Letters

Response to 'The primary care management of perimenopausal depression'

It is encouraging to see *Australian Journal of General Practice* feature menopause in its April 2026 issue. This aligns with the Australasian Menopause Society's aim of advancing knowledge about menopause and the recent International Menopause Society Recommendations on Women's Midlife Health and Menopause,[1] which emphasise the importance of strengthening clinician education and promoting accurate, evidence-based information.

The article 'The primary care management of perimenopausal depression' makes the important observation that women with a previous history of hormone-related mood disorders are at increased risk of depression during perimenopause, highlighting the role of gonadal hormones in the brain.[2]

However, we have several concerns about the claims and suggested treatments in the article.

The claim that perimenopausal depression is a subtype of major depressive disorder appears to rely on an opinion piece in *Australian Doctor*,[3] reflecting a hypothesis rather than an established classification. In addition, the article appears to conflate depressive and other symptoms with clinical depression, risking pathologising common menopausal experiences.

The description of 'perimenopausal depression' symptoms appears to rely in part on the Meno-D scale; however, evidence supporting this tool's ability to distinguish depression from non-depressive menopausal symptoms remains limited.

The assertion that perimenopause is characterised by declining testosterone is not supported by evidence, with no clear link between testosterone levels and menopausal stage.[4]

The authors also make statements regarding treatment that are insufficiently supported by evidence. Hormone therapy is presented as first-line management for depression without adequate qualification of the limited and context-specific evidence base. This recommendation is not in concordance with current treatment guidelines.[1,5] Although limited evidence exists regarding possible benefit for depressive symptoms with estrogen therapy, larger studies are needed before hormone treatments can be universally proposed as first-line treatment in primary care.

Further, there is insufficient evidence to support a role for testosterone in treating depressive symptoms or cognition.[1] Randomised placebo-controlled trial data demonstrate no benefit over placebo, with substantial improvement in both groups, highlighting a significant placebo response.[6,7] Similarly, advice regarding tibolone is made without providing sufficient evidence.

Finally, the statement that there is *no* evidence of increased breast cancer risk with 'body-identical' hormone therapy is potentially misleading and not clearly supported by the cited or current literature.[1]

While the discussion of a possible role of hormonal treatments for depression at perimenopause is interesting, it is essential that management reflects robust evidence to support general practitioners caring for women in midlife.

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Competing interests: KM is a member of QUM Alliance Expert Working group – Menopause and Past President, Australasian Menopause Society (AMS), no longer on the Board; declares travel support to attend AMS meetings and conferences and meetings from Medical and Scientific Advisory Committee, Healthy Bones Australia; honoraria for presentations from Jean Hailes, AMS, The Limbic, Heart Foundation, HealthEd; consulting fees for the QUM Expert Working Group – Menopause Education. SD declares Past President, Australasian Menopause Society; Past President, International Menopause Society; travel support from AMS, IMS, American Heart Association; honoraria from HealthEd, Astellas, Lawley Pharmaceuticals, Besins Healthcare, Bayer; consulting fees from Besins Healthcare, Aviva Bio; Advisory Board payments from Abbott Laboratories, Theramex, Astellas, Mayne Pharma, Besins Healthcare. AM is a member of the publication steering committee for the International Menopause Society Recommendations on Women's Midlife Health and Menopause; declares travel support from AMS, International Menopause Society, The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), HealthEd; Honoraria from Astellas, Theramex; co-investigator in a clinical trial with the study medication and placebo provided by Lawley Pharmaceuticals. CJ is President of AMS and a member of Expert Group, Therapeutic Guidelines Sexual Health and Reproductive Health, and declares travel support to attend AMS meetings and conferences; participation on medical advisory committee Astellas 2023 (unpaid). ML declares

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consulting fees for the QUM Expert Working Group – Menopause Education; travel support to attend AMS meetings and conferences. RR is the Vice President of The Royal Australian College of General Practitioners (RACGP), Chair RACGP WA and RACGP Board Director. RR is also board director of Joint Colleges Training Services (JCTS) and Ishar Multicultural Women's Health Services. She is also the Discipline Head of General Practice, University of Notre Dame, Fremantle and Director for The Garden Family Medical Clinic, Piara Waters.

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Reply

We are pleased to respond to concerns raised about our *Australian Journal of General Practice* (*AJGP*) publication.[1]

First, perimenopausal depression (PD) is not merely a speculative concept. PD is classified within International Classification of Diseases 10th Revision (ICD-10) and 11th Revision (ICD-11) systems. In the ICD-10 Clinical Modification, the code is N95.1 + F32.A or F32.9. The ICD-11 code is 6A70/71/72 + GA 30, recognising PD as a clinical depression associated with perimenopause.[2]

Second, concerns regarding 'pathologising' menopause overlook patients' perspectives. Assessment of menopausal symptoms should be collaborative and comprehensive. Women themselves should decide if depressive symptoms affect their quality of life and whether treatment is desired. Increased rates of depression during perimenopause are well documented across epidemiological studies and systematic reviews.[3]

Third, the symptom profile of PD was *not* derived solely from the Meno-D scale. It reflects extensive phenomenological literature, including historical descriptions, reviews of menopausal depression phenomenology, academic studies and our own clinical work plus practice-based observations.

