

**“Gotta Go”, “Gotta Go” Meds not helping?
Maybe your Patients Ankle Holds the Answer.**

Nerve Stimulation Device Improves Tough-to-Treat Overactive Bladder Symptoms

Percutaneous tibial nerve stimulation (PTNS) is an effective treatment for patients with overactive bladder (OAB) who have failed conservative therapy, according to the results of a multicenter trial released here at the American Urological Association 2010 Annual Scientific Meeting. "This is the first multicenter, randomized, sham-controlled trial proving that tibial nerve stimulation is very safe and effective for the treatment of OAB symptoms."

Neuromodulation Targets Nerves That Control Bladder Function

Percutaneous tibial nerve stimulation (PTNS) is a type of neuromodulation therapy that uses electrical stimulation to target specific nerves in the sacral plexus that control

bladder function. The treatment targets the sacral plexus from which the nerves that control the bladder arise. Stimulation of the posterior tibial nerve at the ankle results in stimulation of these nerves and relieves Overactive Bladder Symptoms (OAB). Unlike InterStim, Percutaneous tibial nerve stimulation (PTNS) is intended for office-based treatment of OAB symptoms and requires no incisions or anesthesia.

Percutaneous tibial nerve stimulation PTNS should be considered an alternative to oral medication therapy (the gotta go drugs) for the treatment of OAB. "Over 75% of patients treated with OAB meds quit taking these within the first year because of a combination of side effects, cost, and lack of efficacy. Tibial nerve stimulation provides an excellent alternative."

This office based minimally invasive treatment is indicated in patients with urinary urgency, urinary frequency, and urge incontinence that are refractory to drugs or whom medications may be contraindicated.

J. Kyle Mathews, MD

3108 Midway Road • Suite 210 • Plano, TX 75093
972-781-1444 • www.drjkm.com

A publication on
Female Pelvic Medicine,
Pelvic Organ Prolapse
and Continence from
Plano Urogynecology Associates /
Plano OB Gyn Associates.
J. Kyle Mathews, MD

WELCOME to POP QUIZ,
A periodic publication to provide the
practicing physician with concise, up to
date, information in Female Pelvic
Medicine, Restorative Pelvic Surgery,
Urogynecology, and Incontinence.

NEWS

Please make note of the new suite number,
#210. I continue to add information, forms
and patient education material to the web
site. Please check often for updates. If you
have a suggestion for a topic to be included
in the newsletter, e-mail me. You can also
follow us on Facebook and Twitter. JKM
www.drjkm.com

IN THIS ISSUE

**Bioidentical Hormones: Sorting Myths
and Facts**

**“Gotta Go”, “Gotta Go” Meds not
helping? Maybe your Patients Ankle
Holds the Answer**

Myths, Mistruths, and Misinformation:

*Home births are safe for most non-high
risk pregnant women.*

*Glucosamine is helpful in the
management of Osteoarthritis of the
lower back.*

*Chocolate is bad for you during
pregnancy.*

MYTHS, MISTRUTHS, AND MISINFORMATION

**Home births are safe for most non-high risk
pregnant women. False.**

*Less medical intervention during planned home birth
is associated with a tripling of neonatal mortality.
The study to be published in the American College of
Obstetrics & Gynecology in September found
perinatal mortality rates were similar for planned
home and hospital births, BUT neonatal mortality
rates were significantly higher with planned home
births.*

**Glucosamine is helpful in the management of
Osteoarthritis of the lower back. False.**

*Glucosamine was no better than placebo for reducing
pain or improving quality of life in patients with
chronic low back pain and degenerative
osteoarthritis. A study from Norway found that
Glucosamine, a precursor molecule involved in the
building of tendons, ligaments, and cartilage, did not
reduce pain or improve quality of life better than
placebo.*

Chocolate is bad for you during pregnancy. False.

*A recent study from Italy found that consuming 30
grams of dark chocolate a day during pregnancy
significantly reduced systolic and diastolic blood
pressure, and reduced the risk of anemia. Researchers
also noted the 160-calorie dose of dark chocolate did
not affect overall weight gain for the pregnancy.*

Bioidentical Hormones: Sorting Myths and Facts



If you see menopausal women in your practice you are certain to be asked about “Bioidentical Hormones”. Hopefully, this article can help you answer questions and dismiss many of the myths surrounding this highly published, highly marketed topic.

The term Bioidentical Hormones is not a medical term, it is a marketing term used to imply an exact copy of the hormones produced in the body. Providers of these compounds often claim they are “A natural, safer alternative to prescription drugs”, “Can help with weight loss”, “Prevent Alzheimer's” and many others unfounded benefits. In addition, these providers often suggest that Bioidentical Hormones can only be obtained from a compounding pharmacy.

