

An Excerpt from What Your Dr. May Not Tell You About Menopause by Dr. John Lee

Libido

(The desire for sex.)

Libido is mistakenly thought by many to come from a shortage of estrogen. Doctors often overlook the fact that those that are still having periods are producing plenty of estrogen (if they were not they could not have periods) yet those same people are frequently low on progesterone. Progesterone is an important factor in libido. Testosterone also improves libido and doctors who are unaware of the role of progesterone in libido are sometimes tempted to give women testosterone to help restore flagging libido. However, this choice is less desirable because of the masculinizing effects of testosterone. The more desirable choice is natural progesterone. The body, in any event, has the capability of converting excess progesterone to other hormones including estrogen and testosterone on an as needed basis.

Among many researchers, testosterone is given credit for being the hormone attached to sex drive in both males and females. Dr. Ben C Campbell and Dr. Peter T Ellision of Harvard university tested the hypothesis that sex drive in fertile women at ovulation correlates with a timely spurt of testosterone. They measured daily salivary levels of testosterone among regularly cycling women and did find a small peak. To verify that women were in fact ovulating they also checked midcycle progesterone levels. To their surprise, seven of the 18 women in the study (age range 24 to 42 years - average age 29 years) did not ovulate although they were menstruating. This result, comments Dr. Lee, supports the fact that anovulating cycles (menstrual cycles where a women does not ovulate) are common amongst relatively young, regularly cycling women in the United States and this of course leads to a deficiency of progesterone in the body.

Libido, although mediated by sex hormones, really is a function of the brain. Specific areas of the brain have been identified in animals as essential for sexual receptivity. When one of these areas are experimentally destroyed, sexual behavior is lost regardless of hormone levels. In female hamsters, with their ovaries removed, estrogen supplementation alone is insufficient to restore sexual receptivity. Progesterone is also required. The inference is that estrogen "primes" the brains cells and progesterone "turns on" the sex drive.

Dr. John Lee reports on his observations over many years saying that some premenopausal women were less interested in sex while others became more interested in sex as they approached menopause. The difference between the women, Dr. Lee observes related to whether or not women were experiencing estrogen dominance. Estrogen dominance is due to continued estrogen effects from monthly periods without

producing correlating quantities of progesterone as occurs when a women does not ovulate (anovulatory periods).

The women losing interest in sex had symptoms such as water retention, fibrocystic breasts, depression, wrinkling skin, vaginal dryness, irregular and sometimes heavy periods. Dr. Lee observes that these are signs and symptoms of a progesterone deficiency caused by a failure to ovulate while estrogen continues to be produced by the body. This is indicative of a loss of sex drive correlating with a progesterone deficiency, not an estrogen deficiency.

Clinical observations over many years clearly demonstrates that loss of libido is restored in those patients that used progesterone supplementation. Dr. Lee comments in his book that his progesterone using patients reported that their sex life after progesterone therapy was better than at any time in the 10 -15 years before menopause.

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