Selección de Resúmenes de Menopausia

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Correlations between 10-year risk of death from cardiovascular diseases and 10-year osteoporotic fracture risk in postmenopausal women.

Kawińska-Hamala A, Kawiński A, Stanek K, Stuss M, Sewerynek E.

INTRODUCTION: The goal was an evaluation of the correlation between 10-year risk of death from CVD and 10-year bone fracture risk (FRAX). MATERIAL AND METHODS: A total of 79 patients (Lodz, Poland), aged 50-83 years, consulted for osteoporosis were divided into two groups: study group - with osteoporosis (O; T-score ≤ -2.5SD) and control - without osteoporosis (T-sc > -2.5). Bone mineral density was evaluated by densitometric scanning of spine (L2-L4 T-score) and/or femoral neck (Neck T-score) and/or total hip (Total Hip T-score). Total cholesterol (TC), fasting glucose, arterial blood pressure, medical history, and family history were obtained. The risk of fatal-CVD was assessed by Euro Heart Score (EHS), and major osteoporotic (MOFR) and hip fracture risk (HFR) by the FRAX scale. RESULTS: 80% of the patients (32/40) with osteoporosis and 51% (20/39) of the patients without osteoporosis revealed a HeartScore ≥ 5%. There was correlation in the group of all patients between EHS and Neck T-score (p = 0.012; Spearman rank correlation coefficient (Rs) = -0.3806), L2-L4 T-score (p = 0.0277; Rs = -0.2891), and Total Hip T-score (p = 0.0027; Rs = -0.3561), and in the control group - between EHS and Neck T-score (p = 0.0457; Rs = -0.3502). There was a 2.33% difference between the average EHS level to the disadvantage of patients with osteoporosis (p = 0.043). EHS positively correlated with MOFR (p = 0.001) and HFR (p = 0.0002) in the whole study population and with MOFR (p = 0.03) and HFR (p = 0.008) in the group of osteoporotic patients. There were differences between groups in TC (p = 0.00013) and BMI (p = 0.00011) levels. CONCLUSIONS: The 10-year risk of fatal-CVD correlated with osteoporosis and with the 10-year osteoporotic fracture risk. This conclusion may help identify patients who require extended cardiotherapy protocols.

Am J Clin Nutr. 2017 Jun 28. pii: ajcn145391. doi: 10.3945/ajcn.116.145391. [Epub ahead of print]

Artificially sweetened beverages, sugar-sweetened beverages, plain water, and incident diabetes mellitus in postmenopausal women: the prospective Women's Health Initiative observational study.

Huang M, Quddus A, Stinson L, Shikany JM, Howard BV, Kutob RM, Lu B, Manson JE, Eaton CB.

Background: Sugar-sweetened beverages (SSBs) have been associated with an increased risk of diabetes mellitus (DM), whereas the association with artificially sweetened beverages (ASBs) is unclear.Objective: We aimed to evaluate the associations of ASB and SSB consumption with the risk of developing DM and the potential benefit of replacing SSBs with ASBs or water.Design: The national Women's Health Initiative recruited a large prospective cohort of postmenopausal women between 1993 and 1998. ASB, SSB, and water consumption was measured by lifestyle questionnaires, and DM was self-reported. Results: Of 64,850 women, 4675 developed diabetes over an average of 8.4 y of follow-up. ASBs and SSBs were both associated with an increased risk of DM with an HR of 1.21 (95% CI: 1.08, 1.36) comparing ASB consumption of ≥2 serving/d to never or <3 serving/mo, and an HR of 1.43 (95% CI: 1.17, 1.75) comparing SSB consumption of ≥2 serving/d to <1 serving/wk (1 serving = one 12-ounce can or 355 mL). Subgroup analysis found an increased risk of DM associated with ASBs only in the obese group. Modeling the substitution of SSBs with an equal amount of ASBs did not significantly reduce the risk of developing DM. However, statistically substituting 1 serving of ASBs with water was associated with a significant risk reduction of 5% (HR: 0.95; 95% CI: 0.91, 0.99), whereas substituting 1 serving of SSBs with water was associated with a risk reduction of 10% (HR: 0.90; 95% CI: 0.85, 0.95). Conclusions: ASBs were associated with a 21% increased risk of developing DM, approximately half the magnitude of SSBs (associated with a 43% increased risk). Replacing ASBs and SSBs with water could potentially reduce the risk. However, caution should be taken in interpreting these results as causal because both residual confounding and reverse causation could explain these results.

