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16 WORLD CONGRESS ON MENOPAUSE
Midlife health in the 21st century

FAIRMONT HOTEL VANCOUVER, CANADA 6–9 JUNE 2018

**Unmet Health care needs
in Latinoamerican Postmenopausal women**

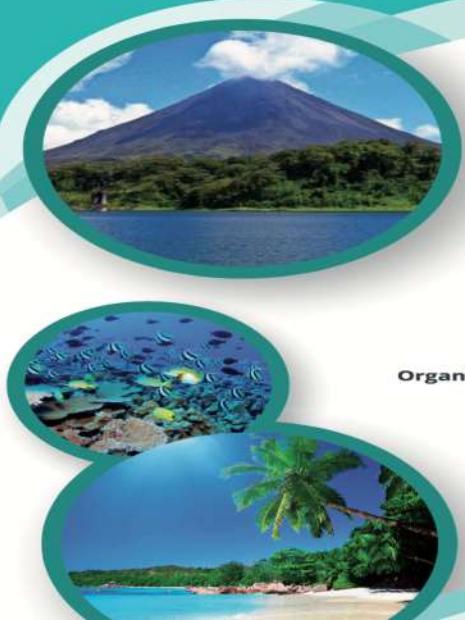
Hall: Waddington
Day: 07/06/2018 from 14:10 to 15:10

Chairman: Dr. Sonia Cerdas. Costa Rica
President of the Latin American Federation of Climacteric and Menopause Societies (FLASCYM)

**IX Congreso de la Federación Latinoamericana
de Sociedades de Climaterio y Menopausia**

**XIX Congreso de la Asociación Costarricense
de Climaterio, Menopausia y Osteoporosis**

**III Congreso de Ginecología
Endocrinológica**



26-29 de Marzo del 2019
Hotel Real Intercontinental,
San José, Costa Rica

Curso Precongreso:
Manejo Básico del Climaterio

Actualización en:

- Síndrome Vasomotor
- Riesgo Cardiovascular y Climaterio
- Síndrome Metabólico
- Diabetes Mellitus y Manejo de la Obesidad en el Climaterio
- Metabolismo Fosfocalcico y Vitamina D
- Terapia de Reemplazo Hormonal
- Uroginecología
- Andropausia
- Oncología y Climaterio

Organizan:

A.C.C.M.Y.O. 

FLASCYM 

Información e Inscripción flascym2019.com

Produce: 



Intercontinental Hotel

26-29 March 2019

San José, Costa Rica

flascym2019.com

Agenda

Welcome and Program presentation	Dr. Sonia Cerdas. Costa Rica
Socioeconomic status and lack of potential access to care in different regions of Latin America.	Dr. Carmen Troya . Panamá.
Unmet needs in cancer prevention.	Dr. Carlos Rencoret. Chile.
Limitations in the preventive strategies of cardiometabolic diseases.	Dr. Sonia Cerdas. Costa Rica
Current challenges for Postmenopausal Osteoporotic fracture prevention.	Dr. Victor Mercado. México.
Genitourinary syndrome and sexual health care needs.	Dr. Hoover Canaval, Colombia.
Closing remarks and questions.	Dr. Carmen Troya, Dr CarlosRencoret, Dr. Victor Mercado,Dr Hoover Canaval. Dra Sonia Cerdas

Unmet Health Care Needs in Latinoamerican Postmenopausal Women



Dr. Carmen Troya. MD. Panamá

Gynecologist and Obstetrician, University of Panama

Master degree in Health Science with specialization in Gynecology and Obstetrics

University of Panama

Subspecialties in Pathology of Lower Genital Tract, Genetics and Reproduction

Scientific Methodology, Reproductive Endocrinology and Hospital management

Latin American Expert in Menopause and Climacteric

Member of the Board of the Panama Osteoporosis Council

Member of the Panama Gynecology and Obstetrics Society



Dr. Carlos Rencoret . MD. Chile

Gynecologist and Obstetrician, University of Chile

Sub-specialization in Breast Surgery, University of Chile

Past President of the Chilean Society of Mastology

Director of the Senology International Society

Director of the Chilean Climacteric Society

Latin American Expert in Menopause and Climacteric

Member of the Chilean Society of Ultrasound in Medicine and Biology

Member of the Latin American Mastology Society

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Unmet Health care needs in Latinoamerican Postmenopausal women



Dr. Victor Mercado. MD. México
Gynecologist and Obstetrician, National Autonomous University of Mexico
Certified by the Mexican Council of Gynecology and Obstetrics
Principal Investigator of the Research Center in Preventive Gynecology
Holder of the Menopause Comprehensive Clinic of the Dalinde Medical Center
Advisor for the elaboration of the Official Mexican Guidelines in Osteoporosis 2017
Professor of the Course of Bone Densitometry by AMMOM-ISCD
Member of the Mexican Association for the Study of the Climacteric, A.C. - AMEC
Past President of the Mexican Bone and Mineral Metabolism Society - AMMOM



