



Selección de Resúmenes de Menopausia

Semana del 29 diciembre 2021 al 4 enero 2022
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Front Glob Womens Health. 2021 Dec 14;2:774308. doi: 10.3389/fgwh.2021.774308. eCollection 2021.

Steroid Hormone Secretion Over the Course of the Perimenopause: Findings From the Swiss Perimenopause Study

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Background: Perimenopause is characterized by a decline in the steroid hormones, estradiol, and progesterone. By contrast, the steroid hormone cortisol, a marker of the hypothalamic-pituitary-adrenal (HPA) axis, increases. Recent longitudinal studies reported fluctuations in steroid hormone levels during perimenopause, and even increases in estradiol levels. To understand these confounding results, it is necessary to conduct a longitudinal, highly standardized assessment of steroid hormone secretion patterns in perimenopausal women. **Methods:** This longitudinal study investigated 127 perimenopausal women aged 40-56 years for 13 months. Estradiol, progesterone, and cortisol were assessed using saliva samples, which were collected for two (during months 2 and 12 for estradiol and progesterone) or three (during months 2, 7, and 12 for cortisol) non-consecutive months over the course of the study. A total of 14 saliva samples per participant were analyzed to investigate the courses of estradiol and progesterone. Cortisol awakening response and fluctuations of cortisol throughout the day were measured using a total of 11 saliva samples per participant (on awakening, +30 min, +60 min, at 12:00 p.m., and before going to bed) for months 2, 7, and 12. **Results:** Multilevel analyses revealed variance in intercept and slope across participants for estradiol [intercept: SD = 5.16 (95% CI: 4.28, 6.21), slope: SD = 0.50 (95% CI: 0.39, 0.64)], progesterone [intercept: SD = 34.77 (95% CI: 25.55, 47.31), slope: SD = 4.17 (95% CI: 2.91, 5.99)], and cortisol (intercept: SD = 0.18 (95% CI: 0.14, 0.23), slope: SD = 0.02 (95% CI: 0.01, 0.02)]. Time predicted cortisol levels [$b = -0.02$, $t(979) = -6.63$, $p < 0.0001$]. Perimenopausal status (early vs. late) did not predict estradiol [$b = -0.36$, $t(1608) = -0.84$, $p = 0.400$], progesterone [$b = -4.55$, $t(1723) = -0.87$, $p = 0.385$], or cortisol [$b = 0.01$, $t(1124) = 0.61$, $p = 0.542$] scores over time. **Discussion:** Our results are consistent with previous findings emphasizing highly individual fluctuations of estradiol and progesterone levels during perimenopause. However, our findings do not suggest a continuous decline during the observed transition phase, implying relatively stable periods of fluctuating hormone levels. Furthermore, given the lack of significant group differences, it may not be necessary to differentiate between early and late perimenopause from the standpoint of hormonal progression.

Br Paramed J. 2021 Dec 1;6(3):41-48. doi: 10.29045/14784726.2021.12.6.3.41.

'Menopause affects us all . . .': menopause transition experiences of female ambulance staff from a UK ambulance service

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Background: There is limited research regarding the menopause transition in the emergency services; however, all women will experience this life phase, which can have a significant impact on personal well-being, workplace attendance and performance. The aim of this survey was to explore personal and work impacts of the menopause for all female staff in the ambulance setting. **Methods:** A purpose-designed, 20-question survey, based on the Menopause Rating Scale and British Menopause Survey, was developed to understand menopausal symptoms and their impact on female staff in one UK ambulance service. Disseminated during 1-31 July 2019, it resulted in a convenience sample of 522 responses, which were analysed using descriptive statistics and thematic approaches. **Results:** Typically, respondents were either pre-menopausal or peri-menopausal, with approximately a third being menopausal or post-menopausal. Over half worked in emergency operational delivery, and typically worked shifts or unsocial hours. For those who had experienced menopause symptoms, the most commonly reported were tiredness or low energy levels, difficulty sleeping (including insomnia) and mood changes (including anxiety or depression). Symptoms impacted respondents' well-being, work and home life. Most had not expected the symptoms they experienced. The majority of respondents did not feel supported at work, with lack of menopausal symptom awareness and personal impact, working times and patterns, and sense of embarrassment of most concern. Other issues included lack of managerial and peer support, inadequate working environment and uniform, lack of dignity and choice, and no dedicated menopause policy.

Conclusions: It is understood that this is the first survey to explore female ambulance staff menopause experiences. The impact of menopausal symptoms can be significant. Menopause awareness in this ambulance service is lacking and there is clear scope for initiatives for improved staff support and well-being. Further research is warranted to explore how best to support ambulance staff with the menopause transition.

Best Pract Res Clin Obstet Gynaecol. 2021 Nov 30;S1521-6934(21)00164-4. doi: 10.1016/j.bpobgyn.2021.10.009. Online ahead of print.

