Selección de Resúmenes de Menopausia

Semana del 8 al 14 de julio 2020

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Why Do Falls and Lower Limb Fractures Occur More Frequently in the Diabetic Patient and How Can They Be Prevented?

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Due to primarily sarcopenia and hypoglycemia but also neuropathy, hypotension, analgesics and polypharmacy, there is an increased incidence of falls and hip fractures in both the type 1 and type 2 diabetic patient. Utilization of insulin, hypotensive drugs, analgesics and perhaps canagliflozin further increases the risk. Thiazolidinedione use may increase the risk of osteoporosis and fracture. Prolonged hyperglycemia resulting in cross-linking of collagen and advanced glycosylation end products alter the microarchitecture and increase bone fragility. Higher serum vitamin D levels seem to decrease the incidence of both falls and fractures. Following a hip fracture, mortality in the diabetic patient is increased largely because of cardiovascular events and pneumonia. Prevention of sarcopenia includes dietary therapy, vitamin D and testosterone replacement when appropriate.

Climacteric. 2020 Aug;23(4):388-396. doi: 10.1080/13697137.2020.1784870.

Removal of uterine polyps: clinical management and surgical approach.

Ludwin A1,2,3, Lindheim SR4, Booth R4, Ludwin I1,2,3.

Endometrial polyps have a reported prevalence from 7.8% up to 30% and are one of the most cost-consuming gynecological conditions for our specialty. There are strong practitioner beliefs that surgical removal of endometrial polyps is highly beneficial, particularly for those with abnormal uterine bleeding and infertility. Additionally, polypectomy is indicated to reduce the risk of malignancy. Transvaginal ultrasound is the first-line diagnostic option for detection of endometrial polyps, while sonohysterography has similar accuracy as hysteroscopy in the diagnostic confirmation. Blind dilatation and curettage is not recommended for polyp removal; rather, hysteroscopy in the operating room and office setting using small-diameter hysteroscopic equipment is the standard approach. This can be performed without anesthesia in most women. While hysteroscopy is an effective method for polypectomy with a low complication rate, it is unknown whether this is truly beneficial for reproductive-age women with infertility and prior assisted reproduction therapy. The risk of malignancy in women with postmenopausal bleeding justifies the necessity of polypectomy with histologic tissue examination. In asymptomatic women, the risk of malignancy is low, and there are no known benefits of polyp removal in the prevention of malignant transformation. Cost-effective studies remain to be done to provide us with the optimal approach to endometrial polyps including the management of asymptomatic and/or infertile women, ideal location including office-based or the operating room setting, complication prevention including intrauterine adhesions, and recurrence issues.

Expert Opin Drug Saf. 2020 Jul 10:1-6. doi: 10.1080/14740338.2020.1791818. [Epub ahead of print]

Postmenopausal hormone therapy in BRCA gene mutation carriers: to whom and which?

Grandi G1, Caroli M1, Cortesi L2, Toss A2,3, Tazzioli G1,4, Facchinetti F1.

INTRODUCTION: Risk-reducing-salpingo-oophorectomy (RRSO) inevitably leads BRCA mutation carriers to premature menopause. AREAS COVERED: To evaluate the existing evidence for use of postmenopausal hormone therapy (HT) in BRCAmc, after RRSO or menopause occurring naturally, for both breast cancer (BC) survivors and those without BC. EXPERT OPINION: All BC survivors are excluded from any HT treatment: in other BRCAmc, before 51 years of age the benefits of HT overcome the risks after RRSO and/or premature ovarian insufficiency (POF). After 51 years of age, it is important to treat only women with important vasomotor symptoms, after the failure of alternative therapies. Estrogens-only therapy plays a key role in hysterectomized women (HW). In the case of an intact uterus (UW), associations with the lowest dose of progestins/natural progesterone derivatives have to be preferred, as progestins has been shown to play an important role in BC transformation, especially in BRCA1mc. No studies have been performed in BRCAmc with regard to 'progestin-free' HT, in particular the old tibolone (both in HW and UW)

and the new tissue-selective estrogen complex (in UW). However, preliminary data obtained from the general population are reassuring about the use of these 'progestin-free' preparations and BC safety.

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Effects of Estradiol Dose and Serum Estradiol Levels on Metabolic Measures in Early and Late Postmenopausal Women in the REPLENISH Trial.

Sriprasert I1,2, Hodis HN1,3,4, Bernick B5, Mirkin S5, Mack WJ1,4.

