Letters to the Editor


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Reply: Hysterectomy and bilateral oophorectomy for severe premenstrual syndrome

Sir,

Dr Renkens’ letter is most interesting and exposes the controversy relating to the role of hormones and depression in women. Renkens has brought up one of the darkest periods in the history of our specialty—and something which is not known to the majority of gynaecologists and psychiatrists. This unholy alliance of the most distinguished members of our specialties is the subject of my address for the annual RCOG historical lecture in November of this year, and any relevance to current practice has recently been published (Studd and Panay, 2004).

Longo (1979), in his masterly account of the rise and fall of Battey’s operation, finally posed the question as to whether it worked or not. If we consider menstrual madness as severe PMS, and if we regard anovulation by GnRH analogues as the equivalent of a medical oophorectomy, then randomized trials strongly suggest that it did work (Leather et al., 1999). The trouble was that enthusiasm for the operation went beyond the bounds of humanity when it was performed for ‘all cases of lunacy’ and even for women who wanted to leave their husbands. In the right patients it would have cured menstrual mania but the mortality from the surgery and subsequent osteoporosis would certainly condemn the procedure.

As Dr Renkens states, Dr Dalton played a major role in making people aware of the syndrome of PMS and the dangers it posed to women’s health. Unfortunately, not one of her several treatments passes the test of scientific scrutiny. On the other hand, treatments which accept that the underlying cause of PMS is the hormonal changes that occur following ovulation, and that therefore rely upon removal of these changes by suppressing ovulation, are effective. Apart from the use of GnRH analogues, estradiol implants (Magos et al., 1986) and anovulatory doses of estradiol by patch (Watson et al., 1989) have been shown to be effective in placebo controlled trials.

If it were possible to perform a placebo hysterectomy, that might persuade the sceptics that the overwhelmingly beneficial effect was not due to the placebo effect of surgery. Isaacs in 1880 performed a sham oophorectomy in a patient with apparent cure, but the patient saw Hegar 1 year later, and he claimed that it was he who eventually cured her by removing the ovaries. It may interest readers to know that the normal ovariectomy was considered to be such an advance that Hegar strongly criticized ‘well meaning objectors who had put back German gynaecology by 20 years’. Never again, he wrote, should we allow German gynaecology to be overtaken by foreigners. Thus, the treatment was so new and promising that there was great academic and national pride at stake. We would suggest that cloning and stem cell research are the contemporary equivalents to what was seen as a major controversial development in surgery in the 19th century.

However misguided was the use of bilateral ovariectomy, there was at least some logic to it. There was no such logic to clitoridectomy, which was not performed for menstrual madness, nor was it ever performed by Marion Sims. But that is another depressing story.

Dr Renkens last paragraph claiming that medical and surgical treatment should be avoided in all cases makes me despair. A large number of women have their reproductive years destroyed by PMS and, if we are to alleviate their suffering, we are duty bound to forget our prejudices and consider the scientific evidence for all potential modes of treatment, whether this is psychotherapy, anti-depressants, treatments based upon anovulation and, in the rare appropriate cases, hysterectomy, bilateral oophorectomy and long term hormone replacement.

References


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Ovarian reserve and reproductive age may be determined from measurement of ovarian volume by transvaginal sonography

Sir,

We read with interest the recent paper by Wallace and Kelsey (2004) on the role of ovarian volume measured by