J Strength Cond Res. 2017 Jun 22. doi: 10.1519/JSC.0000000000002080. [Epub ahead of print]

Muscle Strength is Protective Against Osteoporosis in an Ethnically Diverse Sample of Adults.

McGrath RP, Kraemer WJ, Vincent BM, Hall OT, Peterson MD.

The odds for developing osteoporosis may be impacted by modifiable and non-modifiable factors such as muscle strength and ethnicity. This study sought to 1) determine if increased muscle strength was associated with decreased odds for osteoporosis and 2) identify whether the odds for osteoporosis differed by ethnicity. Data from the 2013-2014 National Health and Nutrition Examination Survey were analyzed. Muscle strength was measured with a hand-held dynamometer and duel-energy x-ray absorptiometry was used to assess femoral neck bone mineral density. A T-score of ≤2.5 was used to define osteoporosis. Separate covariate-adjusted logistic regression models were performed on each sex to determine the association between muscle strength and osteoporosis. Odds ratios (OR) were also generated to identify if the association between muscle strength and osteoporosis differed by ethnicity using non-Hispanic blacks as the reference group. There were 2,861 participants included. Muscle strength was shown to be protective against osteoporosis for males (OR: 0.94; 95% confidence interval (CI): 0.94, 0.94) and females (OR: 0.90; CI: 0.90, 0.90). Although odds ratios varied across ethnicities, non-Hispanic Asian men (OR: 6.62; CI: 6.51, 6.72) and women (OR: 6.42; CI: 6.37, 6.48) were at highest odds for osteoporosis. Increased muscle strength reduced the odds of osteoporosis among both males and females in a nationally-representative, ethnically diverse sample of adults. Non-Hispanic Asians had the highest odds for developing osteoporosis. Irrespective of sex or ethnicity, increased muscle strength may help protect against the odds of developing osteoporosis.

Int J Rheumatol. 2017; 2017:5491676. doi: 10.1155/2017/5491676. Epub 2017 Jun 1.

Evaluation of Vitamin D Status in Rheumatoid Arthritis and Its Association with Disease Activity across 15 Countries: "The COMORA Study".

Hajjaj-Hassouni N, Mawani N, Allali F, Rkain H, Hassouni K, Hmamouchi I, Dougados M.

The aims of this study are to evaluate vitamin D status in 1413 RA patients of COMORA study from 15 countries and to analyze relationship between patients' RA characteristics and low levels of vitamin D. All demographic, clinical, and biological data and RA comorbidities were completed. The results showed that the average of vitamin D serum dosage was 27.3 ng/mL ± 15.1 [0.1-151]. Status of vitamin D was insufficient in 54.6% and deficient in 8.5% of patients. 43% of RA patients were supplemented with vitamin D and absence of supplementation on vitamin D was related to higher prevalence of vitamin D deficiency ($p < 0.001$). Finally, our study shows that the status of low levels of vitamin D is common in RA in different countries and under different latitudes. Absence of supplementation on vitamin D was related to higher prevalence of vitamin D deficiency. Low levels of vitamin D were associated with patients characteristics (age, BMI, and educational level), RA (disease activity and corticosteroid dosage), and comorbidities (lung disease and osteoporosis therapy). This suggests the need for a particular therapeutic strategy to improve vitamin D status in RA patients.

Menopause. 2017 Jun 26. doi: 10.1097/GME.0000000000000936. [Epub ahead of print]

Effect of programmed exercise on insulin sensitivity in postmenopausal women: a systematic review and meta-analysis of randomized controlled trials.

Bueno-Notivol J, Calvo-Latorre J, Alonso-Ventura V, Pasupuleti V, Hernandez AV, Pérez-López FR; Health Outcomes and Systematic Analyses (HOUSSAY) Project.

OBJECTIVE: We performed a systematic review and meta-analysis of randomized controlled trials (RCTs) assessing the effect of programmed exercise for at least 12 weeks, in postmenopausal women on insulin sensitivity-related outcomes (ISROs), including fasting insulin, C-peptide, insulin growth factor (IGF-1) and IGF-binding protein (IGFBP-3), Homeostatic Model Assessment-Insulin Resistance (HOMA-IR), and anthropometric variables. METHODS: Searches were conducted in PubMed-Medline, Embase, Scopus, Web of Science, and Cochrane Library from inception through May 3, 2016, for studies published in all languages. Extracted data included characteristics of the study design, study participants, intervention, and outcome measures. Types of exercise were classified into "mid-term exercise intervention" (MTEI, 3-4 months exercise duration) and a "long-term exercise intervention" (LTEI, 6-12 months exercise duration). Risk of bias in RCTs was evaluated with the Cochrane tool. We used random-effects models for meta-analyses. We adhered to the Preferred Reporting Items for Systematic Reviews and

