



Selección de Resúmenes de Menopausia

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Juan Enrique Blümel. Departamento Medicina Sur. Universidad de Chile

J Midlife Health. 2017 Apr-Jun;8(2):51-54. doi: 10.4103/jmh.JMH_41_17.

Dry Eye Syndrome in Menopause and Perimenopausal Age Group.

Peck T, Olsakovsky L, Aggarwal S.

Dry eye disease (DED) is a multifactorial ocular surface disease that causes symptoms of ocular pain, discomfort, and decreased visual acuity. It significantly affects quality of life of patients. It is more prevalent in the females and is being specifically in the menopausal and postmenopausal age group. This is believed to be due to the changes in balance of sex hormones. Sex hormones - estrogens and androgens - influence production of all components of the tear film including aqueous layer, lipid, and mucin. Various mechanisms such as decrease in hormonal levels, shift in feedback mechanisms, and changes in receptor receptivity interplay to alter the ocular surface homeostasis and subsequently result in DED. Several studies have suggested potential role of hormone replacement therapy in menopause-associated dry eye symptoms. The purpose of this review is to help the non ophthalmic physicians about DED encountered commonly in menopausal age group. It is important for primary care physicians to understand DED due to its high prevalence, often debilitating symptoms and the potentially preventable and treatable nature of the condition.

Eur J Endocrinol. 2017 Sep;177(3):G1-G70. doi: 10.1530/EJE-17-0430.

Clinical practice guidelines for the care of girls and women with Turner syndrome: proceedings from the 2016 Cincinnati International Turner Syndrome Meeting.

Gravholt CH, Andersen NH, Conway GS, Dekkers OM, et al; International Turner Syndrome Consensus Group.

Turner syndrome affects 25-50 per 100,000 females and can involve multiple organs through all stages of life, necessitating multidisciplinary approach to care. Previous guidelines have highlighted this, but numerous important advances have been noted recently. These advances cover all specialty fields involved in the care of girls and women with TS. This paper is based on an international effort that started with exploratory meetings in 2014 in both Europe and the USA, and culminated with a Consensus Meeting held in Cincinnati, Ohio, USA in July 2016. Prior to this meeting, five groups each addressed important areas in TS care: 1) diagnostic and genetic issues, 2) growth and development during childhood and adolescence, 3) congenital and acquired cardiovascular disease, 4) transition and adult care, and 5) other comorbidities and neurocognitive issues. These groups produced proposals for the present guidelines. Additionally, four pertinent questions were submitted for formal GRADE (Grading of Recommendations, Assessment, Development and Evaluation) evaluation with a separate systematic review of the literature. These four questions related to the efficacy and most optimal treatment of short stature, infertility, hypertension, and hormonal replacement therapy.

Health Promot Chronic Dis Prev Can. 2017 Jul;37(7):205-214. doi: 10.24095/hpcdp.37.7.01.

Cancers attributable to excess body weight in Canada in 2010.

Zakaria D, Shaw A.

INTRODUCTION: Excess body weight (body mass index [BMI] ≥ 25.00 kg/m²) is an established risk factor for diabetes, hypertension and cardiovascular disease, but its relationship to cancer is lesser-known. This study used population attributable fractions (PAFs) to estimate the cancer burden attributable to excess body weight in Canadian adults (aged 25+ years) in 2010. **METHODS:** We estimated PAFs using relative risk (RR) estimates from the World Cancer Research Fund International Continuous Update Project, BMI-based estimates of overweight (25.00 kg/m²-29.99 kg/m²) and obesity (30.00+ kg/m²) from the 2000-2001 Canadian Community Health Survey, and cancer case counts from the Canadian Cancer Registry. PAFs were based on BMI corrected for the bias in self-reported height and weight. **RESULTS:** In Canada in 2010, an estimated 9645 cancer cases were attributable to excess body weight, representing 5.7% of all cancer cases (males 4.9%, females 6.5%). When limiting the analysis to types of cancer associated with high BMI, the PAF increased to 14.9% (males 17.5%, females 13.3%). Types of cancer with the

highest PAFs were esophageal adenocarcinoma (42.2%), kidney (25.4%), gastric cardia (20.7%), liver (20.5%), colon (20.5%) and gallbladder (20.2%) for males, and esophageal adenocarcinoma (36.1%), uterus (35.2%), gallbladder (23.7%) and kidney (23.0%) for females. Types of cancer with the greatest number of attributable cases were colon (1445), kidney (780) and advanced prostate (515) for males, and uterus (1825), postmenopausal breast (1765) and colon (675) for females. Irrespective of sex or type of cancer, PAFs were highest in the Prairies (except Alberta) and the Atlantic region and lowest in British Columbia and Quebec. CONCLUSION: The cancer burden attributable to excess body weight is substantial and will continue to rise in the near future because of the rising prevalence of overweight and obesity in Canada.