Background: To identify the association of estradiol (E2) dose and serum E2 levels with metabolic measures in early (<6 years) compared with late (≥10 years) postmenopausal women from the REPLENISH trial. Material and Methods: This is a post hoc analysis of a multicenter randomized clinical trial in the United States. Four doses of TX-001HR, an oral combination of E2 and progesterone (P4), and placebo were tested. This analysis included a total of 1,216 early and 297 late postmenopausal women. Linear mixed-effects models tested the association of E2 dose and serum E2 levels with changes in metabolic parameters; total cholesterol (TC), high-density lipoprotein cholesterol (HDL-C), low-density lipoprotein cholesterol (LDL-C), triglyceride (TG), and glucose (GLUC) levels from six visits over 12 months, adjusted for the serum P4 level. Results: A higher E2 dose was significantly associated with lower TC ($p = 0.02$) and LDL-C ($p = 0.002$) and higher HDL-C ($p = 0.04$) levels in early, but not late, postmenopause. With longer time since menopause, the inverse association of E2 dose with TC and LDL-C and positive association with HDL-C were attenuated (interaction $p < 0.05$). Higher serum E2 levels were significantly associated with lower TC ($p = 0.004$), LDL-C ($p = 0.0001$), and fasting blood GLUC ($p = 0.003$) and higher TG ($p = 0.002$) levels in early postmenopause. Conclusion: E2 dose differentially affects metabolic measures among early compared with late postmenopausal women. No significant main effect of the serum P4 level was found. As the metabolic parameters studied are risk factors for cardiovascular events, these results support the timing hypothesis of E2 therapy and its cardiovascular benefits.

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Is there a role for menopausal hormone therapy in the management of postmenopausal osteoporosis?

Rozenberg S, Al-Daghri N, Aubertin-Leheudre M, Brandi ML, Cano A, Collins P, Cooper C, Genazzani AR, Hillard T, Kanis JA, Kaufman JM, Lambrinoudaki I, Laslop A, McCloskey E, Palacios S, Prieto-Alhambra D, Reginster JY, Rizzoli R, Rosano G, Trémollieres F, Harvey NC.

We provide an evidence base and guidance for the use of menopausal hormone therapy (MHT) for the maintenance of skeletal health and prevention of future fractures in recently menopausal women. Despite controversy over associated side effects, which has limited its use in recent decades, the potential role for MHT soon after menopause in the management of postmenopausal osteoporosis is increasingly recognized. We present a narrative review of the benefits versus risks of using MHT in the management of postmenopausal osteoporosis. Current literature suggests robust anti-fracture efficacy of MHT in patients unselected for low BMD, regardless of concomitant use with progestogens, but with limited evidence of persisting skeletal benefits following cessation of therapy. Side effects include cardiovascular events, thromboembolic disease, stroke and breast cancer, but the benefit-risk profile differs according to the use of opposed versus unopposed oestrogens, type of oestrogen/progestogen, dose and route of delivery and, for cardiovascular events, timing of MHT use. Overall, the benefit-risk profile supports MHT treatment in women who have recently (< 10 years) become menopausal, who have menopausal symptoms and who are less than 60 years old, with a low baseline risk for adverse events. MHT should be considered as an option for the maintenance of skeletal health in women, specifically as an additional benefit in the context of treatment of menopausal symptoms, when commenced at the menopause, or shortly thereafter, in the context of a personalized benefit-risk evaluation.

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Long-term outcome of postmenopausal women with proliferative endometrium on endometrial sampling.

Rotenberg O, Doulaveris G, Fridman D, Renz M, Kaplan J, Xie X, Goldberg GL, Dar P.

INTRODUCTION: Proliferative endometrium has been reported in 15% of endometrial biopsies of women 50 and older. In contrary to endometrial hyperplasia, proliferative endometrium has not been associated with risk of

endometrial cancer. We sought to report on the long-term outcome of postmenopausal women diagnosed with proliferative endometrium. METHODS: Retrospective cohort study of 1808 women 55 and older who underwent endometrial sampling between 1/1997-12/2008. Outcome data was available through 2/2018. Women with proliferative endometrium were compared to those with atrophic endometrium for future development of endometrial hyperplasia or cancer. A sub-analysis was performed for those who presented with postmenopausal bleeding. Uni and multivariable logistic regression analysis were used to assess for confounders. RESULTS: PE was diagnosed in 297 (16.4%) cases. 962 met inclusion criteria, 278 with proliferative endometrium and 684 with atrophic endometrium. Women with proliferative endometrium were younger (61.2 vs. 64.5,p<.0001) and had a higher BMI (33.9 vs. 30.6kg/m2,p<.0001). More African American women had proliferative endometrium Both groups had a similar length of surveillance (11.9 vs. 11.5year,p=0.27). Women with proliferative endometrium developed more endometrial hyperplasia or cancer (11.9% vs. 2.9%,p<.0001), any endometrial cancer (5.8% vs 1.8%,p=0.002), atypical endometrial hyperplasia (2.2% vs. 0.4%,p=0.02) and non-atypical endometrial hyperplasia (2.0 vs. 0.7%,p=0.001). The risk for endometrial cancer and endometrial hyperplasia remained similar after excluding cases on hormonal therapy (12.2% vs. 3%,p=0.001). On logistic regression analysis proliferative endometrium histology (OR=3.89. 95%CI=2.03-7.49,p<.0001), age >60 (OR=1.98, 95%CI=1.03-3.82,p=0.04) and BMI>35 (OR=2.3, 95%CI=1.09-4.83,p < 0.0001) remained significant risk factors for progression to cancer. CONCLUSION: One in six postmenopausal women who underwent endometrial sampling had proliferative endometrium. 11.9% of them developed endometrial cancer or hyperplasia, a four-fold greater incidence than women with atrophic endometrium. The findings of this study suggest that long-term monitoring is warranted for women with postmenopausal bleeding and a proliferative endometrium histology. Further studies are needed to examine if a treatment is required to negate the risk of unopposed estrogen.