The fact is, there are many FDA-approved bioidentical hormone products available in the U.S. today. In fact, they have been available in the U.S. since 1975! Most all FDA-approved bioidentical hormones have been available in the U.S. for a long time and have extensive studies to support their safety and effectiveness. As an example, EstroGel was one of the first bioidenticals in the world with use in France since 1974, FDA-approval in the U.S. in 2004, and now used in more than 70 countries.

To better understand what is meant by Bioidentical Hormones, specifically estrogens and progesterone, the following may be helpful. The 3 primary human estrogens are: E1, Estrone; Serves as the primary “reservoir” of estrogen, and dominant estrogen remaining

AFTER menopause. It is produced primarily in the ovaries, body fat, and breast. E2, Estradiol; Serves as the primarily active estrogen BEFORE menopause and is LOST at menopause when follicles are gone. It is produced primarily in the ovaries with, some, made from testosterone in the brain, breast, and muscle. E3, Estriol; A weak estrogen made by the placenta during pregnancy. There is only one progestin, Progesterone, which is converted to other progestins.

The only FDA-approved estrogen bioidentical hormone is estradiol. Perimenopausal and postmenopausal women do not need the hormones estrone and estriol. However, compounding pharmacies often use Estriol or E3, which is not FDA-approved. Furthermore, pharmacies and doctors may not (or should not by law) use Estriol unless they have an investigational new drug (IND) application with the FDA. Obviously many doctors and pharmacies violate this FDA regulation but are not sanctioned because the FDA does not regulate compound pharmacies, the state does.

These compounding pharmacies obtain the bioidentical or natural hormones, Estradiol, Progesterone, and Testosterone in USP raw powder from for the SAME suppliers the drug companies do. They use different amounts of each but the hormones are the same. Many formulations are based on Saliva testing to “individualize” hormone therapy. It is well documented that hormone levels in saliva vary widely and do not correlate well with blood levels. In addition, it is also known that the plastic tubes used to collect saliva alters hormone levels. Saliva testing is not reliable, period.

Providers and compounding pharmacies often include Progesterone claiming additional health benefits. The fact is progesterone does not add additional benefit other than protection of the uterine lining from unopposed estrogen effects that can result in uterine cancer. Progesterones should not be prescribed in women whom have had a hysterectomy. Progesterones may increase breast cancer risk, promote weight gain, cause depression, and does not prevent bone loss.

The use of testosterone in menopausal women has been studied and shows some benefit at low doses to treat vasomotor symptoms and decreased libido. Higher dosages have been associated with elevated cholesterol, triglycerides, male pattern hair growth, and acne. Cliteromegally is not common unless dosages are excessively high.

So what are the FDA-approved Bioidentical Hormones?

<i>Oral</i>	<i>Transdermal Gels, lotions, sprays</i>	<i>Trandermal patches</i>	<i>Vaginal</i>
<i>Estrace, 1975</i>	<i>EstroGel, gel, 2004</i>	<i>Estraderm, 1985</i>	<i>Estace cream, 84 Vaginal</i>
<i>Estrodiol Generic 1997</i>	<i>Estrasorb, lotion 2006</i>	<i>Vivelle, 1994</i>	<i>Estring, ring 1996</i>
<i>Prometrium, 1998</i>	<i>Divigel, gel 2007</i>	<i>Climaria, 1995</i>	<i>Prochieve 4% gel 1997</i>
	<i>Elestrin gel, 2008</i>	<i>Vivelle Dot, 98</i>	<i>Vagifem Tabs, 98</i>
	<i>Evamist spray, 2008</i>		<i>Femring, 2003</i>

The true indications for hormone therapy are obvious, vasomotor symptoms, vaginal dryness, preventing bone loss, and it is best to start them as close to menopause as possible. Recent data has suggested advantages of transdermal administration over oral administration but further studies are needed.

The North American Menopause Society and others have revised their position statements on hormone therapy as of 2010 stating the use of hormone therapy around the time of menopause has a favorable benefit-risk ratio. They go on to state that hormonal therapy may decrease total mortality when started soon after menopause but does not appear to reduce mortality when started after age 60.

For patients currently on compounded hormones, you should look at the dosage closely. Dosages recommended by compounders are often too high-especially for testosterone and progesterone creams. Those patients that have not had hysterectomy need progesterone, those that have, do not. Relative and absolute contraindications are the same as FDA-approved hormones.

For those considering using compounded hormones, you can advise them there are FDA-approved bioidentical hormones available from the local pharmacy that are well tested and have a long history of safety and efficacy. In addition, most are covered by insurance.

J. Kyle Mathews, MD