Selección de Resúmenes de Menopausia

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Romosozumab: A Review in Postmenopausal Osteoporosis

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Romosozumab (Evenity®), a humanized monoclonal antibody, promotes bone formation and inhibits bone resorption by inhibiting sclerostin, a protein involved in the regulation of bone formation. Subcutaneous romosozumab is approved in several countries, including those of the EU for treating severe osteoporosis as well as in the USA for osteoporosis in postmenopausal women at high risk of fracture. In pivotal phase III trials (FRAME and ARCH), 12 months' once-monthly romosozumab 210 mg significantly reduced vertebral and clinical fracture risk versus placebo and oral alendronate in postmenopausal women with osteoporosis. After patients transitioned from romosozumab to 12-24 months of subcutaneous denosumab or oral alendronate, fracture risks were significantly improved versus placebo-to-denosumab and alendronate-only treatment. In these trials and a phase IIIb trial, romosozumab significantly increased bone mineral density (BMD) relative to placebo, alendronate and subcutaneous teriparatide at 12 months, with these benefits maintained 12-24 months after patients transitioned from romosozumab to alendronate or denosumab in pivotal trials. Romosozumab had a generally manageable tolerability profile. While further clinical experience is needed to more definitively establish its efficacy and safety, including its CV safety, romosozumab extends the treatment options in postmenopausal women with osteoporosis who have a high risk of fracture and in those who have failed or are intolerant to other available osteoporosis therapy.

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Prior depression affects the experience of the perimenopause - findings from the Swiss Perimenopause Study

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Background: There is a prevalence peak of depression in the perimenopause, with this reproductive phase being considered a window of vulnerability due to major biopsychosocial changes. Depression has been associated with physical and psychosocial impairment. Prior depression has been shown to be a risk factor for the development of several somatic and mental diseases. We assume that women with prior depression will exhibit increased burdensome symptoms in the perimenopause compared to women without prior depression. Methods: A total of 135 perimenopausal women aged 40-56 years participated in the longitudinal Swiss Perimenopause Study. For the purpose of this investigation, a cross-sectional design was chosen. A wide range of validated psychosocial questionnaires were used to compare women with and without prior depression regarding their experience of the perimenopause. Findings were statistically adjusted for multiple testing. Results: Women with prior depression showed significantly more depressive symptoms ($U = 1215.5$, $p < .01$), more menopausal symptoms ($U = 1395.0$, $p < .01$), and more sleep disturbances ($U = 1583.5$, $p < .05$) than women without prior depression. Moreover, women with a history of depression reported lower subjective mental health ($U = 1573.0$, $p < 05$) and felt more isolated ($U = 1524.0$, $p < .05$) than those without prior depression. Limitations: Self-report data may affect the results. Furthermore, due to the cross-sectional design, causality cannot be inferred. Conclusions: Prior depression affects women's experience of the perimenopause. Women with prior depression exhibit significantly more negative health outcomes in the perimenopause than those without prior depression.

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Estradiol Replacement at the Critical Period Protects Hippocampal Neural Stem Cells to Improve Cognition in APP/PS1 Mice

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It has been suggested that there is a critical window for estrogen replacement therapy (ERT) in postmenopausal women with Alzheimer's disease (AD); however, supporting evidence is lacking. To address this issue, we investigated the effective period for estradiol (E2) treatment using a mouse model of AD. Four-month-old female APPswe/PSEN1dE9