Endocr Pract. 2017 Jul;23(7):869-880. doi: 10.4158/EP171828.PS.

American Association of Clinical Endocrinologists and American College of Endocrinology position statement on menopause-2017 update.

Cobin RH, Goodman NF; AACE Reproductive Endocrinology Scientific Committee.

EXECUTIVE SUMMARY This American Association of Clinical Endocrinologists (AACE)/American College of Endocrinology (ACE) Position Statement is designed to update the previous menopause clinical practice guidelines published in 2011 but does not replace them. The current document reviews new clinical trials published since then as well as new information regarding possible risks and benefits of therapies available for the treatment of menopausal symptoms. AACE reinforces the recommendations made in its previous guidelines and provides additional recommendations on the basis of new data. A summary regarding this position statement is listed below: New information available from randomized clinical trials and epidemiologic studies reported after 2011 was critically reviewed. No previous recommendations from the 2011 menopause clinical practice guidelines have been reversed or changed. Newer information enhances AACE's guidance for the use of hormone therapy in different subsets of women. Newer information helps to support the use of various types of estrogens, selective estrogen-receptor modulators (SERMs), and progesterone, as well as the route of delivery. Newer information supports the previous recommendation against the use of bioidentical hormones. The use of nonhormonal therapies for the symptomatic relief of menopausal symptoms is supported. Newer information enhances AACE's guidance for the use of hormone therapy in different subsets of women. Newer information helps to support the use of various types of estrogens, SERMs, and progesterone, as well as the route of delivery. Newer information supports the previous recommendation against the use of bioidentical hormones. The use of nonhormonal therapies for the symptomatic relief of menopausal symptoms is supported. New recommendations in this position statement include: **RECOMMENDATION:** the use of menopausal hormone therapy in symptomatic postmenopausal women should be based on consideration of all risk factors for cardiovascular disease, age, and time from menopause. **RECOMMENDATION:** the use of transdermal as compared with oral estrogen preparations may be considered less likely to produce thrombotic risk and perhaps the risk of stroke and coronary artery disease. **RECOMMENDATION:** when the use of progesterone is necessary, micronized progesterone is considered the safer alternative. **RECOMMENDATION:** in symptomatic menopausal women who are at significant risk from the use of hormone replacement therapy, the use of selective serotonin re-uptake inhibitors and possibly other nonhormonal agents may offer significant symptom relief. **RECOMMENDATION:** AACE does not recommend use of bioidentical hormone therapy. **RECOMMENDATION:** AACE fully supports the recommendations of the Comité de l'Évolution des Pratiques en Oncologie regarding the management of menopause in women with breast cancer. **RECOMMENDATION:** HRT is not recommended for the prevention of diabetes. **RECOMMENDATION:** In women with previously diagnosed diabetes, the use of HRT should be individualized, taking in to account age, metabolic, and cardiovascular risk factors.

J Diabetes. 2017 Jul 13. doi: 10.1111/1753-0407.12584. [Epub ahead of print]

Optimism, Pessimism, Cynical Hostility, and Biomarkers of Metabolic Function in the Women's Health Initiative.

Tindle HA, Duncan MS, Liu S, Kuller LH, Fugate Woods N, Rapp SR, Kroenke CH, Coday M, Loucks EB, et al.

BACKGROUND: Psychological attitudes reflecting expectations about the future (optimism, pessimism) and people (cynical hostility) independently predict incident cardiovascular disease and possibly diabetes, but underlying biologic pathways are incompletely understood. We examined the cross-sectional relationship between optimism, pessimism, and cynicism and biomarkers of metabolic function in the Women's Health Initiative. **METHODS:**

