Selección de Resúmenes de Menopausia

Semana del 30 de Julio al 5 de Agosto de 2014

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Application of the 10-item Cervantes Scale among mid-aged Ecuadorian women for the assessment of menopausal symptoms.

Chedraui P[1], Pérez-López FR[2], Sánchez H[2], Sánchez P[2], Miranda O[2], Quispe P[2], Madero-Trelles T[2], Hidalgo L[2], Arboleda D[2], López G[2], Quintero JC[2].

BACKGROUND: The majority of instruments used to evaluate menopausal symptoms are long and complex. In this sense, more simple tests are being designed to rapidly obtain a snapshot of the global clinical picture. OBJECTIVE: To assess menopausal symptoms in mid-aged women using the short 10 item version of the original menopause Cervantes Scale (CS-10). METHOD: This was a cross sectional study in which a total of 451 Ecuadorian women (40-59 years) were surveyed with the CS-10 and a general socio-demographic questionnaire containing personal and partner data. RESULTS: Median age of the whole sample was 48 years. A 41.2% were postmenopausal, 44.3% abdominally obese (waist circumference >88cm), 6% diabetic, 16.9% hypertense, 11.5% smoked, 6.9% currently used hormone therapy, 9.5% phytoestrogens and 6.7% psychotropic drugs. For the entire sample, median [interquartile range] CS-10 global scores were 10.0 [9.5], and for pre-, peri- and postmenopausal women: 5.0 [7.0], 11.0 [9.0] and 13.5 [8.0], respectively. The CS-10 displayed good internal consistency (Cronbach's alpha 0.87). According to the CS-10, the three most prevalent menopausal symptoms were: muscle and joint pains (88.5%), hot flushes (77.6%) and skin dryness (71.4%). Multiple linear regression analysis found that postmenopausal status, parity, unhealthy perceived status, psychotropic drug use, partner erectile dysfunction, lower coital frequency and living at high altitude were related to higher CS-10 global scores. CONCLUSION: In this mid-aged Ecuadorian female sample severity of menopausal symptoms, as determined by the CS-10, were related to environmental and female/partner personal and socio-demographical aspects.

Ther Adv Drug Saf. 2011 Aug;2(4):159-72. doi: 10.1177/2042098611411012.

Safety of drugs used in the treatment of osteoporosis.

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A number of drug classes are licensed for the treatment of osteoporosis including bisphosphonates, recombinant human parathyroid hormone (PTH), strontium, hormone replacement therapy (HRT), selective oestrogen receptor modulators (SERMS) and denosumab. This review discusses the safety of osteoporosis treatments and their efficacies. Recent concerns about the safety of calcium and high-dose vitamin D are discussed. Bisphosphonates have substantial postmarketing experience and a clearer picture of safety issues is emerging. Along with the well recognized effects on the gastrointestinal tract and kidney function, recently described adverse effects such as osteonecrosis of the jaw, oesophageal cancer, atrial fibrillation, subtrochanteric femur fractures and ocular complications of bisphosphonate therapy are discussed. Therapy with PTH is limited to two years' duration because of the development of osteogenic sarcomas in animal studies, which appeared related to dose, duration and timing of therapy. Strontium should be used with caution in patients with renal impairment and its use has been associated with venous thromboembolism. The role of HRT and SERMs in the treatment of postmenopausal osteoporosis is restricted as a result of an increased risk of stroke, venous thromboembolism and breast cancer. Postmarketing experience with denusomab is limited but a number of potential safety concerns including osteonecrosis of the jaw are emerging. All of these drugs have been proven to reduce fractures. The decision to use a drug to reduce fracture risk should be based on risk-benefit analysis of the drug and its suitability for individual patients.

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Polycystic ovary syndrome: Metabolic consequences and long-term management.

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Abstract Young women with polycystic ovary syndrome (PCOS) present an increased risk for type II diabetes and cardiovascular diseases. The prevalence of altered glucose tolerance ranges between 20 and 35 % in patients while the prevalence of type II diabetes ranges between 2 and 8 % and seems related to body weight and ethnic group. Moving from the young fertile age to the 40s and the menopause the prevalence of type II diabetes continues to increase compared to the general female population and may reach 10-16 % of PCOS women. However, prevalence of altered glucose tolerance does not increase. Also cardiovascular risk is increased in a large part of young PCOS women but this risk tends to be normalized with age because of the reduction of ovarian androgen secretion and occurrence of ovulatory cycles in at least one third of PCOS women approaching menopause. It may explain the discrepancy between cardiovascular (CV) risk during young age and observed number of CV events. Long-term management should be directed to aggressively treat obesity and altered glucose tolerance. In non-obese patients with normal glucose tolerance it may be wise to wait until the age of 40 before deciding a long-term management of CV risk.

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The role of dietary protein and vitamin D in maintaining musculoskeletal health in postmenopausal women: A consensus statement from the European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO).

Rizzoli R[1], Stevenson JC[2], Bauer JM[3], van Loon LJ[4], Walrand S[5], Kanis JA[6], Cooper C[7], Brandi ML[8], Diez-Perez A[9], Reginster JY[10]; for the ESCEO Task Force.

