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The Mortar & Pestle:

MD Custom Rx's monthly e-newsletter

July 2016

Greetings!

Thank you for entrusting in the compounding services at MD Custom Rx to help meet the unique medication needs of your patients. We are excited to share our monthly newsletter with you and look forward to continuing to be your medication problem solvers. Please don't ever hesitate to let us know how we can be of further assistance to you and your practice.

Sincerely,
Dan, Monica and John

Progesterone Therapy in Women with Intractable Catamenial Epilepsy

Catamenial epilepsy involves exacerbation of seizures in association with the menstrual cycle, and has been defined as the occurrence of 75% of the seizures during a 10-day period of the menstrual cycle starting 4 days before menstruation. Estradiol has long been known to decrease seizure threshold. Progesterone and some of its metabolites decrease the seizure frequency in women due to the antiepileptic effects of progesterone. Catamenial epilepsy can be due to progesterone deprivation and/or a relative increase in estradiol/progesterone ratio.

A double-blind randomized controlled trial examined the effectiveness of progesterone for treatment of women with intractable catamenial epilepsy. The study group of 38 women with intractable epilepsy received anti-epileptic drugs (AEDs) and progesterone 80 mg daily in the second half of their menstrual cycle from day 15 to 25, and the control group received AEDs and placebo. Age, BMI, epilepsy duration, types of drugs used, progesterone level, and the number of the seizures in 3 months before and after the study were compared. The number of the seizures after treatment significantly decreased in the study group.

In another study conducted in women with catamenial epilepsy, 100 to 200 mg of natural progesterone was used as adjuvant treatment from days 15 to 28 of the menstrual cycle, resulting in a monthly decrease in the number of the seizures of 54% to 68%, in 72% of the patients following 3 months of treatment. Further, 65% of these women have used progesterone as treatment in addition to AEDs for 3 years, with a

reported decrease in the number of seizures of 62% to 74%.

Adv Biomed Res. 2013; 2:8.

Trends in Pharmacy Compounding for Women's Health: Focus on Vulvodynia

To identify trends in women's health and the types of medications used in the treatment of vulvodynia, a survey study was conducted in North Carolina with 653 non-chain pharmacies that compound medications. 200 (31%) responded. Women's health issues ranked third (19%) among the common indications for compounding, preceded by otolaryngology (30%) and dermatology (28%). Of the medications compounded for women's health, the most common indication was bioidentical hormone therapy (73%) followed closely by vaginal dryness (70%) and low libido (65%). Vulvodynia, or vulvar pain, was the fourth most common indication for compounding medication for women's health issues (29%). Vulvovaginal infections were reported as an indication for compounding medications by 16% of respondents. Vulvovaginal symptoms are a common indication for compounding medications in women's health.

South Med J. 2014 Jul;107(7):433-6.

Topical treatments that have been used to successfully treat vulvodynia include amitriptyline 2%, baclofen 2% and gabapentin 3% to 6%.

Effect of Local Estrogen Therapy on Urinary and Sexual Symptoms in Premenopausal Women

The association between vulvodynia and interstitial cystitis/bladder pain syndrome (IC/BPS), a chronic debilitating disease of unknown etiology, may involve sex hormone-dependent mechanisms regulating vulvovaginal health. Researchers aimed to prospectively investigate the effects of 12 weeks of local estrogen therapy on urinary/bladder and sexual symptoms in premenopausal women with IC/BPS. Thirty-four women (mean age: 36.1 diagnosed with IC/BPS were treated vulvovaginally three times per week with estriol 0.5 mg cream by validated questionnaires, vaginal health index (VHI) and maturation index (MI) before and after treatment. Vulvodynia was present in 94.1% of IC/BPS women. A significant positive effect of topical estriol was evident on urinary and sexual function after 12 weeks of therapy, and the VHI and MI also improved. The results of this open study indicate that 12 weeks of local estriol cream at the vaginal and vestibular level may ameliorate urinary/bladder pain symptoms, as well as improve sexual function. The association between vulvar pain and bladder pain could, therefore, be related to a vaginal environment affected by low estrogen.

Gynecol Endocrinol. 2015 Oct;31(10):828-32.

Low-Dose Naltrexone for Refractory Painful Diabetic Neuropathy

Naltrexone is a long-acting, potent, competitive opioid antagonist approved for the treatment of alcohol and opioid dependence at a dose of 50 mg/day. Naltrexone in doses of 1 mg to 5 mg daily, typically referred to as low-dose naltrexone (LDN), has been reported to treat chronic pain and autoimmune disorders. Pilot trials of LDN in Crohn's disease, multiple sclerosis, cancer-related pain, and fibromyalgia have recently been conducted with success. Hota et al. reported a case in which LDN was used for the treatment of diabetic neuropathic pain refractory to most available therapy. In April 2012, a 76-year-old male with a 30-year history of type-2 diabetes and 7 years of diabetic neuropathic symptoms presented in the endocrinology clinic with complaints of burning pain in both legs below the mid-calf level. The first time he sought treatment for neuropathic pain, he received amitriptyline, pregabalin, duloxetine, lamotrigine, and nonsteroidal anti-inflammatory drugs (NSAIDs) in varying doses and combinations. All drugs and combinations were tried for at least 1-2 months. Subsequently, he underwent a lumbar paravertebral nerve block (L2-L4) which produced near complete pain relief, but the pain reappeared in a few weeks. He also received injectable vitamin B complex and vitamin D in therapeutic doses without any benefit. Touch perception was decreased bilaterally below the knees and with hyperalgesia, but no allodynia. The temperature sensation was normal in both legs. His neuropathy symptom score was 9 out of 9. The deep tendon reflexes were absent in both ankles. The patient had adequate glycemic control (HbA1c, 6.4%) and was on metformin, pioglitazone, and insulin with good compliance. Workup for other causes of neuropathy was non-contributory. MRI of lumbar spine showed degenerative changes without any neural involvement. Based upon earlier reports, Oral LDN was prescribed in increasing dosages (1, 2, and 4 mg at bedtime for 2 weeks each). With the 2 mg dose, the patient reported a partial improvement in the burning pain. The 4 mg dose for 2 weeks produced much greater pain relief. He rated his pain to be 5% on VAS as compared to 90% before therapy. On examination, there was no hyperalgesia, but the sensory loss was not improved. Following naltrexone therapy, initially he experienced mild diarrhea, nausea, and somnolence, which subsided spontaneously in a few days without any intervention. At every follow up the patient was satisfied with LDN (4 mg at bedtime) and was continuing the same dose until October 2014 (last follow up) without experiencing any significant side effects. The proposed mechanisms of pain relief with LDN include opioid receptor blockade causing compensatory release of endogenous opioids, and antagonism of Toll-like receptor-4 on microglia.

Pain Med. 2016 Apr;17(4):790-1.

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