



Selección de Resúmenes de Menopausia

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Juan Enrique Blümel. Departamento Medicina Sur. Universidad de Chile

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Sleep Characteristics and Carotid Atherosclerosis Among Midlife Women.

Thurston RC, Chang Y, von Känel R, Barinas-Mitchell E, Jennings JR, Hall MH, Santoro N, Buysse DJ, Matthews K

Midlife, which encompasses the menopause transition in women, can be a time of disrupted sleep and accelerated atherosclerosis accumulation. Short or poor sleep quality has been associated with cardiovascular disease (CVD) risk; few studies have investigated relations among midlife women. We tested whether shorter actigraphy sleep time or poorer subjective sleep quality was associated with carotid atherosclerosis among midlife women. Aims and Methods: Two hundred fifty-six peri- and postmenopausal women aged 40-60 years completed 3 days of wrist actigraphy, hot flash monitoring, questionnaires (Pittsburgh Sleep Quality Index [PSQI], Berlin), a blood draw, and carotid ultrasound [intima media thickness (IMT), plaque]. Associations of objective (actigraphy) and subjective (PSQI) sleep with IMT/plaque were tested in regression models (covariates: age, race, education, body mass index, blood pressure, lipids, insulin resistance, medications, snoring, depressive symptoms, sleep hot flashes, and estradiol). Results: Shorter objective sleep time was associated with higher odds of carotid plaque (for each hour shorter sleep, plaque score ≥ 2 , odds ratio (OR) [95% confidence interval, CI] = 1.58 [1.11-2.27], $p = .01$; plaque score = 1, OR [95% CI] = 0.95 [0.68-1.32], $p = .75$, vs. no plaque, multivariable). Poorer subjective sleep quality was associated with higher mean IMT [β , b (standard error, SE) = 0.004 (0.002), $p = .03$], maximal IMT [b (SE) = 0.009 (0.003), $p = .005$], and plaque [plaque score ≥ 2 , OR (95% CI) = 1.23 (1.09-1.40), $p = .001$; score = 1, OR (95% CI) = 1.06 (0.93-1.21), $p = .37$, vs. no plaque] in multivariable models. Findings persisted additionally adjusting for sleep hot flashes and estradiol. Conclusions: Shorter actigraphy-assessed sleep time and poorer subjective sleep quality were associated with increased carotid atherosclerosis among midlife women. Associations persisted adjusting for CVD risk factors, hot flashes, and estradiol.

J Voice. 2017 Mar 27. pii: S0892-1997(16)30526-4. doi: 10.1016/j.jvoice.2017.02.019. [Epub ahead of print]

Effect of Hormonal Replacement Therapy on Voice.

Hamdan AL, Tabet G, Fakhri G, Saredidine D, Btaiche R, Seoud M.

OBJECTIVE: This study aimed to investigate the effect of hormonal therapy (HRT) on voice in a group of menopausal women, taking into consideration body mass index (BMI) as a confounding factor and its potential role as a substitute for HRT. **SUBJECTS AND METHODS:** A total of 53 menopausal women, 34 not on HRT and 19 on HRT, were recruited. Demographic variables included age, gender, smoking, and BMI. All subjects were asked about the presence or absence of the following symptoms: hoarseness, deepening of the voice, pitch breaks, throat clearing, dryness in the throat, and vocal fatigue. Acoustic analysis was performed, and Voice Handicap Index-10 was also completed. **RESULTS:** The mean BMI was 25.90 ± 5.39 and 25.77 ± 4.26 in patients on HRT and not on HRT, respectively. There was no statistical difference in the Voice Handicap Index-10 score and the prevalence of any of the phonatory symptoms in menopausal women not on HRT compared with menopausal women on HRT. However, menopausal women not on HRT had significantly lower habitual pitch than those on HRT (P value of 0.022). On the other hand, the jitter was significantly higher in those on HRT (P value of 0.033). **CONCLUSION:** Hormonal therapy has an impact on the habitual pitch in menopausal women with comparable BMI. Those on HRT have a higher habitual pitch than those not on HRT.

Med Hypotheses. 2017 Apr;101:44-47. doi: 10.1016/j.mehy.2017.02.006. Epub 2017 Feb 15.

Dying for love: Perimenopausal degeneration of vaginal microbiome drives the chronic inflammation-malignant transformation of benign prostatic hyperplasia to prostatic adenocarcinoma.

Reece AS.

