PMS / PMDD

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PMS or PMDD ?????


MAJOR GENERAL
BENEDICT ARNOLD
AMERICAN PATRIOT
RESIDED HERE FROM
1796 UNTIL HIS DEATH
JUNE 14, 1801

Charles Dickens

- St Luke's hospital for the insane 1846

  F > M x 2

"most common in women of the servant class"

Depression twice as common in women than men

- Community studies
- Hospital admissions
- Suicide attempts
- Prescription of anti-depressants

- **Why?**

Doctors often make mistakes by not learning the cause by accurate questioning, but they proceed to heal as if they were men's diseases (Hippocrates Diseases of women)

Depression in women is very often different in women than men and the causation and treatment different because of the hormonal component of estradiol and progesterone in women

Depression associated with ↑ in

- CHD
- Strokes
- Hypertension
- Metabolic syndrome
- Osteoporosis
- Alzheimers
- Non suicide deaths
- Obesity

Schmidt P 2007 Menopause international

“Reproductive Depression”

2012 Reprod Endocrin

Studd J Nappi R

Premenstrual depression

Post natal depression

Climacteric depression

“Reproductive Depression”

Studd J Nappi R 2012 Reprod Endocrin

Premenstrual depression

(good mood during pregnancy)

Post natal depression

(return of PMS as periods recur)

Climacteric depression

Reproductive Depression

In later life after years of depression and antidepressants they will state that they were last well without depression during her last pregnancy

REPRODUCTIVE DEPRESSION and RESPONSE TO ESTROGENS

Pre-menstrual depression

Magos Studd (1987) BMJ

Watson Savvas Studd (1995) BMJ

Post-natal depression

Gregoire Studd Kumar et al(1996)Lancet

Climacteric depression

Montgomery Studd Appleby et al (1985) Lancet

Soares 2004

Review **Studd J Panay N 2004 Climacteric**

Gynecological Endocrinology, February 2007; 23(2): 63–64

EDITORIAL

Why are estrogens rarely used for the treatment of depression in women?

JOHN STUDD

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The short answer to this question could be that they do not work, but that is not true. It is much more likely that a turf war is developing between psychiatrists and gynaecologists/endocrinologists for this common disorder. This is not surprising as we are all products of our training, with hormones and vaginal bleeding an unchartered country for some. As depressed women would normally gravitate to their family doctor and to psychiatrists, it is usual that psychiatric intervention including anti-depressants would be the first line of therapy. However, there are

last well, the frequent reply is that it wa
last pregnancy, several years previously
natal depression occurred, followed by
menstrual depression which then be
constant as the menopause approache
tients respond well to moderately hi
transdermal estrogens. Unfortunately, th
of depression with these reproductive ev
sought in a history taking by psychiatris
the enquiry about how many good day
woman experiences, reveals not only th

Increase in antidepressant medication in US adult population 1990 – 2003

Mojtabai Psychother Psychosom 2008 77 : 83-92

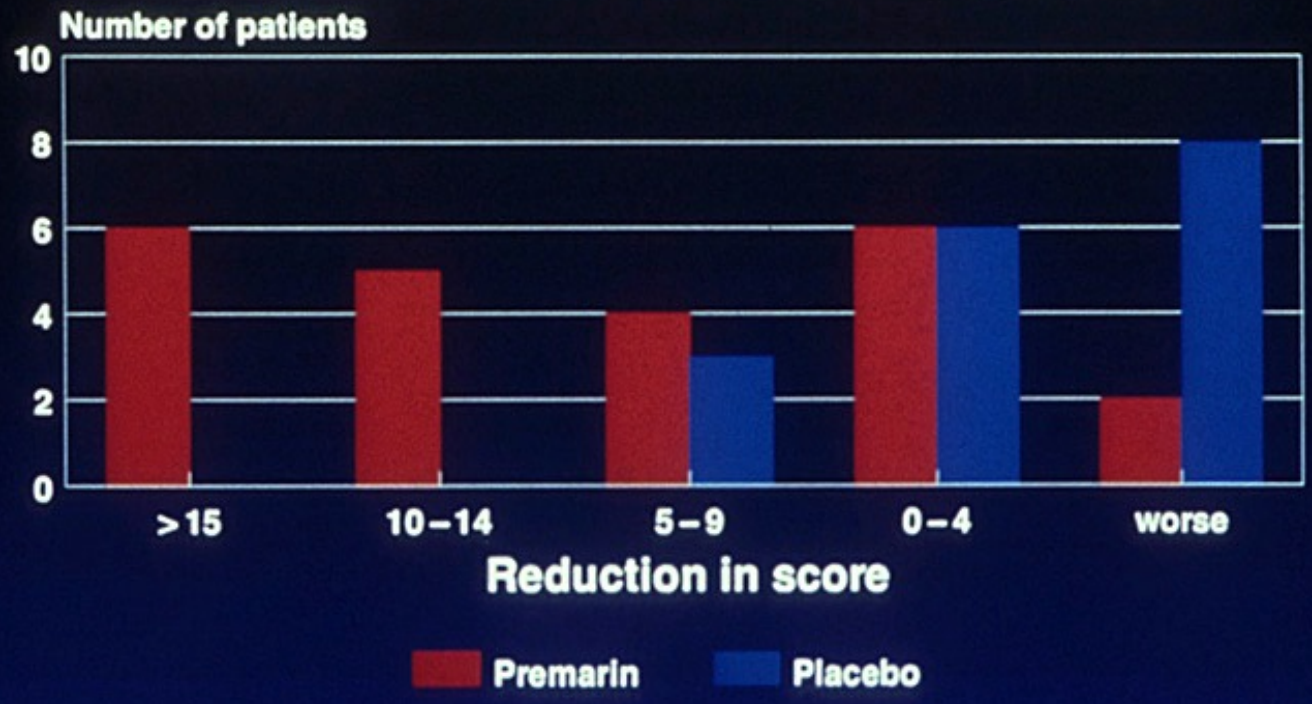
	1990 -92	2001-2003
Total %	2.2	10.1
Age 18-24	1.2	5.2
Age45-54	2.6	14
White	2.4	12.4
Black	1.3	4.9
Low income	2.1	12.1
High income	2.3	9.8

Severe Depression – the first estrogen placebo controlled study

- Klaiber ('79)
- Severely depressed in-patients
- Commenced CEE in high doses (5mg) and increased weekly to a max. of 25mg each day
- Highly significant reduction in depression scores in CEE treated group

Estrogen and Major Depression

Improvement in Hamilton Depression Scores: Premarin versus Placebo



(Klaiber et al 1979)

PREMENSTRUAL DEPRESSION

Treatment of PMS (PMDD)

Treatment of PMS (PMDD)

Keep

Treatment of PMS (PMDD)

Keep

Them

Treatment of PMS (PMDD)

Keep

Them

Away

Treatment of PMS (PMDD)

Keep

Them

Away

From

Doctors

Who have no knowledge or interest in hormone therapy

Effect of hormones on mood

- Estrogen very often improves mood
- Testosterone improves mood , energy and libido
- Progestogen often produces depression tiredness bloating etc

PMS

- Symptoms cyclical - every month ?
- How many bad day a month ?
- How many very bad days a month ?
- How many good days a month ?
- Worst day ?
- Best day ?

PMS

- Symptoms cyclical - every month
- How many bad day a month ? 14
- How many very bad days a month ? 7
- How many good days a month ? 14
- Worst day ? +14 or -2 and -1
- Best day ? +1,2,3

Certain ways of treating PMS

Wait for menopause

Pregnancy

Hysterectomy and BSO

Hysterectomy and ovarian preservation does not help

Human Reproduction Update 1997, Vol. 3, No. 2 pp. 159–171

© European Society for Human Reproduction and Embryolog

Progestogen intolerance and compliance with hormone replacement therapy in menopausal women

Nicholas Panay and John Studd[1]

Academic Department of Obstetrics and Gynaecology, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH, UK

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Treatment of the premenstrual syndrome by subcutaneous estradiol implants and cyclical oral norethisterone: placebo controlled study.