Among 3443 postmenopausal women, biomarkers of metabolic function (fasting insulin and glucose) were measured at baseline and used to calculate insulin resistance (HOMA-IR) and pancreatic beta cell activity (HOMA-B). Psychological attitudes were assessed by the Life Orientation Test, Revised (LOT-R, full scale and optimism and pessimism subscales) and the Cook-Medley cynicism subscale. Multivariable linear regression modeled the association of psychological attitudes with biomarker levels, adjusting for sociodemographics, health conditions, and health behaviors. Because obesity promotes insulin resistance, and obese individuals tend to report higher levels of pessimism and cynical hostility, we explored an interaction with BMI. **RESULTS:** In fully-adjusted models, only pessimism remained independently associated with higher fasting insulin levels and insulin resistance (HOMA-IR). Scoring one point higher on the pessimism subscale was associated with a 1.2% higher fasting insulin level, while scoring one-standard deviation higher was associated with a 2.7% higher fasting insulin level ($p = 0.03$); (results similar for HOMA-IR). An interaction term with BMI was not significant. **CONCLUSIONS:** In multivariable models, higher dispositional pessimism was associated with worse metabolic function, and these findings were not modified by obesity status. Results extend prior work by linking pessimism to an objective biomarker of insulin resistance in elderly women. **HIGHLIGHTS:** In postmenopausal women, higher levels of pessimism were related to worse metabolic function. For each additional point on the pessimism scale, a woman's fasting insulin level was 1.2% higher, holding other health-related factors constant, while scoring one standard deviation higher was associated with almost 3% higher insulin levels. Future research should address whether interventions to modify pessimistic attitudes could potentially reduce a woman's risk of diabetes and/or cardiovascular disease.

J Diabetes Res. 2017; 2017:2042980. doi: 10.1155/2017/2042980. Epub 2017 Jun 18.

All-Cause Mortality Risk in Australian Women with Impaired Fasting Glucose and Diabetes.

de Abreu LLF, Holloway KL, Mohebbi M, Sajjad MA, Kotowicz MA, Pasco JA.

AIMS: Impaired fasting glucose (IFG) and diabetes are increasing in prevalence worldwide and lead to serious health problems. The aim of this longitudinal study was to investigate the association between impaired fasting glucose or diabetes and mortality over a 10-year period in Australian women. **METHODS:** This study included 1167 women (ages 20-94 yr) enrolled in the Geelong Osteoporosis Study. Hazard ratios for all-cause mortality in diabetes, IFG, and normoglycaemia were calculated using a Cox proportional hazards model. **RESULTS:** Women with diabetes were older and had higher measures of adiposity, LDL cholesterol, and triglycerides compared to the IFG and normoglycaemia groups (all $p < 0.001$). Mortality rate was greater in women with diabetes compared to both the IFG and normoglycaemia groups (HR 1.8; 95% CI 1.3-2.7). Mortality was not different in women with IFG compared to those with normoglycaemia (HR 1.0; 95% CI 0.7-1.4). **CONCLUSIONS:** This study reports an association between diabetes and all-cause mortality. However, no association was detected between IFG and all-cause mortality. We also showed that mortality in Australian women with diabetes continues to be elevated and women with IFG are a valuable target for prevention of premature mortality associated with diabetes.

Menopause. 2017 Jul 10. doi: 10.1097/GME.0000000000000919. [Epub ahead of print]

The association of surgical versus natural menopause with future left ventricular structure and function: The Coronary Artery Risk Development in Young Adults (CARDIA) Study.

Appiah D, Schreiner PJ, Nwabuo CC, Wellons MF, Lewis CE, Lima JA.

OBJECTIVE: To evaluate the association between surgical menopause (SM) versus natural menopause (NM) in relation to later left ventricular (LV) structure and function, while taking into account the LV parameters and other cardiovascular disease risk factor (CVDRF) levels that predate the menopausal transition. **METHODS:** We studied 825 premenopausal women from the Coronary Artery Risk Development in Young Adults study in 1990 to 1991 (baseline, mean age 32 years) who later reached menopause by 2010 to 2011 and had echocardiograms at these two time points. **RESULTS:** During 20 years of follow-up, 508 women reached NM, whereas 317 underwent SM (34% had bilateral oophorectomy). At baseline, women who later underwent SM were more likely to be black, younger, have greater parity, and higher mean values of systolic blood pressure, body mass index, and also lower mean high-density lipoprotein cholesterol and physical activity than women who reached NM. No significant differences in LV structure/function were found between groups. In 2010 to 2011, SM women had significantly higher LV mass, LV mass/volume ratio, E/e' ratio, and impaired longitudinal and circumferential strain than NM women. SM women with

bilateral oophorectomy had adverse LV measures than women with hysterectomy with ovarian conservation. Controlling for baseline echocardiographic parameters and CVDRF in linear regression models eliminated these differences between groups. Further adjustment for age at menopause/surgery and hormone therapy use did not change these results. **CONCLUSION:** In this study, the adverse LV structure and function observed among women with SM compared with NM were explained by their unfavorable presurgical CVDRF profiles, suggesting that premenopausal CVDRF rather than gynecologic surgery predispose SM women to elevated future cardiovascular disease risk.