Prostatic carcinoma is the second commonest cancer in males and is so common as to become almost holoendemic with advancing age. The recent demonstration that far from being benign, "benign" prostatic hypertrophy is a likely a reaction of the prostate to chronic untreated lower genital tract infection, and that this chronic inflammation is likely the usual precursor to the frequent occurrence of prostatic carcinoma has far reaching implications. The obvious source for the chronic inflammatory stimulus in the prostate is the documented dramatically altered lower female genital microbiota associated with the menopause. Hence the major hypothesis is that prostatic cancer may arise due to chronic infection and inflammation in the prostate gland consequent upon the altered microbiome of the menopausal female genital tract. This has implications for testing and diagnosis, treatment, population health and personal hygiene practices. It suggests that male dyspareunia, although almost never encountered in clinical practice may in fact be relatively common in older males, and in particular if diagnosed, represents a critical opportunity for therapeutic intervention to interrupt the chronic inflammation - cancer transformation and progression which has been well documented in other tissues. It implies that the coordinated application of next generation sequencing to the microbiome of the lower genital tracts of male and female couples, including seminal fluid, will have both research applications to further explore this sequence, as well as finding application as a potential population level screening procedure as is presently done for the "Thin Prep" cervical screening for human papillomavirus in females. Moreover this insight opens up new opportunities for chemointervention and chemoprevention for this important clinicopathological progression. These considerations give rise to the exciting possibility that prostatic malignancy may be preventable by various methods of local hygiene in the female partner or some antibacterial method in males. Since the long term application of oral antibiotics is likely to be of limited efficacy this indicates the need for new antimicrobial solutions.

Am J Epidemiol. 2017 Mar 6:1-9. doi: 10.1093/aje/kwx023. [Epub ahead of print]

Risk of Diabetes After Hysterectomy With or Without Oophorectomy in Postmenopausal Women.

Luo J, Manson JE, Urrutia RP, Hendryx M, LeBlanc ES, Margolis KL.

The aim of this study was to determine the associations between hysterectomy, bilateral salpingo-oophorectomy (BSO), and incidence of diabetes in postmenopausal women participating in the Women's Health Initiative (WHI), a series of trials conducted in the United States, during the period 1993-1998. A total of 67,130 postmenopausal women aged 50-79 years were followed for a mean of 13.4 years. Among them, 7,430 cases of diabetes were diagnosed. Multivariable Cox proportional hazards models were used to assess the association between hysterectomy/ oophorectomy status and diabetes incidence. Compared with women without hysterectomy, women with hysterectomy had a significantly higher risk of diabetes (hazard ratio = 1.13, 95% confidence interval: 1.06, 1.21). The increased risk of diabetes was similar for women with hysterectomy only and for women with hysterectomy with concomitant BSO. Compared with hysterectomy alone, hysterectomy with BSO was not associated with additional risk of diabetes after stratification by age at hysterectomy and hormone therapy status. In our large, prospective study, we observed that hysterectomy, regardless of oophorectomy status, was associated with increased risk of diabetes among postmenopausal women. However, our data did not support the hypothesis that early loss of ovarian estrogens is a risk factor for type 2 diabetes. The modest increased risk of diabetes associated with hysterectomy may be due to residual confounding, such as the reasons for hysterectomy.

Int J Gynecol Cancer. 2017 Mar 23. doi: 10.1097/IGC.0000000000000943. [Epub ahead of print]

Review Article: Sexuality and Risk-Reducing Salpingo-oophorectomy.

Tucker PE, Cohen PA.

INTRODUCTION: Women with familial cancer syndromes such as hereditary breast and ovarian cancer syndrome (BRCA1 and BRCA2) and Lynch syndrome are at a significantly increased risk of developing ovarian cancer and are advised to undergo prophylactic removal of their ovaries and fallopian tubes at age 35 to 40 years, after childbearing is complete. **METHODS:** A comprehensive literature search of studies on risk-reducing salpingo-oophorectomy (RRSO), sexuality, and associated issues was conducted in MEDLINE databases. **RESULTS:** Risk-reducing salpingo-oophorectomy can significantly impact on a woman's psychological and sexual well-being, with women wishing they had received more information about this prior to undergoing surgery. The most commonly reported sexual symptoms experienced are vaginal dryness and reduced libido. Women who are premenopausal at the time of surgery may experience a greater decline in sexual function, with menopausal hormone therapy improving but not alleviating sexual symptoms. Pharmacological treatments including testosterone patches and flibanserin are available

but have limited safety data in this group. **CONCLUSIONS:** Despite the high rates of sexual difficulties after RRSO, patient satisfaction with the decision to undergo surgery remains high. Preoperative counseling with women who are considering RRSO should include discussion of its potential sexual effects and the limitations of menopausal hormone therapy in managing symptoms of surgical menopause.