A L Magos, M Brincat, and J W Studd

BMJ 1986

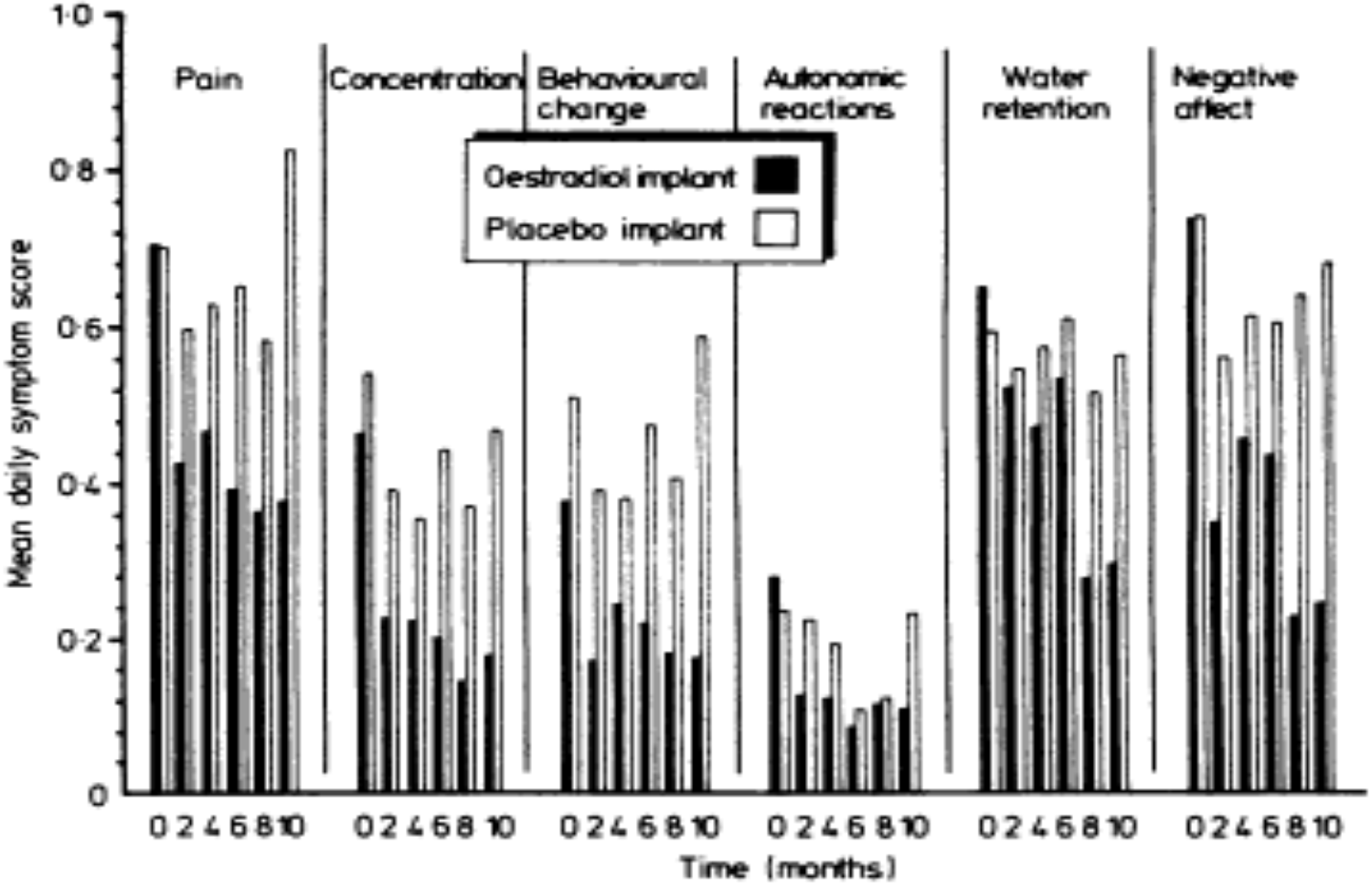


FIG 3—Effect of treatment on mean daily symptom scores.

Treatment of the premenstrual syndrome by subcutaneous estradiol implants and cyclical oral norethisterone: placebo controlled study.
A L Magos, M Brincat, and J W Studd
BMJ

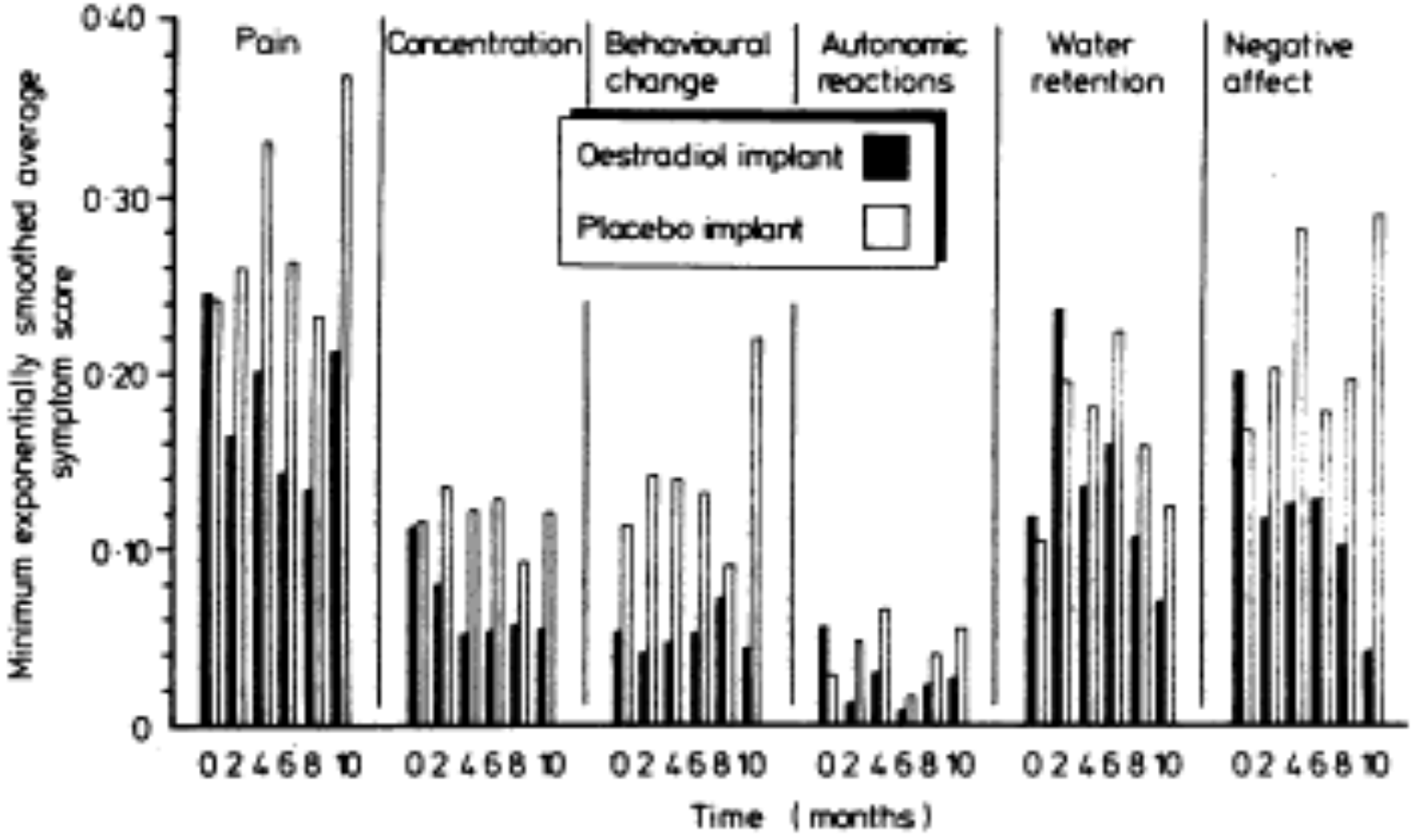


FIG 4—Effect of treatment on minimum exponentially smoothed average symptom scores.

