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Guest Editorial

THE OBSOLETE MENOPAUSE

ROBERT A. WILSON, M.D.

This article was reviewed by O. N. Stern, M.D., of Wilmington, who highly recommended the principles expressed. He did caution that the doses used under such a philosophy should be only a fraction of the usually accepted dose.

A girl becomes a woman when estrogen and progesterone arrive. When they depart, she is a woman by courtesy only—in reality a castrate, condemned by tradition and a mystique that surround this time of her life in an almost impenetrable cloak.

The favorable metabolic effects of estrogen and progesterone on every body cell are not fully realized. Estrogen improves cell permeability and regulates the supply of micro-nutrients, enzymes, glucose, minerals, water, etc.¹ Progesterone, while essentially catabolic, is definitely needed for balanced cell metabolism. Both are essential for homeostasis.

In the past, because the menopause happened to every woman, it was generally thought to be normal. So long as there was no remedy, this was a comforting, almost necessary idea. Today the effects of estrogen and progesterone deficiency are so completely documented that to list them would be repetitious. We know that menopausal women are not normal; they suffer from a deficiency disease with serious sequelae and need treatment.

The removal of the ovaries and uterus in women in the twenties and thirties is sometimes necessary, and denying them *full* hormonal replacement is the rule rather than the exception—a form of “medical barbarism.”

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This is also true when the denial is in the forties or fifties, and even later. Although the insult decreases with age, every cell is adversely affected. If there is to be denial—a cutoff point—at what age is it to be? Who is to decide? On what research is it to be based?

When the thyroid weakens with age, replacement therapy, continued indefinitely, causes no concern; this applies to the pancreas and adrenals too. But when the gonads fail at the menopause, a different philosophy prevails—“Don’t interfere with nature.”

Precise diagnosis and treatment is the rule when ovarian failure occurs in the twenties or early thirties, yet after about age 35 this is seldom the case. Failure is attributed to early menopause and there is a loss of therapeutic interest. The patient is told to expect amelioration and preparation for future adjustment, but not cure.

About ten per cent of women maintain a high estrogen titer as late as age 60. One of these women visits her gynecologist. After examination plus an analysis of the vaginal smear, he compliments her on her perfect condition—her high estrogenicity. A few days later he is visited by her twin sister with atrophic breasts, senile vaginitis and many bizarre symptoms of the menopause. Finding a low cornification index, he reluctantly prescribes estrogen in low dosage and a tranquilizer “to tide her over this trying time.” She immediately challenges him. “Logically, Doctor, my estrogen level must be elevated to that of my sister, or you must reduce her level to mine. You cannot have it both ways.”

Replacement therapy with both hormones presents few problems when the ovaries have been removed accompanied by hysterectomy.

If the ovaries are removed or functionally dead but the uterus intact, cyclic replacement therapy will result in withdrawal bleeding. This cannot be dispensed with because of the systemic metabolic effects of progesterone in addition to its needed target action on the perilobular and alveolar tissues of the breasts. This bleeding prevents endometrial hyperplasia. Endometrial cancer may be inhibited, or even cured, by progesterone and its derivatives.² Early *in situ* endometrial cancer is surely restricted from further invasion by the wholesale destruction of surrounding tissues and its subsequent lavage by rhythmic bleeding.

If steroid hormones remained in their glands or origin, they would be useless to body economy. Target or any other cells do not care where their estrogen and progesterone originate. Fundamentally the gonads are pharmaceutical laboratories; when the ovaries close up shop, the soma is quite content to receive its steroids from the corner pharmacy.

The percentage of superficial cells in the Papanicolaou smear is a valuable tool in estimating estrogen deficiency—"treat the smear."³

The ingestion of a tablet daily represents the essential difference between a life partly lived or a full one—a body and mind of multiple divisions or homeostasis, the complete woman. Over a hundred years ago, a French gynecologist graphically described postmenopausal women . . . "Compelled to yield to the power of time, women now cease to exist for the species, and henceforward live only for themselves. Their futures are stamped with the impress of futility." One of our best-known and loved professors recently said, "Something must be done for these poor women." The menopause became as obsolete as the bow and arrow the day potent oral progestogens were born.

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USE OF WHITE MINERAL OIL IN ENEMAS

(Continued from Page 9)

to provide effective and comfortable evacuation of the colon without irritation.

2. The value of white mineral oil as an additive to the soap and water enema was studied in cases of fecal impaction, dyschezia, chronic atonic constipation, and preparation for proctoscopy or roentgenography.

3. For routine use and for chronic atonic constipation a standard evacuant oil emulsion enema consisting of 1 quart of warm water, 1 gram (one level teaspoonful) of mild soap and 2 oz. of white mineral oil is recommended. The soap is dissolved in the water and the mineral oil added to form an emulsion.

4. For fecal impaction, the recommended procedure is a straight white mineral oil retention enema, introduced by means of a rectal bulb, in an amount varying between 1 and 3 ounces. This enema may be retained

from two to eight hours, depending on the length of time needed to soften the hard masses of stool. Subsequent evacuant enemas should be given consisting of warm water, mild soapsuds and mineral oil.

5. For proctoscopy and roentgenography complete evacuation of the rectum and bowel was observed, allowing clear proctoscopic and roentgenographic visualization when an oil emulsion enema was given on the evening before and again on the morning of the examination.

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