Meta-Analyses guidelines. RESULTS: Seven RCTS (n=580) evaluating the effects of programmed exercise on ISROs were included. In three RCTs, MTEI significantly lowered insulin levels (mean difference [MD] -6.50pmol/L, 95% confidence interval [CI] -11.19, -1.82, P=0.006) and HOMA-IR values (MD -0.18, 95% CI -0.34, -0.03, P=0.02) when compared with controls. LTEI had no significant effect on insulin levels (P=0.19) or HOMA-IR values (P=0.68) in four and three RCTs, respectively. There were no significant differences between exercise intervention versus controls in circulating IGF-1, glucose, triglycerides with both MTEI and LTEI, and in IGFBP-3 with LTEI. There were significant reductions in body mass index (BMI, kg/m) (MD -1.48, 95% CI -2.48, -0.48, P=0.004) and in body fat percentage (MD -2.99, 95% CI -4.85, -1.14, P=0.01) after MTEI; and in waist circumference after both MTEI (MD -1.87, 95% CI -3.02, -0.72, P=0.001) and LTEI (MD -3.74, 95% CI -6.68, -0.79). Heterogeneity of effects among studies was moderate to low. CONCLUSION: Exercising for 3 to 4 months significantly lowered insulin levels and HOMA-IR values, BMI waist circumference, and percentage body fat mass; exercising for 6 to 12 months lowered waist circumference in postmenopausal women.

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Low-Fat Dietary Pattern and Breast Cancer Mortality in the Women's Health Initiative Randomized Controlled Trial.

Chlebowski RT, Aragaki AK, Anderson GL, Thomson CA, Manson JE, Simon MS, Howard BV, Rohan TE, et al.

Purpose Earlier Women's Health Initiative Dietary Modification trial findings suggested that a low-fat eating pattern may reduce breast cancers with greater mortality. Therefore, as a primary outcome-related analysis from a randomized prevention trial, we examined the long-term influence of this intervention on deaths as a result of and after breast cancer during 8.5 years (median) of dietary intervention and cumulatively for all breast cancers diagnosed during 16.1 years (median) of follow-up. Patients and Methods The trial randomly assigned 48,835 postmenopausal women with normal mammograms and without prior breast cancer from 1993 to 1998 at 40 US clinical centers to a dietary intervention with goals of a reduction of fat intake to 20% of energy and an increased intake of fruits, vegetables, and grains (40%; n = 19,541) or to a usual diet comparison (60%; n = 29,294). Results In the dietary group, fat intake and body weight decreased (all P < .001). During the 8.5-year dietary intervention, with 1,764 incident breast cancers, fewer deaths occurred as a result of breast cancer in the dietary group, which was not statistically significant (27 deaths [0.016% per year] v 61 deaths [0.024% per year]; hazard ratio [HR], 0.67; 95% CI, 0.43 to 1.06; P = .08). During the same period, deaths after breast cancer (n = 134) were significantly reduced (40 deaths [0.025% per year] v 94 deaths [0.038% per year]; HR, 0.65; 95% CI, 0.45 to 0.94; P = .02) by the dietary intervention. During the 16.1-year follow-up, with 3,030 incident breast cancers, deaths after breast cancer also were significantly reduced (234 deaths [0.085% per year] v 443 deaths [0.11% per year]; HR, 0.82; 95% CI, 0.70 to 0.96; P = .01) in the dietary group. Conclusion Compared with a usual diet comparison group, a low-fat dietary pattern led to a lower incidence of deaths after breast cancer.

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The 2017 hormone therapy position statement of The North American Menopause Society.

