Cycle suppression for catamenial dermatoses: Transdermal estradiol prevents perimenopausal premenstrual genital herpes

RCOG WORLD CONGRESS 2022 13 - 15 JUNE
POSTER PP.0117
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"Any physical or mental symptom with a precisely repeating cyclical timing must have a hormonal cause, thus could have a hormonal solution"

At least 15 dermatological conditions may repeatedly present premenstrually or catamenially: Gynaecologists are often invited to initiate cycle suppressing or ablating hormonal regimes for such conditions as Behçet's syndrome, hidradenitis suppurativa, autoimmune progesterone dermatitis, etc[1]. ***Herpes catamenialis*** has been recognised for over a century, occuring more commonly in perimenopausal women, but there is no work published in the English language on its treatment.

Design: We used transdermal estradiol (TE2) to treat perimenopausal women with premenstrual syndrome (PMS) who had simultaneous cyclically-recurrent genital herpes (CGH), by observing self-reported changes in herpes & PMS recurrence rates after they stopped taking Aciclovir & started TE2 to treat severe PMS.

Method: Proof of concept study reviewing 15 perimenopausal women median age 41 years (range 36-46) between 2005–17, each meeting the *DSM IV* or *V* criteria for severe PMS.

Each had experienced at least 4 consecutive monthly episodes of CGH (culture or PCR-proven HSV2) before starting luteal-phase Aciclovir suppression (400mg bd or tds), then all switched to TE2 gel (Sandrena®) 0.5mg or 1.0mg daily for 14 days taken luteally or every day continuously if using Mirena® (LNG-IUS).

Subjects self-reported mood parameters and herpetic symptoms with a modified daily symptom score chart (DRSP) over nine months follow-up when no Aciclovir was taken pre-emptively, but was available in case of recurrence.

ITT analysis – using Student's t-test – included 11 cycles where TE2 was omitted in error.

Results: When TE2 was correctly taken, all women experienced substantial or complete relief of PMS in all but four cycles, with only 15 symptomatic herpes episodes occurring on treatment over 124 woman-months of observation. Three women* whose PMS (& herpes) was not prevented by 0.5mg TE2, had no further PMS on increasing to 1.0mg TE2 daily.

Both conditions recurred in each of the 11 cycles when treatment was omitted in error.

Recurrences over 9 Months' Observation: ON treatment NO treatment

Pt	AGE	Month 1	2	3	4	5	6	7	8	9	PMS	CGH
1	45										0	0
2	36				HERPES			HERPES	BOTH	BOTH	2	4
3	42						HERPES				0	1
4	44							HERPES			0	1
5	41			BOTH					BOTH		2	2
6	39				BOTH					HERPES	1	2
7	44		HERPES			HERPES		BOTH			1	3
8	38*	BOTH							HERPES		1	2
9	43				BOTH				BOTH		2	2
10	41				BOTH		BOTH			HERPES	2	3
11	43										0	0
12	42*	BOTH				HERPES		BOTH			2	3
13	37							HERPES			0	1
14	46*	BOTH									1	1
15	41				BOTH						1	1
RATIO Observed / Expected		**0.11 PMS**			**0.19 Herpes**		*p<0.0001* (Student's t-test)				**15**	**26**

In all there were 15 episodes of PMS and 26 of CGH over 135 months
The observed-to-expected ratio was 0.11 for PMS, 0.19 for CGH (*p<0.0001*)
This represented reductions of 89% for PMS and 81% for Herpes

Conclusions: This study is the first to demonstrate that transdermal estradiol is a novel and effective method of preventing catamenial genital herpes and confirms its proven success in treating perimenopausal PMS[2]

Working by stabilising the hormonal milieu, it suppresses luteal phase fluctuation of ovarian estradiol which causes catamenial immunosuppression, the effect being exacerbated during perimenopause.

Currently, women receive ineffective SSRIs for perimenopausal PMS and suppressive or episodic Aciclovir for CGH, to treat ***symptoms***: TE2 (+/- LNG-IUS) is an effective, biologically plausible & holistic treatment of the ***cause*** of both conditions. Thus it should be deployed *a priori* for other catamenial dermatoses similarly triggered by luteal phase immunosuppression, such as recurrent vulvovaginal candidosis.

"Treat the underlying CAUSE, not just the SYMPTOM"

References
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