different from the characteristics of BPD. Patients with Severe PMS have a history of-

1 Depression worse before each period
2 cyclical somatic symptoms such as bloating headaches even migraine and breast pain before a period
3 In good mood during pregnancy
4 Postnatal Depression
5 PMS returns as periods return
6 Depression continuing to the transition phase
7 Has recurrent cyclical depression but does not have manic episodes
8 Responds well to oestrogens and not antidepressants
9 Responds badly to progesterone/progestogen whether it is oral or depot

Having made the association of typical symptoms particularly depression and behavioural changes with the periods the mode of treatment by hormones should be clear. As PMS is the result hormonal changes following ovulation the cornerstone of treatment should be suppression of ovulation and the subsequent removal of these endocrine changes particularly progesterone.

Why progesterone? Many years ago my team and I reported the effect of repeated 12 days of Norethisterone in hysterectomised women receiving oestrogen. The progestogens produced depression anxiety with loss of energy which more severe the higher the dose used. The paper was even subtitled "A model for the premenstrual syndrome" We wanted to continue the study on patients who had PMS before the hysterectomy. Not surprisingly we were not able to find volunteers for this extension of the study

Suppression of ovulation is most easily achieved by the birth control pill and there are many publications supporting its use in PM. This is a mystery because although an OC will stop the cycles and cyclical symptoms the depression and related problems become continuous rather than cyclical. In my experience PMS often becomes worse regardless of whether it is an "old pill" or the newer much heralded new pills such as Yas or Yasmin containing drospirenone.

The most effective treatment is by transdermal oestrogens as these are more effective and safer than oral hormones by avoiding the first pass effect and the production of coagulation factors in the liver. There is no evidence of an increased thrombosis or stroke or heart attack risk with oestrogen gel, patches or implants.

Oestrogen patches 100 to 200ug twice weekly have been the product used in the various research studies and is very effective and acceptable even though it does leave temporary skin marks. Evorel or Estradot are commonly used. Oestradiol gels avoid that problem and allow variation of dose. It can also be used with testosterone gel as testosterone patches are no longer available.

The same non oral medication can be given by implants with the usual dose being oestradiol 50mg and testosterone 100mg. The implant is usually repeated every 6 months. It is a very simple painless outpatient procedure taking less than 5 minutes.

This testosterone component is important as the depression of PMS is usually associated with loss of energy, libido and self-confidence. 93% of my depressed patient also have testosterone. The addition of testosterone makes an enormous difference to a woman's general wellbeing and it is regrettable that GPs and even gynaecologists are unwilling to prescribe .Since the patch has been taken off the market for purely commercial reasons testosterone is no longer licensed for women and it is perceived to be a male hormone which it is not as young women have almost 10 times the amount of circulating testosterone than oestradiol

Most women will have their PMS well controlled by this treatment for many years with the only problem being the PMS symptoms caused by the cyclical progesterone necessary for endometrial protection. Sometimes this unacceptable. The solution to this progestogens intolerance may be by changing the type and duration of the progesterone, using the vaginal

route, by using a Mirena IUS or by having a laparoscopic hysterectomy with removal of ovaries. This not as radical as it sounds as the time in convalescence is just a few days and don't forget that 4% of women die from cancer of the uterus cervix or ovaries. That will mostly be avoided by this surgery. It will also cure the most severe PMS

Women happy on this treatment should continue for many years as it will prevent osteoporosis and prevent the 1 in 3 women sustaining an osteoporotic fracture There are also fewer heart attacks, cardiac deaths and certainly no increase in breast cancer .If there is a slight increase with HRT it is entirely in women taking continuous progestogen. All studies of oestrogen alone have shown no change or a small reduction of breast cancer.

This suggested treatment is as effective as it is obvious but how do suffering women receive this simple curative treatment instead of years of antidepressants. GPs can be persuaded once they overcome the totally incorrect view that hormone are dangerous and recognize that antidepressants are not effective and have many side effects of more heart attacks and strokes weight gain and inevitably loss of libido.

The problem is the clever bone headed psychiatrists who do not understand or wish to understand the hormonal basis of this debilitating condition. I lecture all around the world but my request to lecture at the Royal College of Psychiatrists has always been refused because "nobody is interested" It is just a question of territory.

P.S. Although I am away for most of August the clinic is open for bone scans and repeat bone scans and Neale Watson and Michael Savvas will be doing a few clinics.

I am off to the sunshine in Zimbabwe – can't wait!!