Fourth, the Meno-D specifically captures the distinctive physical and psychological features of PD – different to major depressive disorder. The robust validation study[4] identified five internally consistent subscales – somatic, cognitive, self-esteem, sleep and sexual symptoms – with good discriminant, convergent and construct validity. We emphasised the importance of detailed clinical histories and broader assessment plus Meno-D in our *AJGP* paper.

Fifth, regarding menopausal hormone therapy, evidence in depression currently extends to National Health and Medical Research Council (NHMRC) Level 2. There are useful clinical data emerging on testosterone treatment in PD.[4] More randomised controlled trials (RCTs) are needed overall, but clinical decision making requires clinical expertise to contextualise research findings, assess individual patient needs and identify risks not always captured in trials.[5]

Sixth, recommendations regarding tibolone are supported by a growing evidence base. At least 12 tibolone publications now focus on PD, including our double-blind RCT demonstrating significant improvement in depression with adjunctive tibolone treatment.[6]

Finally, on breast cancer risk and body-identical progesterone, we cited a systematic review (NHMRC Level 1) concluding that estrogen combined with micronised progesterone does not increase breast cancer risk for up to 5 years of treatment, while acknowledging the need for counselling regarding longer-term risks and other breast cancer risk factors.

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Competing interests: JK was the developer of the Meno-D scale that is referenced in this letter; has received funding over the past 30 years from Jansen Cilag, Boehringer Ingelheim and Servier pharmaceutical industries for clinical trials research in schizophrenia and depression; is the recipient of National Health and Medical Research Council Investigator Grants; and declares honoraria from Lundbeck Pharmaceuticals and Servier Pharmaceuticals. CC and EH are co-founders of Healthy Hormones, which received conference funding in 2025 from Besins Healthcare, Lawley Pharmaceuticals, Theramex and Orion Pharma for Menopause Conference 'So Hot Right Now'. CG was involved in further development of the Meno-D scale. EH is founder of Remi telehealth. SC declares funding from Besins Healthcare.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

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References are available online only.

Response to 'Reapplying knowledge on sunscreen and photoprotection: A narrative review'

Thank you to the authors for their informative narrative review,[1] which serves as a timely reminder of the importance of ultraviolet (UV) protection in preventing skin cancer, photoageing and exacerbation of photosensitive conditions.

For educational purposes, we would like to clarify some of the technical aspects of sunscreen science, which can influence patients' sunscreen choice and usage.

Application timing: The article states that chemical (organic) sunscreens need to be applied 20 minutes before sun exposure to allow absorption into the stratum corneum. However, like mineral (inorganic) sunscreens, chemical sunscreens actually provide immediate protection,[2] and application 20 minutes prior to UV exposure is recommended for all sunscreens for the purpose of allowing a uniform layer to form and adhere to skin.[3]

Reapplication: As highlighted by the authors, chemical sunscreen ingredients in isolation (particularly avobenzone) can degrade significantly with UV irradiation. In contemporary sunscreens, photostabilising technologies are employed to achieve sustained protection even with intense UV exposure.[4] As such, the longevity of any sunscreen is primarily limited by mechanical disruption of the sunscreen layer, and consequently reapplication is recommended for all.[3]

Mechanism of action: The article states that mineral sunscreens reflect and scatter UV, in contrast to chemical sunscreens, which absorb UV. While this is widespread

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in the literature, the smaller zinc oxide and titanium dioxide particles in modern sunscreens also primarily attenuate UV via absorption.[5] One study estimated that <5% of incoming UV is reflected by mineral ingredients, comparable to the UV reflected by the chemical sunscreens methylene bis-benzotriazolyl tetramethylbutylphenol and tris-biphenyl triazine.[6]

There are far more similarities between chemical and mineral sunscreens than differences, despite many misunderstandings circulating on social media that can affect product selection. This misinformation particularly relates to marketing myths concerning human and environmental safety.

Together with the authors, we would like to reiterate that both types of sunscreen are considered safe and effective. We firmly agree with the recommendation that patients should choose a broad-spectrum sunscreen with a high sun protection factor that they find comfortable and will use consistently, and that sunscreen use should be combined with other forms of sun protection.

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AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

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Reply

We are grateful to the authors for their correspondence and interest in our recent narrative review regarding sunscreen and photoprotection.[1] We appreciate their clarification regarding application timing, reapplication and the mechanisms of action of sunscreen agents. We agree with the points raised and acknowledge that these nuances warrant emphasis.

We agree with the emphasis on the impact of clothing, physical activity, sweat and water on the loss of sunscreen over time,[2] and therefore the need for both appropriate application timing and frequent reapplication. Regarding application timing, current guidelines recommend that sunscreen be applied 20 minutes before sun exposure. While this recommendation has been attributed to allowing absorption of chemical filters into the stratum corneum,[3] the authors have astutely highlighted studies demonstrating that chemical filters present on the skin surface also provide protection. In a study of five chemical filters, Chamberlain et al concluded that the total sun protection factor (SPF) of a sunscreen product likely reflects a combination of the formulation on the skin and penetration of ultraviolet (UV) filters into the stratum corneum.[4]

We also concur with the authors' emphasis that both mineral and chemical sunscreens are safe and effective, and that patients should select a high-SPF, broad-spectrum product they are comfortable using consistently. In addition, we wish to re-emphasise that sunscreen forms only one component of photoprotection and should be used as part of comprehensive measures, including protective clothing, sunglasses, a broad-brimmed hat and seeking shade.

We thank the authors for their valuable contribution to this important discussion.

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