A model for the causation of the Premenstrual Syndrome

Magos Brincat Studd

PMS is caused by the cyclical hormonal changes produced by the ovary following ovulation (or anovulatory cycles)

The effective treatment of severe PMS should be based on the abolition of these changes by suppression of ovulation or cyclical ovarian activity

Hormonal treatment for PMS (PMDD)

Transdermal estrogens gel,patch or implant

GnRH

OC ? Yasmin or Yaz– not good

Progestogen only pill-the worst

TAHBSO with E and T replacement

?? V low dose cyproterone acetate daily but no data

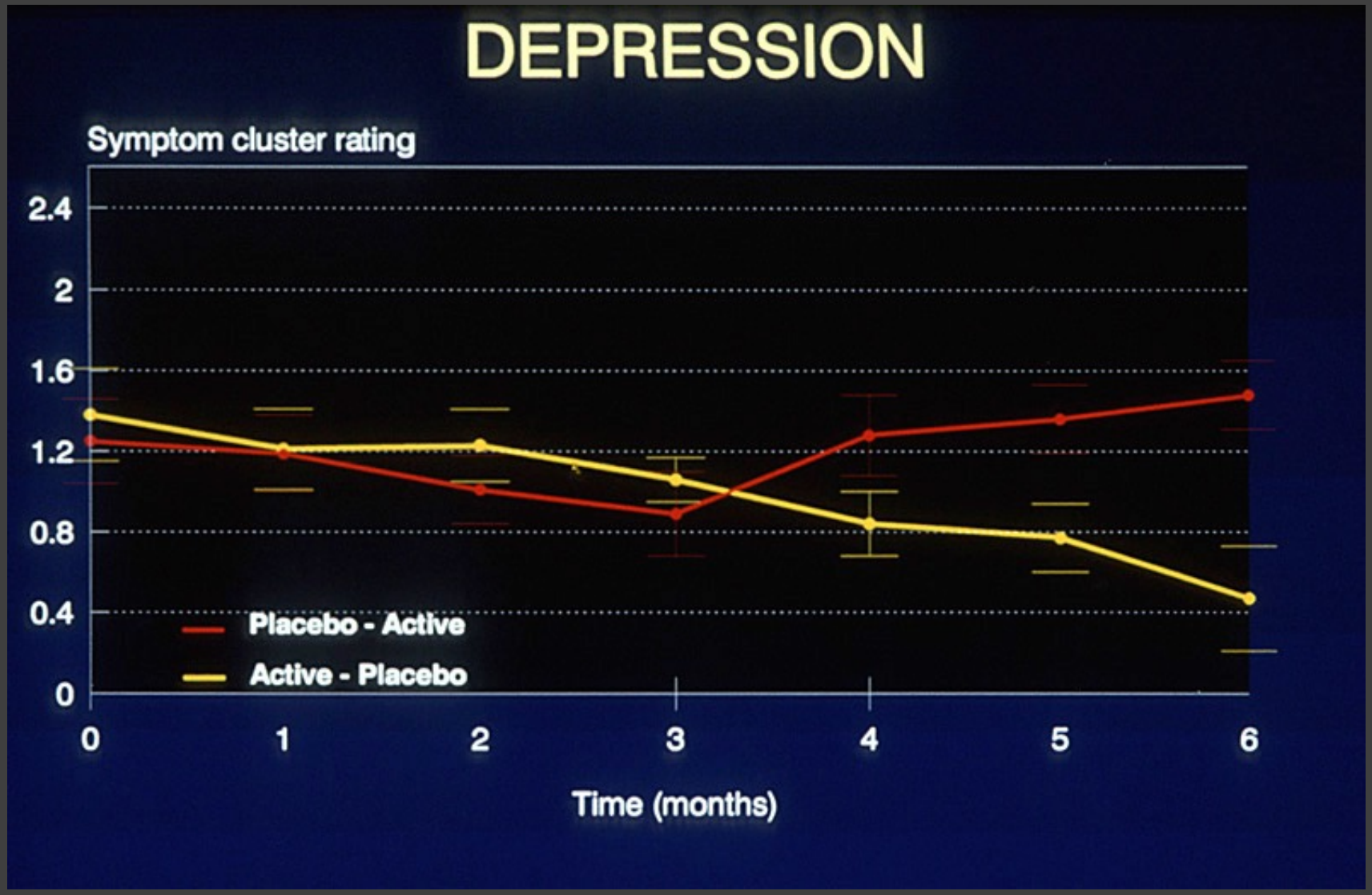
Transdermal oestradiol

Crossover study 17βestradiol 200μg patch vs placebo

Watson & Studd Lancet 1989

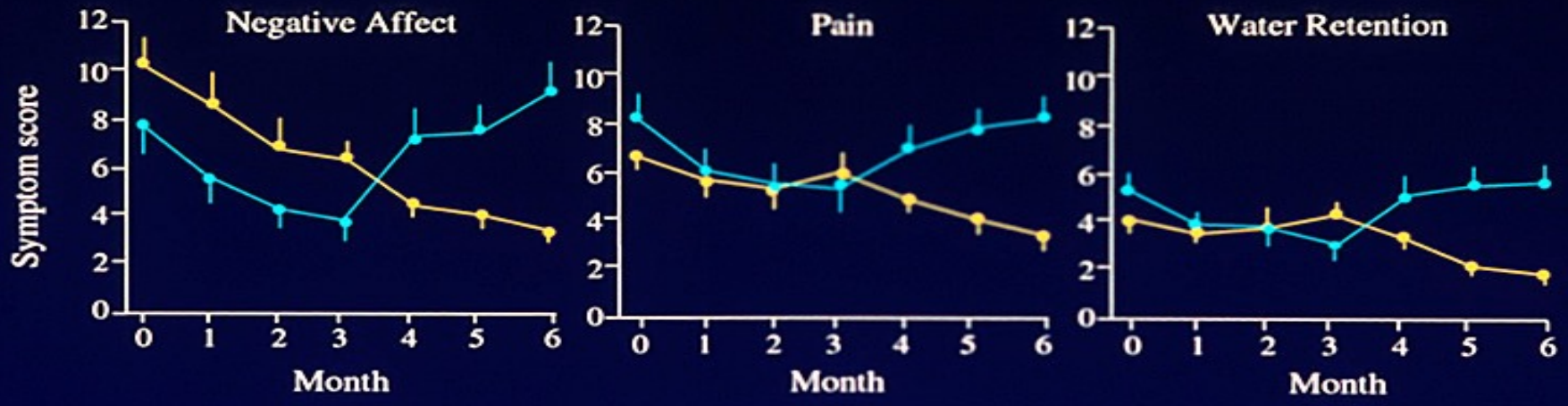
60% reduction in physical and psychological symptoms of PMS


MOOD SWINGS
Symptom cluster rating
2
1.6
1.2
0.8
0.4
0
Placebo - Active
Active - Placebo
0
1
2
3
4
5
6
Time (months)


DEPRESSION
Symptom cluster rating
2.4
2
1.6
1.2
0.8
0.4
0
Placebo - Active
Active - Placebo
0
1
2
3
4
5
6
Time (months)

