Newsletter February 2020

My apologies for this late newsletter but there has not been a lot to report as HRT is now accepted as safe and useful maintaining a woman's health in the menopausal years and also has a proven value in treating depression in younger women who still having their cycles and suffer with the cyclical depression of PMS . There was some anxiety in July when the Oxford Epidemiology group again reported the increase in breast cancer on HRT preparations, but this was really an extension of their previous much criticised work about 10 years ago. If there is any increase in breast cancer it almost certainly is related to the continuous progestogen found in some preparations. Every paper that has looked at estrogens alone has shown no increase or even a decrease in breast cancer. My research team first described the use of continuous estrogen and progestogen 30 years ago in order to avoid a monthly bleed I never use it now. That is a clear message.

Cyclical progestogen or better still the natural progesterone Utrogestan should be used for 10-12 days each month for endometrial protection but even then progesterone / progestogen can have a depressive effect (as in PMS) and a shorter duration of 7 days can sometimes be used or a Mirena coil inserted to avoid these progestogenic side effects.

AVAILABILITY OF HRT PREPARATIONS

The only problem these days appears to be fear of lack of availability which has become headline news in the press and BBC. This is surprising because there is no reason why there should be a shortage of any HRT preparation. There has been anxiety that the Evorel patch is not available but a virtually identical preparation Estradot is. I'm not sure about oral because I never used them as there is a tiny increase risk of heart attacks and strokes with all oral estrogens whether it is the form of all oral contraception in younger women or HRT in older women. Oral estrogens pass straight to the liver where hepatic coagulation factors are stimulated. There is no such thrombogenic risk with transdermal estrogens. There is no shortage of the testosterone gels that I frequently prescribe.

If you have any problems obtaining your HRT I suggest you contact Madesil pharmacy at 20 Marylebone High Street Phone 02079353078 They have reassured me that they have everything in stock and would even post the medication to the patient once they receive the usual prescription.

BENEFITS OF HRT

Many years ago I published a paper “10 reasons to be happy about HRT “ It can be found on my website but a brief summary is –

1. HRT will stop your hot flushes and sweats

2. HRT will stop vagina dryness and the many causes of painful intercourse and loss of libido

3. HRT increases bone density and prevents osteoporotic fractures

4. HRT protects the intervertebral discs
5. HRT does reduce the number of heart attacks
6. HRT helps depression in many women
7 HRT improves libido
8 HRT improves the texture and quality of the skin
9. ”I am a nicer person to live with “
10 HRT is safe

The full text of this paper can be found can be found on my website

There is perhaps another #11 advantage to add to this list. There is increasing evidence that HRT decreases the risk of Alzheimer's disease. This is logical because the earlier the menopausal the greater the risk of Alzheimer's in later life but it's difficult to prove this to everybody's satisfaction. Certainly, population studies particularly the huge Utah study suggest a decreased risk, but the demands of precise epidemiology insist that a randomised controlled trial with the placebo group is conducted. The problem is at what age should this huge study begin - at the age of 60 ,50, 40 or even earlier and what happens to the placebo group when the patient begins to suffer hot sweats insomnia and depression. She will then move on to estrogens. The problem will never be solved by a vastly expensive and impossible study, so we have to rely on the population data that we have at the moment. It is worth remembering that when Sir Richard Doll’s observation that lung cancer was 13 times more common in smoking doctors than non-smoking doctors was criticised for the absence of a trial, he famously replied that you don’t need a randomised trial to prove the bleeding obvious.

HRT FOR DEPRESSION

The next challenge is to clarify the role of estrogens in the treatment of depression in women. Depression is twice more common in women than men with more hospital admissions for depression the use of antidepressants and suicide attempts. The clear message is that depression in women is often different from depression in men because there is a massive hormonal component in women not occurring in men. Depression occurs at times of hormonal flux often beginning within a few years of the first period becoming worse with age. Significantly this depression usually disappears during pregnancy when there are no hormonal fluctuations only to recur as post-natal depression after delivery when estrogen levels fall. This post-natal depression can be delayed if the woman breast feeds for a long time but when she stops breast feeding the periods return and depression returns as PMS often becoming worse with age particularly in the few years before the menopause in the period called the menopausal transition. Thus, we have a combination of Premenstrual depression, postnatal depression and premenopausal depression occurring in the same woman. This is Reproductive Depression , Unfortunately psychiatrists are not aware of this and do not want be bothered with this new information . I have tried!!

Rather than accept a hormonal component they will misdiagnose many women with severe PMS as having “bipolar disorder” when the treatment and prognosis is very different. Alternatively, they have a diagnosis “drug resistant depression ‘not being aware that the depression is resistant because treatment is wrong. They also use the frequent diagnosis of ‘borderline personality disorder’. This is an ongoing tragedy for many women with “reproductive depression “related to hormonal changes it is very treatable with transdermal estrogens and women can avoid the inappropriate treatment by antidepressants antipsychotics tranquilizers and even ECT which can all have a devastating effect upon there long term health.

I summarised here the simple differences between PMS curable with oestrogens and bipolar disorder which is not helped by hormones. This is a summary of the characteristics of PMS but in some cases, there is an overlap. Once again, the full paper can be found on my website

1 There is a history of mild or severe PMS is it teenager

2 There is relief of depressive symptoms during pregnancy

3 Depression started or recurred postpartum as postnatal depression
.
4 Premenstrual depression recurred with menstruation returned months after delivery.

5 Premenopausal depression became worse with age blending with the menopausal transition and becoming less cyclical

6 In PMS there is often coexistence of cyclical somatic symptoms such as menstrual migraine, abdominal bloating or mastalgia

7 These PMS patients usually have runs of 7 to 10 good days per month

8 These PMS patients have recurrent episodes of depression we rarely have episodes of mania

OSTEOPENIA AND OSTEOPOROSIS

Most women are aware of the dangers of osteoporosis and broken bones after the menopause and this is why we have a Hologic bone density machine to 46 Wimpole Street for women who may be at risk. It is of course well known that low bone density occurs after the menopause, but it can occur much earlier. A healthy lifestyle and exercise can to some extent reduce the risk but there is a danger of putting too much confidence in lifestyle. Osteoporosis occurs more commonly in women you are thin and not overweight as estrogens are produced in the body fat and being fat is to a large extent protective of the bones. Such patients develop more diabetes, heart attacks and strokes but they will have good bones. It is therefore a false sense of security in healthy women who walk the dog for

2 hours a day or exercise addicts who spend an hour a day in the gym as these are just the women who if slim have a higher risk and there is no way of diagnosing this than by measuring bone density or waiting for a fracture to occur . Then the patient can have transdermal estrogens by gels patches or implants which is by far the most effective and the safest way of protecting the skeleton

I wish you all a healthy symptom free and fracture free 2020 so continue with your HRT

John studd