Cognition and mental health in menopause: A review

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Cognitive and mood changes are frequently mentioned as complaints before, during and after menopausal transition. There is substantial biological evidence for such associations to occur, as there are many mechanisms through which oestrogens can affect the brain: by regulating metabolism, increasing cerebral blood flow and dendritic outgrowth, by acting on nerve growth factors through the co-localisation of receptors via neurotransmitter synthesis and turnover and many more. However, the evidence for objective and longer-term changes in cognitive function and mental health over the menopausal transition and beyond is less clear. While hormone treatment (HT) including oestrogens could potentially reverse these psychological issues, the evidence of long-term benefit is also inconclusive. However, for women with severe menopausal complaints, and particularly for those who undergo early menopause, including women with premature ovarian insufficiency, personalised HT at least up to the natural age of menopause around 50 should be considered, which is probably safe up to 10 years of treatment, unless contraindicated. This paper reviews the evidence for changes in psychological health related to menopausal transition and HTs.

J Urol. 2021 Dec 30;101097JU000000000002380. doi: 10.1097/JU.000000000002380. Online ahead of print.

Impact of Lifetime Obesity on Urinary Incontinence in the Women's Health Initiative

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Materials and methods: Using data from the Women's Health Initiative (WHI), we evaluated the cumulative impact of obesity over a postmenopausal woman's lifetime on the development of UI. Analyses using logistic models assessed the relationship between overweight/obesity duration and the development of UI during the WHI study at Year 3. Results: Of the 15,420 women aged 50-79, 4,568 (30.0%) of whom developed UI by Year 3. When controlling for covariates, the duration of overweight (OWY) and obese years (OBY) was significantly associated with overall UI. The number of OWY was associated with an increased risk of developing UI post-menopausally (odds ratio [OR]: 1.17, 95% CI 1.13-1.22) compared to those with 0 OWY. The number of OBY was associated with a higher risk of developing UI post-menopausally (OR: 1.28, 95% CI 1.18-1.39). Severity of UI was also associated with higher OWY/OBY. Compared to participants who maintained normal weight, those who gained weight from age 18 to 50 were more likely to report increased UI (OR 1.26, 95% CI 1.16-1.37), as did those who remained overweight/obese (OR 1.27, 95% CI 1.04-1.55). Those who lost weight reported no difference in rates of any UI. Conclusions: Chronic, increased BMI status is associated with an elevated risk of UI later in life. Symptom severity also appears to be worsened with duration of increased BMI status. Weight management should be supported throughout one's lifetime, as it may impact UI in later stages of life.

Pharmacotherapy. 2021 Dec 30. doi: 10.1002/phar.2657. Online ahead of print.

Use of Hormonal Contraceptives in Perimenopause: A Systematic Review

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Introduction: Hormonal contraceptives have been used in perimenopausal women to manage a variety of symptoms and prevent unintended pregnancy. However, it is unclear what contraceptive regimen is best for these women. Objective: To evaluate hormonal contraceptive methods in women experiencing perimenopause using two prespecified outcomes: perimenopausal symptom management and long-term effects. Methods: A literature search of PubMed and EMBASE databases was performed (January 1990 to October 2021) using search terms "perimenopause" and "contraception." Relevant full-text articles in English were included. Results: Fifteen clinical articles were reviewed. Fourteen were internationally-based and one study was conducted in the United States. Nine articles evaluated symptom resolution, and six of these nine reported statistically significant changes in favor of treating perimenopausal women

with hormonal contraceptives compared with no treatment. Seven studies evaluated long-term outcomes including bone loss and metabolic parameters, and six of these seven showed statistically significant improvements with hormonal contraceptives. Based on limited data and a lack of comparative studies, the use of a levonorgestrel intrauterine device with supplemental low-dose menopausal estrogen has positive results for the management of disruptive perimenopausal symptoms and long-term outcomes. Conclusion: Hormonal contraception in perimenopausal women improves symptom management and long-term outcomes if patients do not have contraindications. When selecting a contraceptive for women in perimenopause, clinicians and pharmacists need to address specific patient risk factors, symptom profiles, long-term risks and benefits, and patient preferences.

Best Pract Res Clin Obstet Gynaecol. 2021 Nov 17;S1521-6934(21)00166-8. doi: 10.1016/j.bpobgyn.2021.10.010.

Menopause review: Emerging treatments for menopausal symptoms

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Vasomotor symptoms (VMS) affect 2 out of 3 women during menopause and are highly disruptive and intolerable. They exert a negative impact on a woman's physical and mental well-being and are considered a high clinical priority requiring effective treatment. Although hormone therapy remains the gold-standard treatment for hot flashes, it is associated with several side effects and contraindications. Furthermore, alternative treatments for VMS are currently less efficacious and have limited availability; therefore, a new medication to treat VMS would benefit millions of women worldwide. Neurokinin 3 receptor (NK3R) antagonists have recently been developed as novel therapeutic agents for the amelioration of VMS through their action on NK3 receptors within the hypothalamus and consequent regulation of the thermoregulatory centre. So far, three NK3R antagonists have been studied in menopausal women, which have demonstrated significant reductions in VMS frequency and severity and have shown their ability to transform patients' quality of life.