PMS Study 200µg oestradiol patches

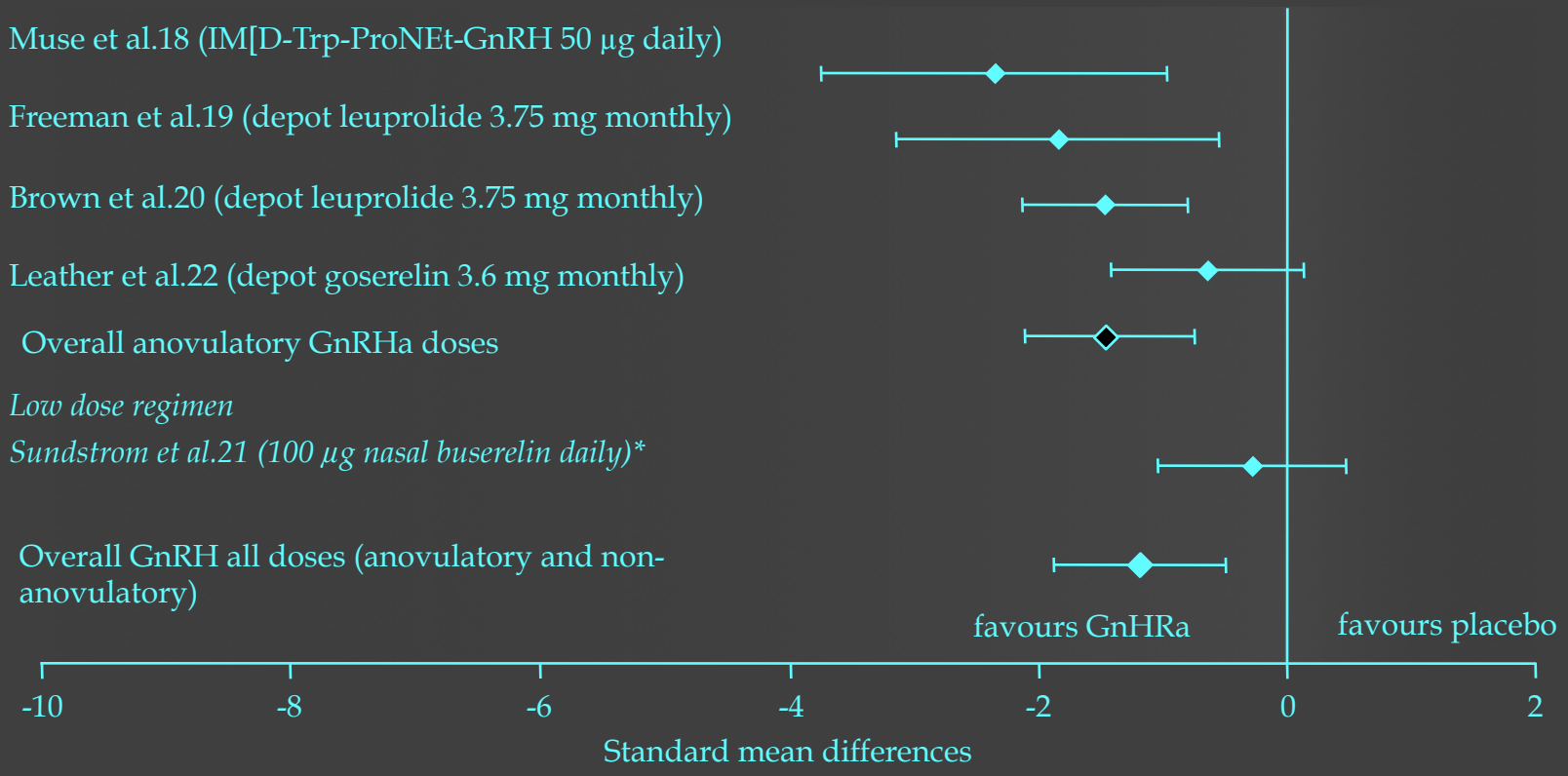
Watson Savvas Studd 1989 Lancet



Mean (SE) ESA_{max} scores ●——● = group I (active treatment to placebo,
●——● = group II (placebo to active treatment). Crossover at 3 months

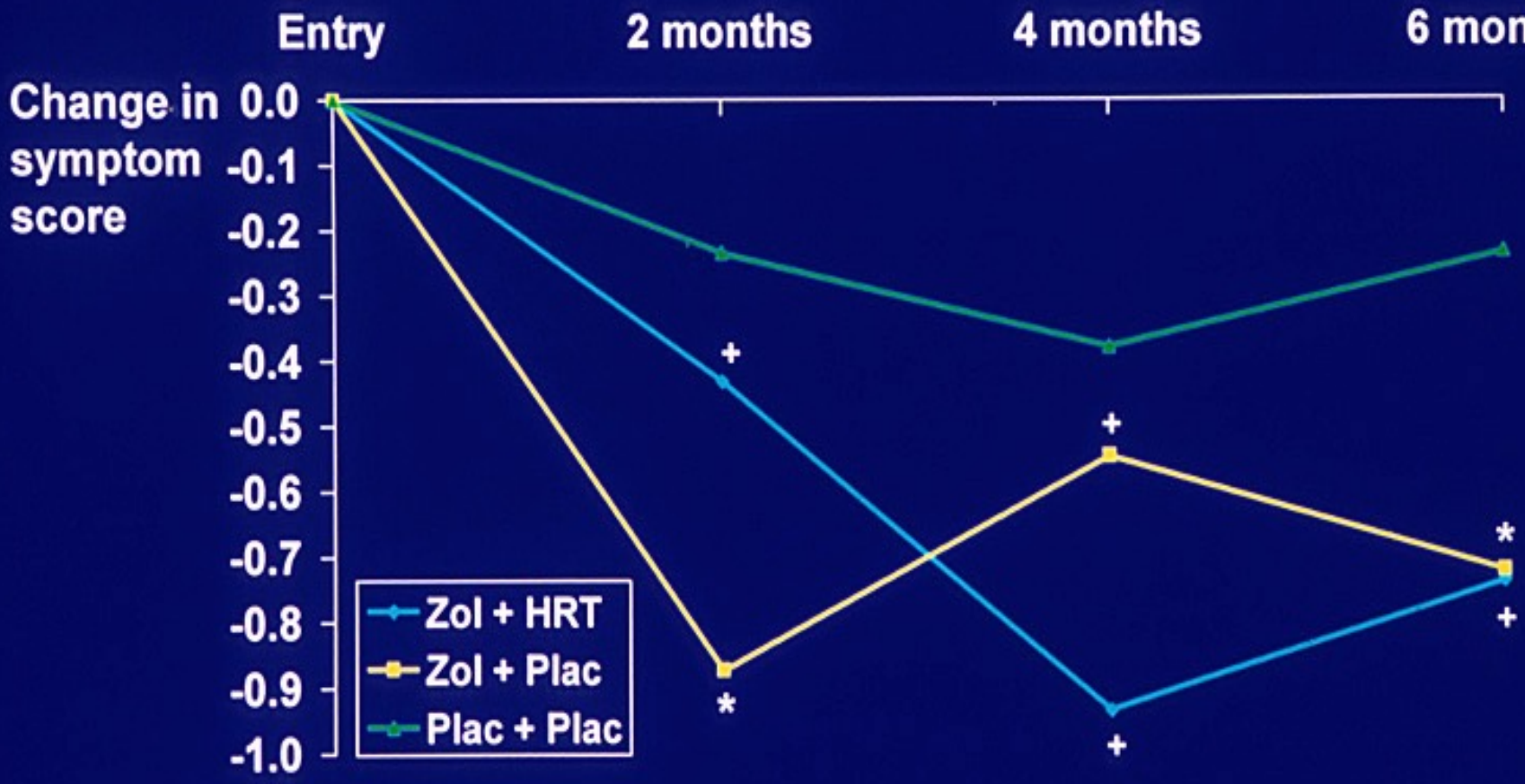
Suppression of ovulation by GnRH analogues

Meta Analysis of RCTs (GnRHa vs placebo)



Wyatt et al 2004

Change in depression



* p<0.05 vs Baseline and Plac + Plac

\+ p<0.05 vs Baseline

Suppression of ovulation by GnRH analogues

- But needs add back with E+P
- Or E +Mirena IUS
- Livial
- Danazol

PROGESTOGEN NECESSARY IN WOMEN WITH INTACT UTERUS BUT PMS PATIENTS ARE OFTEN PROGESTOGEN INTOLERANT

Less potent progestogen/progesterone

Shorter 7 or 10 day course of progestogen

Vaginal progesterone

Mirena progestogen IUS

hysterectomy + BSO

TAHBSO + HRT

- 14 women
- Unresponsive to conservative therapy
- Danazol completely relieved symptoms
- TAH/BSO effected lasting relief

