DEPRESSION & MENOPAUSE

Prof J.KULKARNI
HealthEd

PERIMENOPAUSAL DEPRESSION

- Very high incidence of first onset depression in perimenopause. Even higher relapse risk of depression in women with past history.
- Overall depression rates increase up to sixteen times in 42-52 year old women.
- Second highest completed suicide group –in Australia – women aged 45-52
- Declining/ chaotic HPG axis function occurring from age 43-55. CNS changes first – up to 5 years before hot flushes, amenorrhoea

PERIMENOPAUSE DEPRESSIVE SYMPTOMS

- Plummeting self – esteem
- Paranoid ideation
- Aggressive
- Disconnection
- No libido
- Irritable / agitated
- Weight gain
- Poor sleep (compounded by hot flushes)
- Memory/ concentration changes
- Anxiety /Panic

Aetiology of Perimenopausal Depression

- A subset of women seem to be predisposed to experience mood disturbances triggered by hormonal fluctuations.
- This subset includes women with a history of mood disorders or of premenstrual and postnatal mood-related symptoms or a female family history of mood disorders related to hormone events.
- Women with no previous history of mood disorders at all can develop severe perimenopausal depression de novo.
- Not found with usual HPG axis lab investigations – this is CNS estradiol fluctuation

PERIMENOPAUSE DEPRESSION MANAGEMENT

- Depression in middle aged – multifactorial
- Antidepressants or MHT? Usually both, but if possible better to start with MHT
- Sleep regulation
- Natural medicines
- Psychotherapy

Menopause Hormone Treatment

- Currently, the evidence base in terms of clinical trials conducted with menopausal hormone treatments in actual perimenopausal depression is limited.
- MHT is useful in treating perimenopausal depression
- MHT Practice Suggestions: International Menopause Society (IMS) guidelines updated in 2016
- The MHT types that are available for use in perimenopausal depression treatment include – conjugated equine estrogen (CEE) or transdermal estradiol 75–100 mg/day or oral ethinylestradiol Micronized progesterone can be administered as a cyclic regimen.

COCs for Perimenopausal Depression

- In early transition to menopause, the combined estrogen/progestogen contraceptive pills (COCs) are useful treatments, although it is important to keep in mind that many COCs may be associated with increases in depression.
- Zoely as a COC has less depression than other COCs

TIBOLONE

- Tibolone is a synthetic steroid and has a mixed hormonal profile. Its estrogenic potency is about 1/50 of that of ethinyl-estradiol, its progestogenic potency is 1/8 that of norethisterone acetate and the androgenic potency is about 1/3 that of norethisterone. It has been proven to relieve climacteric symptoms and improve libido as well as assist in the management of perimenopausal anxiety and mild depression
- Adverse effects with tibolone is intermenstrual bleeding. but an advantage of tibolone treatment is that it does not cause increased breast density.

MHT for Depression

- The risks and benefits of MHT differ for women during the menopause transition compared to those for older women. Bioidentical hormones are not recommended by the IMS because of standardization and dosing issues.

Treating women with new depression related to perimenopause

- Assess and monitor severity (including suicidality) – new doesn't mean less severe
- HT more acceptable to most women
- Natural therapies
- Psychotherapies - support but don't treat this depression
- Combinations of the above
- Address weight gain and physical health issues

"I'm a wife, a mother, a daughter, an executive, a cook, a housekeeper, a teacher, a chauffeur, and a soccer coach. *That's only 19 pounds per woman!"*

Antidepressant Use - Depression in Perimenopause

- Commonly used to treat anxiety, depression, sleep problems, hot flushes
- SNRIs popular (low dose venlafaxine)
- Issues – discontinuity problems, blunting, aggression, problems with tachyphylaxis
- Match symptom with antidepressant eg: agitation worsened by fluoxetine
- Consider circadian rhythms restoration

NEW APPROACHES : OUR RESEARCH

- Recognition of the condition
- Safe, shorter –term hormone treatment
- Different antidepressant approach (on/off)
- Physical health overview – tackle weight gain, wine consumption, lack of exercise
- Working with natural medicines too

CASE STUDY

- Kate is a 48 year old nurse, who has three children aged 17, 14 and 12.
- Married for 21 years.
- No past history of any psychiatric illness, no family history
- Symptoms were tiredness, tearfulness, poor sleep pattern, weight gain, excessive alcohol use, constant anxiety

CASE STUDY

- Kate, was working in a private hospital as a theatre nurse and found that she couldn't concentrate – although she had done this work well for the past 15 years.
- "I felt so tired and foggy all time – but also 'wired and edgy' at the same time"
- Sleeping pattern changed – woke up about 3-4 times per night, then ruminating over the days work, household issues, children, husband
- Changed from Theatre to Recovery work – not enjoyed as much, felt like a "demotion"
- Gained 5 kg
- Drinking nearly one bottle red wine per night – to "drown out everything"

CASE STUDY

- Kate began to think about her life as being futile
- She often thought about methods of committing suicide
- She attended her GP and told him about her symptoms and her thoughts of suicide
- Kate started on fluoxetine – agitated, felt worse, despairing. Dose increased every 4 days to 80mg/day – even worse (poor sleep, agitation)
- Discussing suicide ideas daily with husband, she took sick leave, not able to care for children
- Referred to WMH Clinic

CASE STUDY

Diagnosis: Perimenopausal Depression

Treatment:

Risk Assessments done

HRT - Tibolone started

- Decreased dose of Fluoxetine to 40mg/day(with aim to cease over time) (www.genesfx.com testing showed slow metabolism)
- Low dose quetiapine (12.5mg nocte)
- Psychotherapy (with husband as well)
- Alcohol withdrawal programme

CASE STUDY

After 3 months:

- Kate's comment : "I feel better, and nearly myself again"
- Sleeping, eating better. No suicidal ideation
- No alcohol

After 8 months:

- "I'm back"
- Continuing on tibolone
- No quetiapine
- No fluoxetine
- No alcohol

WHAT HAPPENED TO JENNY?

- **Biological**
  - Hormone shifts related to perimenopause
  - Depression related to change in brain neuroendocrinology
- **Psychological**
  - No particular psychopathology, but self-esteem plummeted
- **Social**
  - Life roles, relationship changes, work

PERIMENOPAUSE

- A biopsychosocial approach is imperative
- A time of great upheaval for many

BUT

- Happy endings are very possible