Epidemiology and End Results (SEER) Program SEER & Stat Database).

We agree that effects of ovulation induction should continue to be investigated for a variety of cancers. However, in order for results not to cause unnecessary alarm, it is important that they be carefully communicated. We therefore caution against our findings for breast cancer being communicated as a significant increase, since the only statistically significant increase pertained to a relatively small subgroup, namely clomiphene users who developed invasive cancers after 20 or more years of follow-up (Brinton et al., 2004). The results, however, support the need for further evaluation of long-term effects of fertility drugs.

References


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Hysterectomy and bilateral oophorectomy for severe premenstrual syndrome

Sir,

A curious coincidence: the publication of the paper by Cronje et al. (2004) on hysterectomy and bilateral oophorectomy for severe premenstrual syndrome and the death of Katharina Dalton (1916–2004), a pioneer and populariser of the ‘illness’ PMS on September 17 in Britain. In O’Connor’s obituary in the New York Times of 28 September, Dr Shangold, a gynaecologist is quoted as saying ‘Many people did not believe it was a real entity’. She continued: ‘She really brought it into the public eye, and eventually it became an accepted disorder for which we now have good treatments’. She did not elaborate on these treatments, of which I am not aware at all, but I certainly do not think that the treatment as proposed by Cronje et al. could qualify in this respect.

I really thought that the old times in which women with psychiatric symptoms were operated upon by gynaecologists was long behind us, but I am wrong. In a retrospectively mortifying period in the history of our profession, from about the 1870s until 1910, many women were castrated by the so-called ‘normal ovariotomy’, which was called Battey’s operation by J. Sims, as others underwent clitoridectomies for ‘nymphomania’. In Europe the German gynaecologist Hegar performed many of these operations, while in the US this role was performed by Battey. The details of this history can be found in the instructive chapter ‘Gynaecological Surgery and the Desire for an Operation’ in Shorters excellent book (1992) on the history of psychosomatic illness.

We think that PMS is a psychosomatic illness in which the contribution of abnormal ovarian function has never been proven. Since 1983 it is called ‘Late luteal dysphoric disorder’ in the Diagnostic and Statistical Manual of Mental Disorders (DSM). It is there that it belongs, and not in books on gynaecologic surgery. Treatment for this type of functional syndrome should be along psychosocial lines and not even the most severe symptoms should be taken as an indication for the removal of healthy organs.

In this kind of illness (cf Charcot’s grande hysterie, chronic fatigue syndrome, postnatal depression, post-whiplash syndrome etc.) there is a striking contrast between the extreme visibility of the symptoms and the lack of objective findings. Although this category of patients do seek a medical solution for their problems, doctors should refrain from medical treatments, as the problem is incurable with conventional medical modalities such as surgery or medicines.

The apparently successful and sustained cures of PMS by hysterectomy and oophorectomy, as reported by Cronje et al. (2004) can be explained in other ways. It is well known that surgery does have strong placebo effects (Johnson, 1994) and the PMS sufferer initially gets all the rewards that a sickness surgery does have strong placebo effects (Johnson, 1994) and the PMS sufferer initially gets all the rewards that a sickness role in our society provokes. After recovering from surgery these women are converted into ‘chronic patients’, depending on hormone replacement therapy and this again will please most of them, because of the prolonged attention this entails. It should be possible to manage these women in other ways and medical treatment—especially surgery—should in my opinion be avoided in all cases.

References

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