Casson l Reid R L; Am J Obstet Gynecol, 1990

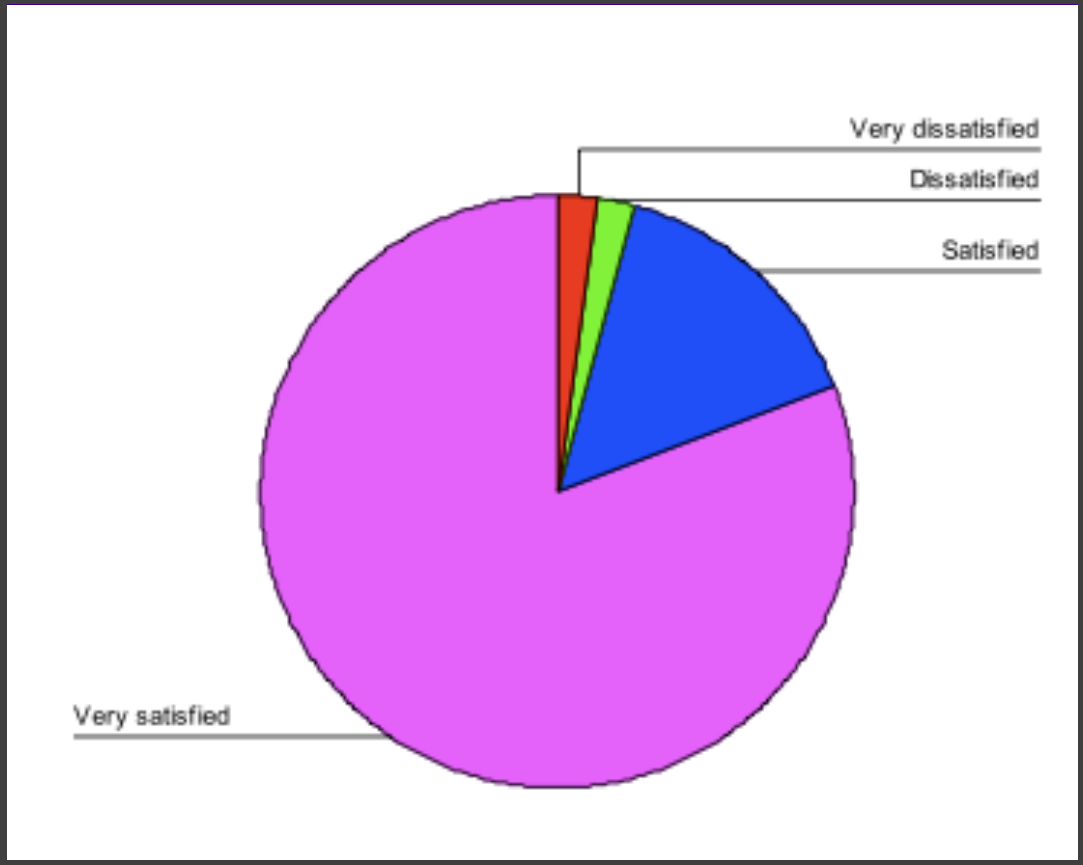
TAH BSO for severe PMS (PMDD)

- 47 women over 10 years
- Median age: 42 years (IQR 39.8 - 46.6)
- Suffered mean 9.68 years (SD 6.8)
- Mean treatment prior to referral: 3.57 years (SD 2.0)
- Mean specialist treatment: 1.21 years (SD 0.4)

Cronje Vashisht Studd 2004 Human Reprod

TOTAL ABDOMINAL HYSTERECTOMY AND BILATERAL SALPINGO-OOPHORECTOMY FOR PREMENSTRUAL SYNDROME

Cronje Vashisht Studd 2004 Reprod Med 20 1113



Transdermal estradiol and testosterone “always” necessary after TAH+*BSO* in premenopausal women

Female androgen deficiency syndrome (FADS)

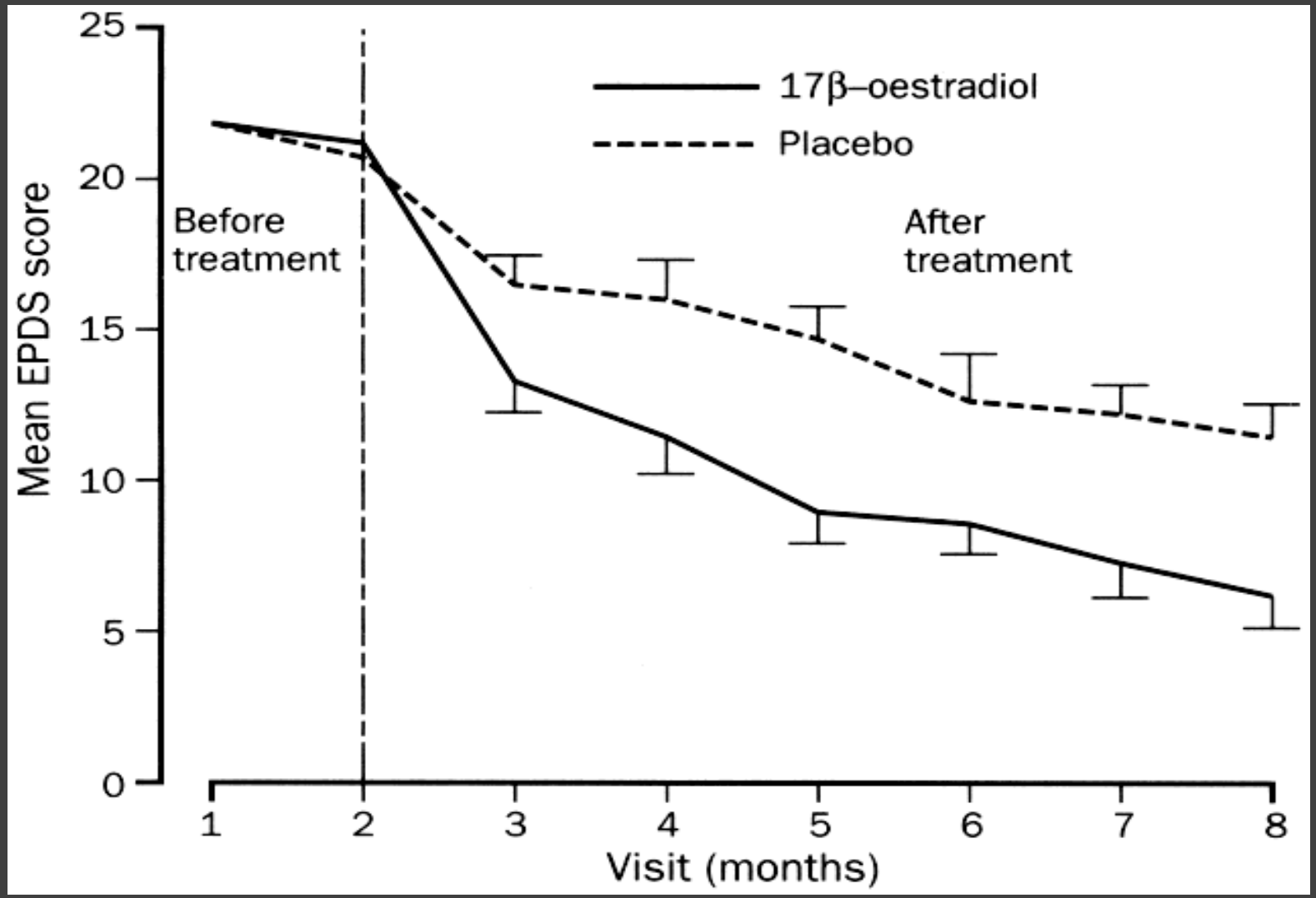
- Depression
- Tiredness
- Loss of libido
- Loss of self confidence
- Headaches