Menopause. 2017 Jul 10. doi: 10.1097/GME.0000000000000899. [Epub ahead of print]

Comparison of clinical outcomes among users of oral and transdermal estrogen therapy in the Women's Health Initiative Observational Study.

Crandall CJ, Hovey KM, Andrews C, Cauley JA, Stefanick M, Shufelt C, Prentice RL, Kaunitz AM, et al.

OBJECTIVE: To examine associations of estrogen preparations with an index of health risks versus benefits. **METHODS:** Using data from 45,112 participants of the Women's Health Initiative Observational Study (average follow-up 5.5 years), we examined associations of estrogen type and oral conjugated equine estrogen (CEE) dose with time to first global index event (GIE), defined as coronary heart disease, breast cancer, stroke, pulmonary embolism, hip fracture, colorectal cancer, endometrial cancer, or death. **RESULTS:** Oral CEE less than 0.625mg/d+progestogen (P) users had a lower risk of a GIE (adjusted hazard ratio 0.74, 95% confidence interval 0.56-0.97) than oral CEE 0.625mg/d+P users. GIE risk in oral CEE 0.625mg/d+P users was greater with at least 5-year use (adjusted hazard ratio 1.22, 95% confidence interval 1.06-1.41) than with less than 5-year use. In women with prior hysterectomy, compared with women taking oral CEE 0.625mg/d for less than 5 years, GIE risk was similar with oral CEE below 0.625mg/d, oral estradiol (E2), and transdermal E2, whether used for less than 5 years or for at least 5 years. There was no difference in GIE risk between users of the following: oral CEE+P versus oral E2+P; oral CEE+P versus transdermal E2+P; oral E2+P versus transdermal E2+P. Findings were similar among women with hysterectomy taking estrogen alone. **CONCLUSIONS:** The summary index of risks versus benefits was similar for oral CEE versus oral or transdermal E2-containing regimens. CEE+P containing less than 0.625mg/d of CEE (vs 0.625mg/d) for less than 5 years appeared safer.

Eur J Phys Rehabil Med. 2017 Jul 10. doi: 10.23736/S1973-9087.17.04533-6. [Epub ahead of print]

Can vitamin D deficiency influence muscle performance in post-menopausal women? A multicenter retrospective study.

Iolascon G, Letizia Mauro G, Fiore P, Cisari C, Benedetti MG, Panella L, DE Sire A, Calafiore D, et al.

BACKGROUND: The presence of the vitamin D receptor (VDR) has been recently demonstrated in human muscle supporting the theory of a role of vitamin D in the proliferation and differentiation of muscle cells. So far only few studies investigated the association between vitamin D and muscle performance in post-menopausal women. **AIM:** To define the functional impact of vitamin D deficiency. **DESIGN:** Multicenter retrospective study. Five Italian outpatient services of Physical and Rehabilitation Medicine (PRM). **POPULATION:** Post-menopausal women. **METHODS:** We divided the population in two groups based on the threshold of 30 ng/ml as cut-off to define sufficient and insufficient serum levels of 25-hydroxyvitamin D3 [25(OH)D3]. Outcome measures were: appendicular lean mass (ALM); ALM-to-BMI ratio (ALMBMI); total fat mass (FM); visceral adipose tissue (VAT); Hand Grip Strength (HGS); Knee Isometric Extension Strength (KES); Short Physical Performance Battery (SPPB); 4-meter gait speed (4MGS). **RESULTS:** We analyzed the data records of 401 post-menopausal women (mean age 66.93 ± 8.47 years): 203 with hypovitaminosis D (mean age 66.81 ± 8.11 years) and 198 with normal levels of 25(OH)D3 (mean age 67.04 ± 8.84 years). The analysis showed a significant difference between the two groups in terms of: ALMBMI (0.002), FM (p 0.001), VAT mass (0.010), VAT volume (p =0.006), HGS (p<0.001), KES (p<0.001), SPPB score (p<0.001), percentage of people with a 4MGS ≤ 0.8 m/s (p<0.001). Furthermore, there were significant correlations (p<0.001) between serum levels of 25(OH)D3 and HGS (r=0.323), KES (r=0.510), and SPPB sit to stand (r=-0.362) and walking sub-scores (r=-0.312). **CONCLUSION:** This multicenter study demonstrated that post-menopausal women with vitamin D deficiency had a significant reduction of appendicular muscle strength and physical performance. **CLINICAL REHABILITATION IMPACT:** This study reported the frequency of

hypovitaminosis D in postmenopausal women and its influence on the reduction of muscle mass, strength, and physical performance in a typical population referring to the physiatrist for musculoskeletal disorders.