From 50 years of age, postmenopausal women are at an increased risk of developing sarcopenia and osteoporosis as a result of deterioration of musculoskeletal health. Both disorders increase the risk of falls and fractures. The risk of developing sarcopenia and osteoporosis may be attenuated through healthy lifestyle changes, which include adequate dietary protein, calcium and vitamin D intakes, and regular physical activity/exercise, besides hormone replacement therapy when appropriate. Protein intake and physical activity are the main anabolic stimuli for muscle protein synthesis. Exercise training leads to increased muscle mass and strength, and the combination of optimal protein intake and exercise produces a greater degree of muscle protein accretion than either intervention alone. Similarly, adequate dietary protein intake and resistance exercise are important contributors to the maintenance of bone strength. Vitamin D helps to maintain muscle mass and strength as well as bone health. These findings suggest that healthy lifestyle measures in women aged >50 years are essential to allow healthy ageing. The European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO) recommends optimal dietary protein intake of 1.0-1.2g/kgbodyweight/d with at least 20-25g of high-quality protein at each main meal, with adequate vitamin D intake at 800IU/d to maintain serum 25-hydroxyvitamin D levels >50nmol/L as well as calcium intake of 1000mg/d, alongside regular physical activity/exercise 3-5 times/week combined with protein intake in close proximity to exercise, in postmenopausal women for prevention of age-related deterioration of musculoskeletal health.

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Menopausal Hormone Therapy and Lung Cancer-Specific Mortality Following Diagnosis: The California Teachers Study.

Clague J[1], Reynolds P[2], Henderson KD[1], Sullivan-Halley J[1], Ma H[1], Lacey JV Jr[1], Chang S[3], Delclos GL[4], Du XL[5], Forman MR[6], Bernstein L[1].

Previous results from research on menopausal hormone therapy (MHT) and lung cancer survival have been mixed and most have not studied women who used estrogen therapy (ET) exclusively. We examined the associations between MHT use reported at baseline and lung cancer-specific mortality in the prospective California Teachers Study cohort. Among 727 postmenopausal women diagnosed with lung cancer from 1995 through 2007, 441 women died before January 1, 2008. Hazard Ratios (HR) and 95% Confidence Intervals (CI) for lung-cancer-specific mortality were obtained by fitting multivariable Cox proportional hazards regression models using age in days as the timescale. Among women who used ET exclusively, decreases in lung cancer mortality were observed (HR, 0.69; 95% CI, 0.52-0.93). No association was observed for estrogen plus progestin therapy use. Among former users, shorter duration (<5 years) of exclusive ET use was associated with a decreased risk of lung cancer mortality (HR,

0.56; 95% CI, 0.35-0.89), whereas among recent users, longer duration (>15 years) was associated with a decreased risk (HR, 0.60; 95% CI, 0.38-0.95). Smoking status modified the associations with deceases in lung cancer mortality observed only among current smokers. Exclusive ET use was associated with decreased lung cancer mortality.

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National Osteoporosis Society Vitamin D Guideline Summary.

Aspray TJ[1], Bowring C[2], Fraser W[3], Gittoes N[4], Javaid MK[5], Macdonald H[6], Patel S[7], Selby P[8], Tanna N[9], Francis RM[10].

The National Osteoporosis Society (NOS) published its document, Vitamin D and Bone Health: A Practical Clinical Guideline for Patient Management, in 2013 as a practical clinical guideline on the management of vitamin D deficiency in adult patients with, or at risk of developing, bone disease. There has been no clear consensus in the UK on vitamin D deficiency its assessment and treatment, and clinical practice is inconsistent. This guideline is aimed at clinicians, including doctors, nurses and dieticians. It recommends the measurement of serum 25 (OH) vitamin D (25OHD) to estimate vitamin D status in the following clinical scenarios: bone diseases that may be improved with vitamin D treatment; bone diseases, prior to specific treatment where correcting vitamin D deficiency is appropriate; musculoskeletal symptoms that could be attributed to vitamin D deficiency. The guideline also states that routine vitamin D testing is unnecessary where vitamin D supplementation with an oral antiresorptive treatment is already planned and sets the following serum 25OHD thresholds: <30 nmol/l is deficient; 30-50 nmol/l may be inadequate in some people; >50 nmol/l is sufficient for almost the whole population. For treatment, oral vitamin D3 is recommended with fixed loading doses of oral vitamin D3 followed by regular maintenance therapy when rapid correction of vitamin D deficiency is required, although loading doses are not necessary where correction of deficiency is less urgent or when co-prescribing with an oral antiresorptive agent. For monitoring, serum calcium (adjusted for albumin) should be checked 1 month after completing a loading regimen, or after starting vitamin D supplementation, in case primary hyperparathyroidism has been unmasked. However, routine monitoring of serum 25OHD is generally unnecessary but may be appropriate in patients with symptomatic vitamin D deficiency or malabsorption and where poor compliance with medication is suspected. The guideline focuses on bone health as, although there are numerous putative effects of vitamin D on immunity modulation, cancer prevention and the risks of cardiovascular disease and multiple sclerosis, there remains considerable debate about the evaluation of extraskeletal factors and optimal vitamin D status in these circumstances.

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Impact of smoking on estrogenic efficacy.

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Author information

Abstract
Depending on the type, duration and intensity of cigarette smoking, the efficacy of endogenous and exogenous estrogen can be reduced or completely cancelled. Not only does smoking diminish the beneficial effects of estrogen on hot flushes and urogenital symptoms and its positive effects on lipid metabolism, but smoking also can reduce estrogen's ability to prevent osteoporosis and perhaps also cardiovascular diseases. This is mainly caused by dose-dependent elevated hepatic clearance, partially in conjunction with lower estrogen levels, and has been demonstrated so far only with oral estrogen applications. Compensation for the failure of therapeutic action should not be made by increasing the dose in smokers since this might result in the production of potentially mutagenic estrogen metabolites associated with a higher risk of breast cancer. Since the favorable effects of estrogens seem to be not lost in smokers when estrogens are applied transdermally, this route should be preferred in smokers. The most important conclusion from the data presented is that the effects of smoking are very complex and dependent on a multiplicity of factors, so that different types of clinically relevant negative effects must be expected. Women who continue to smoke despite all warnings should be informed that smoking, in addition to all its other negative effects, can also jeopardize the success of hormone replacement therapy.