POST-NATAL DEPRESSION

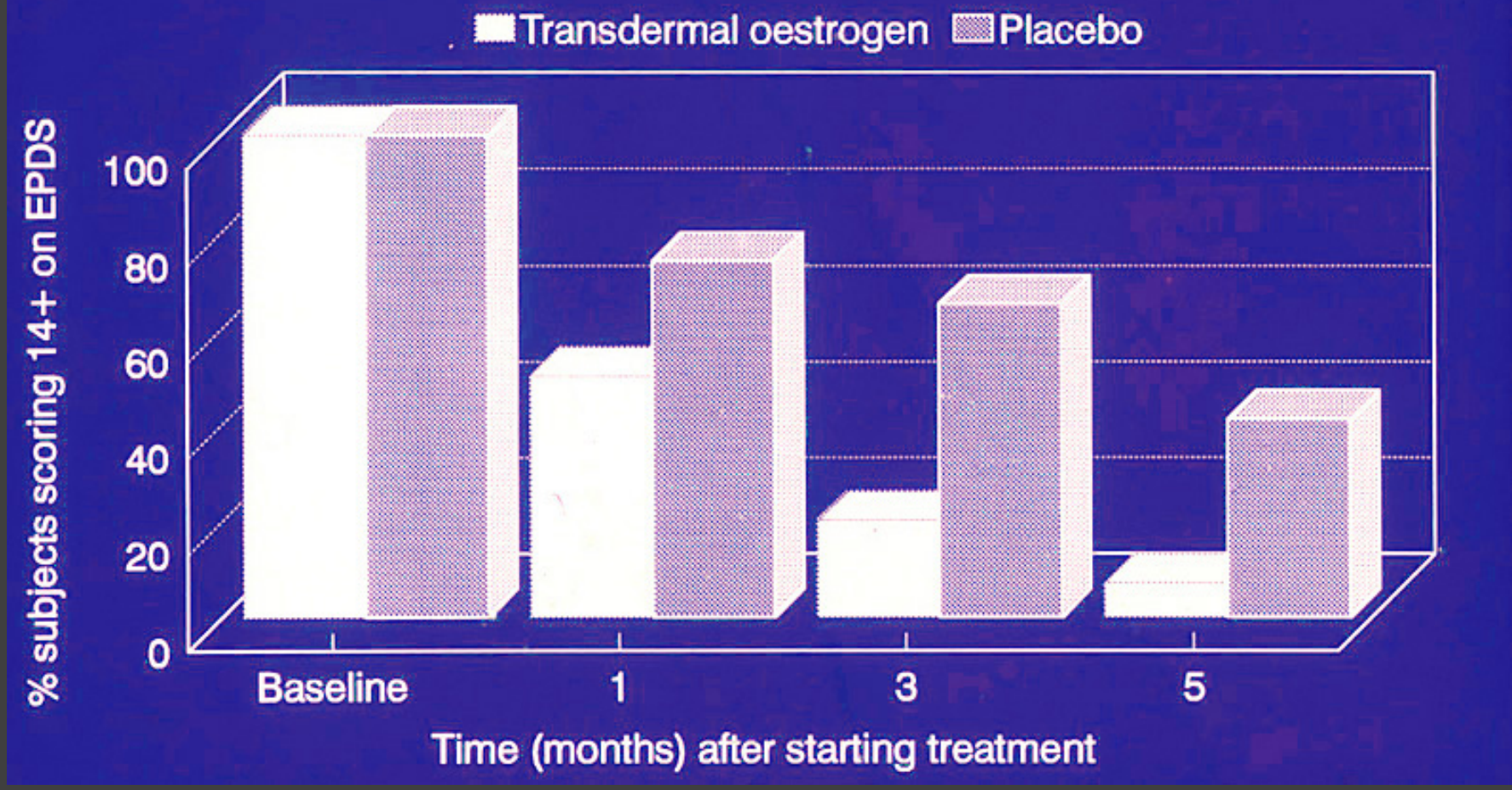
Transdermal oestrogens in the treatment of postnatal depression

Transdermal oestradiol in postnatal depression

Gregoire, Studd et al Lancet 1996



Proportions of subjects scoring above screening threshold for major depression



Estrogen deficiency in severe post -natal depression

Ahakas et al 2002

- after 1 week recovery in 12/23 patients
- After 2 weeks recovery in 19/23 patients
- (but uncontrolled study in women with very low E2 levels)

Oestrogens and progestins in the prevention and treatment of post natal depression Dennis CL Ross LE Herxheimer A 2008

Progestogen given within 48 hours of birth is associated with a significantly higher risk of developing PND

Transdermal oestrogens are associated with a greater improvement in depression scores than placebo in women with severe PND

Cochrane Database Review 2008 CD 001690

Oestrogens and progestogens for preventing and treating postnatal depression

- Transdermal oestrogen better than placebo

  Gregoire Kumar Studd 1996

- Depot progestogen worse than placebo

  Lawrie et al 1998

Can we mimic postnatal depression hormonally?

- 16 women, 8 with a history of postnatal depression
- Induced hypogonadism with leuprolide acetate
- Simulated pregnancy by adding back supraphysiological doses of E and P for 8 weeks, and then withdrawing both steroids

Bloch M. Am J Psychiatry 2000

And lactation ???

Probably worse when breast feeding stops and cycles return

“Reproductive Depression”

Studd J Nappi R 2012 Reprod Endocrin.

Premenstrual depression

(good mood during pregnancy)

Post natal depression

(Prolonged Lactation helps but return of PMS and depression as periods recur)

Climacteric depression

PERI MENOPAUSAL DEPRESSION

Depression in the transition phase

Women with a history of PND and PMS have a higher risk of developing depression in the peri menopausal years (Studd and Panay 2006)

BUT

Women without a history of depression have twice the incidence of depression on entering the transition phase compared with women of the same age who remain premenopausal

Cohen LS Soares C et al 2006 Arch Gen Psychiatry 63 385-90

Climacteric Depression

- 8 year Longitudinal
- In depressed women 4x ↑ CES-D scores in menopause transition

HR 4.29 (2.39 -7.72)

- Depression 2.5 x (OR, 1.25-5.02; *P=.01)* more likely during menopause transition

in women with no history of depression

Freeman EW, et al Arch Gen Psych 2006 63(4):375

Pre menstrual symptoms and perimenopausal depression

- 70 depressed perimenopausal women
  Compared with
- 35 **non** depressed perimenopausal women

- 26% of depressed and 9% of nondepressed women reported pre menstrual symptoms

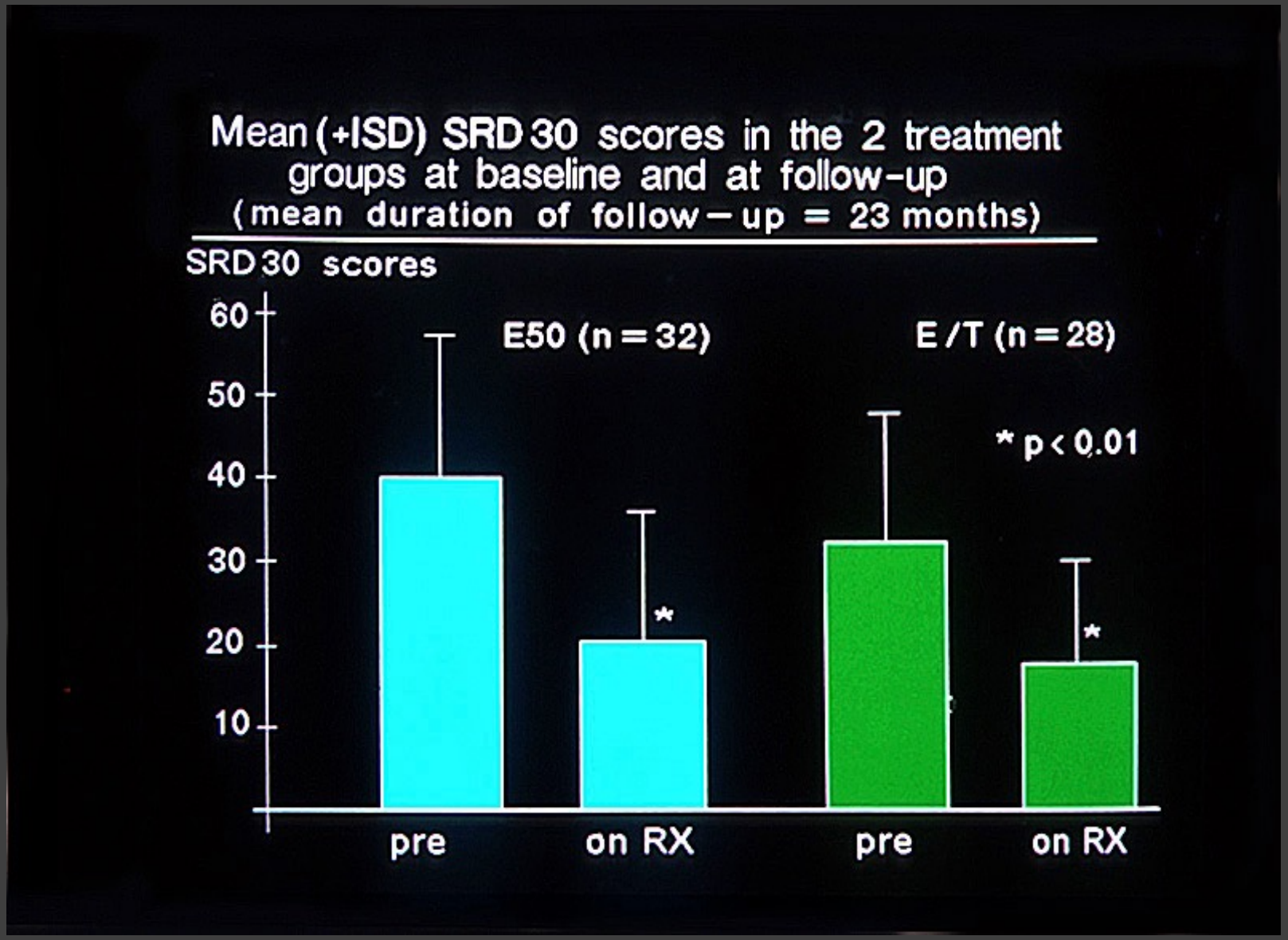
Richards Rubinow Daly Schmidt 2006 Am J Psych