(APP/PS1) mice were ovariectomized (OVX) and treated with E2 for 2 months starting at the age of 4 months (early period), 6 months (mid-period), or 8 months (late period). We then evaluated hippocampal neurogenesis, β-amyloid (Aβ) accumulation, telomerase activity, and hippocampal-dependent behavior. Compared to age-matched wild type mice, APP/PS1 mice with intact ovaries showed increased proliferation of hippocampal neural stem cells (NSCs) at 8 months of age and decreased proliferation of NSCs at 10 months of age; meanwhile, Aβ accumulation progressively increased with age, paralleling the reduced survival of immature neurons. OVX-induced depletion of E2 in APP/PS1 mice resulted in elevated Aβ levels accompanied by elevated p75 neurotrophin receptor (p75NTR) expression and increased NSC proliferation at 6 months of age, which subsequently declined; accelerated reduction of immature neurons starting from 6 months of age, and reduced telomerase activity and worsened memory performance at 10 months of age. Treatment with E2 in the early period post-OVX, rather than in the mid or late period, abrogated these effects, and p75NTR inhibition reduced the overproliferation of NSCs in 6-month-old OVX-APP/PS1 mice. Thus, E2 deficiency in young APP/PS1 mice exacerbates cognitive deficits and depletes the hippocampal NSC pool in later life; this can be alleviated by E2 treatment in the early period following OVX, which prevents Aβ/p75NTR-induced NSC overproliferation and preserves telomerase activity.

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Defining an international cut-off of two-legged countermovement jump power for sarcopenia and dysmobility syndrome

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We aimed to establish jump power cut-offs for the composite outcome of either sarcopenia (EWGSOP2) or dysmobility syndrome using Asian and Caucasian cohorts. Estimated cut-offs were sex specific (women: < 19.0 W/kg; men: < 23.8 W/kg) but not ethnicity specific. Jump power has potential to be used in definitions of poor musculoskeletal health. Purpose: Weight-corrected jump power measured during a countermovement jump may be a useful tool to identify individuals with poor musculoskeletal health, but no cut-off values exist. We aimed to establish jump power cut-offs for detecting individuals with either sarcopenia or dysmobility syndrome. Methods: Age- and sex-matched community-dwelling older adults from two cohorts (University of Wisconsin-Madison [UW], Korean Urban Rural Elderly cohort [KURE], 1:2) were analyzed. Jump power cut-offs for the composite outcome of either sarcopenia defined by EWGSOP2 or dysmobility syndrome were determined. Results: The UW (n = 95) and KURE (n = 190) cohorts were similar in age (mean 75 years) and sex distribution (68% women). Jump power was similar between KURE and UW women (19.7 vs. 18.6 W/kg, p = 0.096) and slightly higher in KURE than UW in men (26.9 vs. 24.8 W/kg, p = 0.050). In UW and KURE, the prevalence of sarcopenia (7.4% in both), dysmobility syndrome (31.6% and 27.9%), or composite of either sarcopenia or dysmobility syndrome (32.6% and 28.4%) were comparable. Low jump power cut-offs for the composite outcome differed by sex but not by ethnicity (< 19.0 W/kg in women; < 23.8 W/kg in men). Low jump power was associated with elevated odds of sarcopenia (adjusted odds ratio [aOR] 4.07), dysmobility syndrome (aOR 4.32), or the composite of sarcopenia or dysmobility syndrome (aOR 4.67, p < 0.01 for all) independent of age, sex, height, and ethnicity. Conclusion: Sex-specific jump power cut-offs were found to detect the presence of either sarcopenia or dysmobility syndrome in older adults independent of Asian or Caucasian ethnicity.

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Uterine bleeding with hormone therapies in menopausal women: a systematic review

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Uterine bleeding is a common reason why women discontinue menopausal hormone therapy (HT). This systematic review compared bleeding profiles reported in studies for continuous-combined HT approved in North America and Europe for moderate to severe vasomotor symptoms in postmenopausal women with a uterus. Non-head-to-head studies showed that uterine bleeding varies by formulation and administration route, with oral having a better bleeding profile than transdermal formulations. Cumulative amenorrhea over a year ranged from 18 to 61% with oral HT and from 9 to 27% with transdermal HT, as reported for continuous-combined HT containing 17β-estradiol (E2)/progesterone (P4) (56%), E2/norethisterone acetate (NETA) (49%), E2/drospirenone (45%), conjugated equine estrogens/medroxyprogesterone acetate (18-54%), ethinyl estradiol/NETA (31-61%), E2/levonorgestrel patch (16%), and E2/NETA patch (9-27%). Amenorrhea rates and the mean number of bleeding/spotting days improved over time.

The oral E2/P4 combination was amongst those with lower bleeding rates and may be an appropriate alternative for millions of women seeking bioidentical HT and/or those who have bleeding concerns with other HT.