The 2017 Hormone Therapy Position Statement of The North American Menopause Society (NAMS) updates the 2012 Hormone Therapy Position Statement of The North American Menopause Society and identifies future research needs. An Advisory Panel of clinicians and expert researchers in the field of women's health and menopause was recruited by NAMS to review the 2012 Position Statement, evaluate new literature, assess the evidence, and reach consensus on recommendations, using the level of evidence to identify the strength of recommendations and the quality of the evidence. The Panel's recommendations were reviewed and approved by the NAMS Board of Trustees.Hormone therapy (HT) remains the most effective treatment for vasomotor symptoms (VMS) and the genitourinary syndrome of menopause (GSM) and has been shown to prevent bone loss and fracture. The risks of HT differ depending on type, dose, duration of use, route of administration, timing of initiation, and whether a progestogen is used. Treatment should be individualized to identify the most appropriate HT type, dose, formulation, route of administration, and duration of use, using the best available evidence to maximize benefits and minimize risks, with periodic reevaluation of the benefits and risks of continuing or discontinuing HT.For women aged younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the benefit-risk ratio is most favorable for treatment of bothersome VMS and for those at elevated risk for bone loss or fracture. For

women who initiate HT more than 10 or 20 years from menopause onset or are aged 60 years or older, the benefit-risk ratio appears less favorable because of the greater absolute risks of coronary heart disease, stroke, venous thromboembolism, and dementia. Longer durations of therapy should be for documented indications such as persistent VMS or bone loss, with shared decision making and periodic reevaluation. For bothersome GSM symptoms not relieved with over-the-counter therapies and without indications for use of systemic HT, low-dose vaginal estrogen therapy or other therapies are recommended.

Eur J Contracept Reprod Health Care. 2017 Jun 26:1-6. doi: 10.1080/13625187.2017. [Epub ahead of print]

Women's preferences for menstrual bleeding frequency in 12 European countries: The Inconvenience Due to Women's Monthly Bleeding (ISY) survey.

Fiala C, Chabbert-Buffet N, Häusler G, Jamin C, Lete I, Lobo P, Nappi RE, Pintiaux A.

OBJECTIVES: Our aim was to assess the level of inconvenience associated with menstrual bleeding and determine how many women across 12 European countries would prefer a bleeding frequency of less than once a month and what would motivate their choice. METHODS: A 15-min quantitative online survey was conducted in two waves among 5728 women aged between 18 and 45 years, with an equal distribution of women using a combined hormonal contraceptive (CHC group, n = 2739) and women using a non-hormonal contraceptive or no contraceptive (non-HC group, n = 2989). The first wave was carried out in Austria, Belgium, France, Italy, Poland and Spain, in February 2015, and the results have been published. The second wave was conducted in the Czech Republic, Germany, Hungary, Portugal, Latvia and the Netherlands, between August and September 2015. RESULTS: The menstrual period was significantly longer (5.0 versus 4.6 days) and heavier (15 versus 7%) in non-HC users than in CHC users ($p < .0001$). Given the choice, ~60% of women would like less frequent menstrual bleeding. There was heterogeneity in the preference across countries. Sexuality, social life, work and sporting activities were key factors affecting women's preference. CONCLUSION: The majority of women in the 12 European countries would prefer to reduce the frequency of menstrual periods. Quality of life was the main factor affecting their preference.

Arch Iran Med. 2017 Jun;20(6):361-367. doi: 0172006/AIM.008.

An Explanation for Variation in Age at Menopause in Developing Countries Based on the Second National Integrated Micronutrient Survey in Iran.

Parsaeian M, Pouraram H, Djazayery A, Abdollahi Z, Dorosty A, Jalali M, Khodaverdian K, Sotoudeh G, et al.

BACKGROUND: It is reported that women in developing countries reach menopause earlier compared to developed countries. This seems to be due to underestimation of age at menopause as pre-menopause women who will reach menopause at older ages are commonly excluded in cross-sectional settings. In this study, we propose an estimation method which can deal with this bias. We also assessed major determinants of menopause. METHODS: The second national integrated micronutrient survey in Iran completed in 2015 is a population-based study with a nationally representative sample of 4,898 Iranian women aged 50 to 60 years. We used data on menopause status and menopausal age (asked retrospectively) to estimate the median survival time. We also used Logistic regression to model menopausal status on the current age and to estimate the median age, at which 50% of women will experience menopause. Demographic, lifestyle, and anthropometric determinants were also examined. RESULTS: The estimated age at menopause was 51.2 (51.0-51.3) years in the logistic model and 50.5 (48.1, 53.7) years in survival analysis. In both models, the age at menopause was significantly lower among rural and underweight women. In addition, survival analysis showed that smokers and women with smaller family size had significantly lower age at menopause.

CONCLUSION: While many studies stress a gap in age at menopause between developed and developing countries, this study with a reliable estimation method showed that such a gap might originate from an underestimation of age at menopause in developing countries rather than a real difference.