Effect of oestrogen and testosterone implants on the psychological disorders in the climacteric

(Montgomery, Studd Lancet 1987)

Both oestrogens and oestrogen - testosterone better than placebo at two months in the peri-menopausal woman with depression

But no improvement in the depression of post-menopausal women with this treatment


Mean (+ISD) SRD 30 scores in the 2 treatment groups at baseline and at follow-up
(mean duration of follow – up = 23 months)
SRD 30 scores
60
50
40
30
20
10
E50 (n = 32)
E /T (n = 28)
* p < 0.01
*
*
pre
on RX
pre
on RX

Transdermal estrogens in peri-menopausal depression

50 depressed peri-menopausal women

26 Major depressive disorder

11 Dysthymic

13 Minor depressive disease

100 μg estradiol patches in 12 week placebo controlled study

- Soares et al 2001 Arch Gen Psych.58 529-34

Transdermal estrogens in peri-menopausal depression – placebo controlled trial

Soares et al 2001

- Remission of depression in 17/25 (68%) of E2 patients
- Remission of depression in 5/25 (20%) of placebo patients

- Regardless of DSM-IV diagnosis

Depression and the menopause: why antidepressants are not enough 2009

- "The combination of antidepressants with HRT seems to offer the best therapeutic potential in terms of efficacy , rapidity of improvement and consistency of remission in the follow up"

Graziottin A Serafini A 2009 Menopause International 15 76-81

Hormone therapy for depression
Diagnosis

- Hormone levels not helpful
- History most important

1. PMS as teenager
2. Relationship to periods
3. History of post natal depression
4. History of good mood during pregnancy
5. Often have cyclical menstrual headaches
6. How many good days a month?

Hormone therapy for depression
Treatment

- Transdermal E2 100 μg or 200μg
- Often requires plasma levels of >600p.mols for effect and to suppress cycles
- Consider adding testosterone for depression and libido
- Require cyclical progestogen or Mirena IUS if patient still has uterus
- Ultimately the most effective long term treatment may be E + T + Mirena IUS- or even TAHBSO + HRT

PMS or BPD

Severe PMS and Bipolar Disorder- a frequent tragic confusion

Bipolar depression

Longstanding “bipolar depression” diagnosed by psychiatrists often disappears when severe PMS / PMDD is treated with transdermal estradiol or TAHBSO

MI-12-018

Menopause International 2012; **00**: 1–5. DOI: 10.1258/mi.2012.012018

Original article

Severe premenstrual syndrome and bipolar disorder: a tragic confusion

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Abstract

Bipolar disorder and severe premenstrual syndrome (PMS) have many symptoms in common, but it is important to establish the correct diagnosis between a severe psychiatric disorder and an endocrine disorder appropriately treatable with hormones. The measurement of hormone levels is not helpful in making this distinction, as they are all premenopausal women with normal follicle-stimulating hormone and estradiol levels. The diagnosis of PMS should come from the history relating the occurrence of cyclical mood and behaviour changes with menstruation, the improvement during pregnancy, postnatal depression and the presence of runs of many good days a month and the somatic symptoms of mastalgia, bloating and headaches. Young women with severe PMS do not respond to the antidepressants and mood-stabilizing drugs typically used for bipolar disorder.

Keywords: Premenstrual depression, bipolar disorder, postnatal depression, estrogens, hysterectomy

The treatment of severe premenstrual syndrome (PMS) or premenstrual dysphoric disorder (PMDD) by ovulation

women is that they will have teenage premenstrual mood swings and when the hormone levels cease to fluctuate as

Case History 1

1 First seen Dec 2005 Age 36

2 Many in patient visits for "manic depression"

3 PMS since teenager

4 Para 2 aged 4 and 3

5 Good mood during pregnancy x2 è PND x2

6 Many SSRIs did not help- did not take suggested Lithium

7 estradiol patch "99% better" – like pregnancy -- gels implant

8 Progesterone intolerance TAHBSO Oct 07

9 Well no depression no antidepressants .

Doctors do not understand what a near death experience cycles can produce

Case History CB

- The same story but 20 years of lithium and now has renal failure with GFR of 30 mls/min

- Now off all antidepressants and mood stabilizing drugs

Case History 2

- First seen aged 44 Nov 05 depression / CFS for 20+years
- Had TAH with ovarian conservation 2000
- Has cycles depression irritable 7good days a month
- Has been in patient x 3 . 10 years of sodium valporate ,ritalin, lithium , prozac , rivotril, assendine amoxapine , tegratol from 1987
- Transdermal estrogens Oct 06 “best summer for years and years”
- Estradiol and testosterone implants every 6 months –

- ***no CFS no depression but unhappy because she can not remember her children growing up !***

Case History SS

- First met 1968 aged 26
- Depression from aged 20
- Was sterilized age 28 during PhD studies - No children
- Very successful author and academic .
- E and T for PMS/Depression aged 32
- Now aged 62 . Well and after 30 years will not come off HRT as her GP suggests

Case History SS

- First met 1968 aged 26
- Depression from aged 20
- Was sterilized age 30 during PhD studies - No children
- Very successful author and academic .
- E and T for PMS/Depression aged 32
- Now aged 62 . Well and after 30 years will not come off HRT as her GP suggests

- Diagnosed Bipolar in USA aged 20 .
- Lithium for two years and anti depressants for 20 years
- Sterilized due to misdiagnosis !!

But a failure

- A fifty-year-old woman diagnosed with postnatal depression and bipolar disorder that attempted suicide nineteen months after the birth of the baby. She survived but the baby died. Severe depression started in 1987 but there had been a history of moderate premenstrual depression. She was very well during pregnancy, breastfed for one year and had good bonding with the child, but nineteen months after the birth became depressed and was not helped by antidepressants .
- She was was admitted to hospital for one year. She has had many drugs for twenty years including Venlafaxine and lithium. She has had eight episodes of ECT during this time.
- Some little improvement in depression with estrogens. No longer suicidal.
- Psychiatrist refused further treatment and removed all NHS support services

The 8 characteristics of severe PMS not found in bipolar disorder

1. Depression related to menstrual cycle
2. The relief of depression during pregnancy
3. Post natal depression
4. PMS when periods return
5. PMS becomes worse with age to perimenopausal depression
6. co-existence of somatic cyclical symptoms i.e. mastalgia headaches or bloating
7. Usually have monthly runs of 7-10 good days a month
8. Cyclical depression but rarely has highs

The 8 characteristics of severe PMS not found in bipolar disorder

retrospective audit of 10 patients with "bipolar disorder" who have been "cured" with hormone therapy

1. Depression related to menstrual cycle 10/10
2. The relief of depression during pregnancy 9/10
3. Post natal depression 8/10
4. PMDD when periods return 10/10
5. PMDD becomes worse with age to perimenopausal depression ? 5/5
6. co-existance of somatic cyclical symptoms i.e. mastalgia headaches or bloating 10/10
7. Usually have monthly runs of 7-10 good days a month 10/10
8. Cyclical depression but rarely has highs 9/10

PMDD or Bipolar Disorder

- **1) There was a history of mild or severe PMS as a teenager.**
- All 10 patients had such a history involving cyclical depression starting soon after puberty In 5 cases this was recognized as being a result of simple teenage behavioural and period problems that were not regarded as abnormal but 4 cases were given antidepressants before the age of 20

PMDD or Bipolar Disorder

- **2) There was a relief of depressive symptoms during pregnancy**

- In all eight of the patents who became pregnant depression was not a problem in 6 who claimed to be in good mood during pregnancy in spite of first trimester problems such as nausea and tiredness but 2 remained on their antidepressants throughout. All eight patients reported that they were at their best with least or no depression during their pregnancies

The ultimate irony

"women with bipolar disorder have an 8 fold increased incidence of postnatal depression"

Jones 2010

True and logical if BPD was in fact severe PMS

Studd 2012

Bipolar – Postnatal Depression

- Women with Bipolar I have 50% chance of PND

- Women with bipolar II have 40% chance of PND

  Perinatal episodes across the mood disorder spectrum

  Di Florio Jones I 2013 JAMA Psych.70 168-175

And others in last 5 years with no mention of PMS or PMDD

Depression and oestradiol

Optimal oestradiol level of **600 +** pmol/L for alleviating hormone responsive depression

Climacteric depression

- BUT it is the changing plasma levels rather than the absolute values that are important in producing symptoms.

  Brincat & Studd Lancet 1984 1:16-18

Safety of estrogens for depression

- Young premenopausal women
- Transdermal route and little/no effect on hepatic coagulation factors
- Minimal progestogen or none if after hysterectomy
- Most recent data confirms decrease in CHD and no increase in breast cancer
- Safer and more effective than antidepressants

Complications of antidepressants and mood stabilizing drugs

- Stroke
- CHD
- Renal failure
- Pregnancy and newborn problems
- Weight gain
- Loss of libido
- Failure of orgasm or erection
- Confusion / sedation
- Tremor
- Overdose /suicide
- Arrhythmias

Complcations of antidepressants and mood stabilizing drugs

And they often don’t work !

Psychiatrists reasons for failure !!!

- "drug resistant depression"
- "Borderline personality disorder"
- "Pre morbid pathology"
- "Bipolar Disorder"

Original article

POST REPRODUCTIVE HEALTH

Post Reproductive Health
2014, Vol. 20(4) 132–137
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sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/2053369114557883
prh.sagepub.com

SAGE

Hormone therapy for reproductive depression in women

John Studd

Abstract

An email survey of patients attending a PMS and Menopause Centre produced 238 patients whose principal presenting symptom was depression. Seventy-seven percent claimed to have had severe or moderate depression, 17% had had at least one psychotic episode and 14% had attempted suicide. Fifty-eight percent had seen a psychiatrist. Seventy-one percent had received antidepressants and 17% had received mood stabilising drugs. Twelve percent had been admitted to a psychiatric hospital and 3.8% had received electroconvulsive therapy. Sixty-eight percent had premenstrual syndrome as a teenager and 145 women (89%) out of 165 women who had been pregnant had no depression during pregnancy but 110 (66%) developed postnatal depression. Ninety-seven women (58%) who had been pregnant had suffered both premenstrual depression and postnatal depression. All were treated with transdermal estrogens and 93% also had transdermal testosterone. One hundred and seventy-one patients had a uterus and received cyclical progestogen to protect the endometrium and 63% of these developed the premenstrual syndrome-type symptoms of progesterone intolerance during the progestogen days. Thirty-five percent of patients claimed to be cured and 55% had a considerable improvement with estrogen therapy. Only 3.7% reported that there was no improvement. For 94%, the hormone therapy was a life-changing event for the better. None were worse. Forty patients had hysterectomy and bilateral oophorectomy for progesterone intolerance or heavy uterine bleeding and 38 replied that it was life changing for the better with less or no depression. It is concluded that premenstrual and postnatal depressions appear in the same vulnerable women. These women are typically well during pregnancy and are a sub group of reproductive depression which also develops climacteric depression in the transition phase. These types of depression are the product of hormonal changes and respond well to transdermal hormone therapy.

Email questionnaire of 236 depressed patients

Past medical history

17% had had a "psychotic episode" in the past

58% had seen a psychiatrist

71% had antidepressants prescribed

17% had mood stabilizing drugs

12%(28) had been an in patient for depression

3.8% (9) had received ECT

14% (34) had attempted suicide

Email questionnaire of 236 depressed patients

Therapy

All 238 patients had transdermal estrogens

132 by gel

47 by implant (but always gels first)

59 by both gel and implant

224 (93%) patients also had transdermal Testosterone by gel or implant

Email questionnaire of 236 depressed patients

Association of PMS and PND

162 of 238 (68%) had pms as teenager

145 of 165 (89%) patients who had been pregnant were in good mood without depression during pregnancy

but 110 (66%) had postnatal depression

97 (58%) of those pregnant suffered both premenstrual and post natal depression and 90 (92%) of these were well during pregnancy.

Email questionnaire of 236 depressed patients

Progestogen intolerance

63% of the 171 patients who took cyclical progestogen had severe PMS symptoms

59 patients had a Mirena IUS inserted

40 (17%) had a hysterectomy- usually a laparoscopic TAHBSO

Email questionnaire of 236 depressed patients

- 40 women had laparoscopic TAHBSO

- 38 “life changing for the better” - 2 no reply
- 24 no longer on antidepressants
- 6 antidepressants but lower dose
- 10 never had antidepressants

Email questionnaire of 236 depressed patients

How did hormone therapy compare with anti-depressants?

- 37% Did not have anti-depressants

- 61.2% Better
- 6.2% The same
- 0.4% Worse

Email questionnaire of depressed patients

Was hormone therapy life changing for you?

Yes for the better 225(94.2%)

No 13(5.8%)

Yes for worse 0

(Very) long term HRT

- Better general health – energy mood libido
- Less osteoporosis and fewer osteoporotic fractures
- Probably less breast cancer without progestogen
- With transdermal therapy fewer heart attacks fewer cardiac deaths and fewer strokes

  ?? Less AZ ??

For more information

www.studd.co.uk

Original article

POST REPRODUCTIVE HEALTH

Post Reproductive Health
2014, Vol. 20(4) 132–137
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DOI: 10.1177/2053369114557883
prh.sagepub.com

SAGE

Hormone therapy for reproductive depression in women

John Studd

Abstract

An email survey of patients attending a PMS and Menopause Centre produced 238 patients whose principal presenting symptom was depression. Seventy-seven percent claimed to have had severe or moderate depression, 17% had had at least one psychotic episode and 14% had attempted suicide. Fifty-eight percent had seen a psychiatrist. Seventy-one percent had received antidepressants and 17% had received mood stabilising drugs. Twelve percent had been admitted to a psychiatric hospital and 3.8% had received electroconvulsive therapy. Sixty-eight percent had premenstrual syndrome as a teenager and 145 women (89%) out of 165 women who had been pregnant had no depression during pregnancy but 110 (66%) developed postnatal depression. Ninety-seven women (58%) who had been pregnant had suffered both premenstrual depression and postnatal depression. All were treated with transdermal estrogens and 93% also had transdermal testosterone. One hundred and seventy-one patients had a uterus and received cyclical progestogen to protect the endometrium and 63% of these developed the premenstrual syndrome-type symptoms of progesterone intolerance during the progestogen days. Thirty-five percent of patients claimed to be cured and 55% had a considerable improvement with estrogen therapy. Only 3.7% reported that there was no improvement. For 94%, the hormone therapy was a life-changing event for the better. None were worse. Forty patients had hysterectomy and bilateral oophorectomy for progesterone intolerance or heavy uterine bleeding and 38 replied that it was life changing for the better with less or no depression. It is concluded that premenstrual and postnatal depressions appear in the same vulnerable women. These women are typically well during pregnancy and are a sub group of reproductive depression which also develops climacteric depression in the transition phase. These types of depression are the product of hormonal changes and respond well to transdermal hormone therapy.

Keywords

Hysterectomy, menopausal depression, PMDD, PND, transdermal estrogens

Introduction

The increased incidence of depression in women is well recognised[1,2] occurring at times of hormonal fluctuations within a woman's reproductive life.[3,4] These episodes of mental illness include premenstrual depres- and then developed premenstrual symptoms as a teenager. They would have been in good mood during pregnancy only to develop PND. When the cycles and periods return after delivery, the cyclical PMS returns.[5] Perimenopausal mood changes are characteristically at

Email questionnaire of 236 depressed patients

Therapy

All 238 patients had transdermal estrogens

132 by gel

47 by implant (but always gels first)

59 by both gel and implant

224 (93%) patients also had transdermal Testosterone by gel or implant

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