Dr. Hoover Canaval-Erazo MD, Colombia
Gynecologist and Obstetrician, Universidad del Valle, Cali, Colombia
Specialist in Health Services Administration of Universidad de Antioquia, Colombia
Professor of Gynecology and Obstetrics and Specialization in Family Medicine,
Universidad del Valle, Cali, Colombia
Past President of the Colombian Society of Menopause
Past President of the Anemia Working Group Latin America
Member of the Colombian Society of Gynecology and Obstetrics
Latin American Expert in Menopause and Climacteric - FLASCYM

Unmet Health care needs in Latinoamerican Postmenopausal women



**Dr. Sonia Cerdas. MD, FACE. Costa Rica
Endocrinologist, University of Costa Rica**

Fellow of Endocrinology, Hospital Cochin. Universidad René Descartes, Paris, France

Fellow of the American College of Endocrinology

Professor of Endocrinology, University of Costa Rica

Past President and Founder of the Costarrican Society of Menopause and Osteoporosis

Member of the IOF Regional Council for Latin America

President of the Latin American Federation of Climacteric and Menopause Societies

Socioeconomic status and lack of potential access to care in different regions of Latin America



**Dr. Carmen Troya
Panamá**



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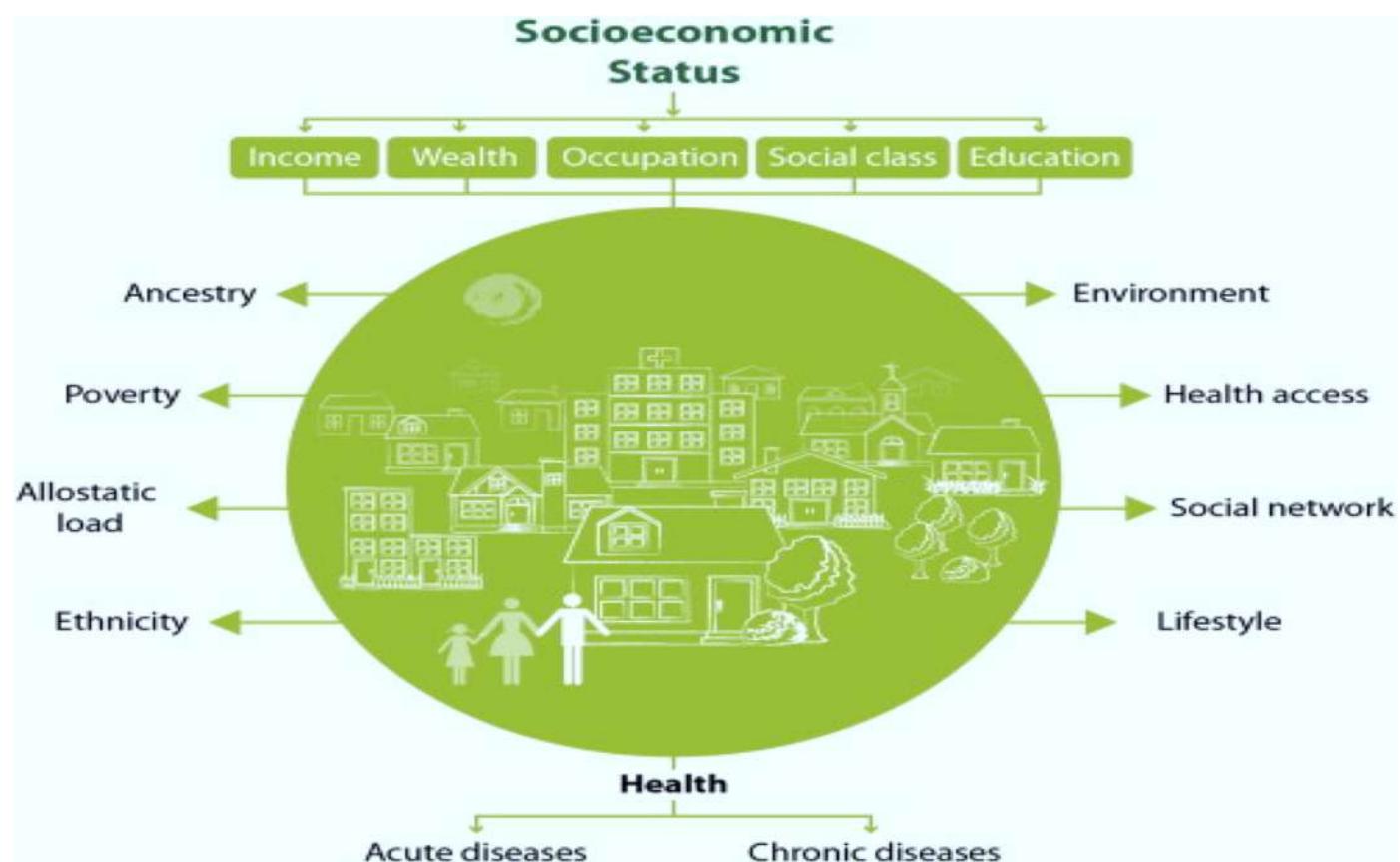
Financial Disclosures

**Dr. Carmen Troya
Panamá**

I have no financial relationships to disclose

Learning Goals

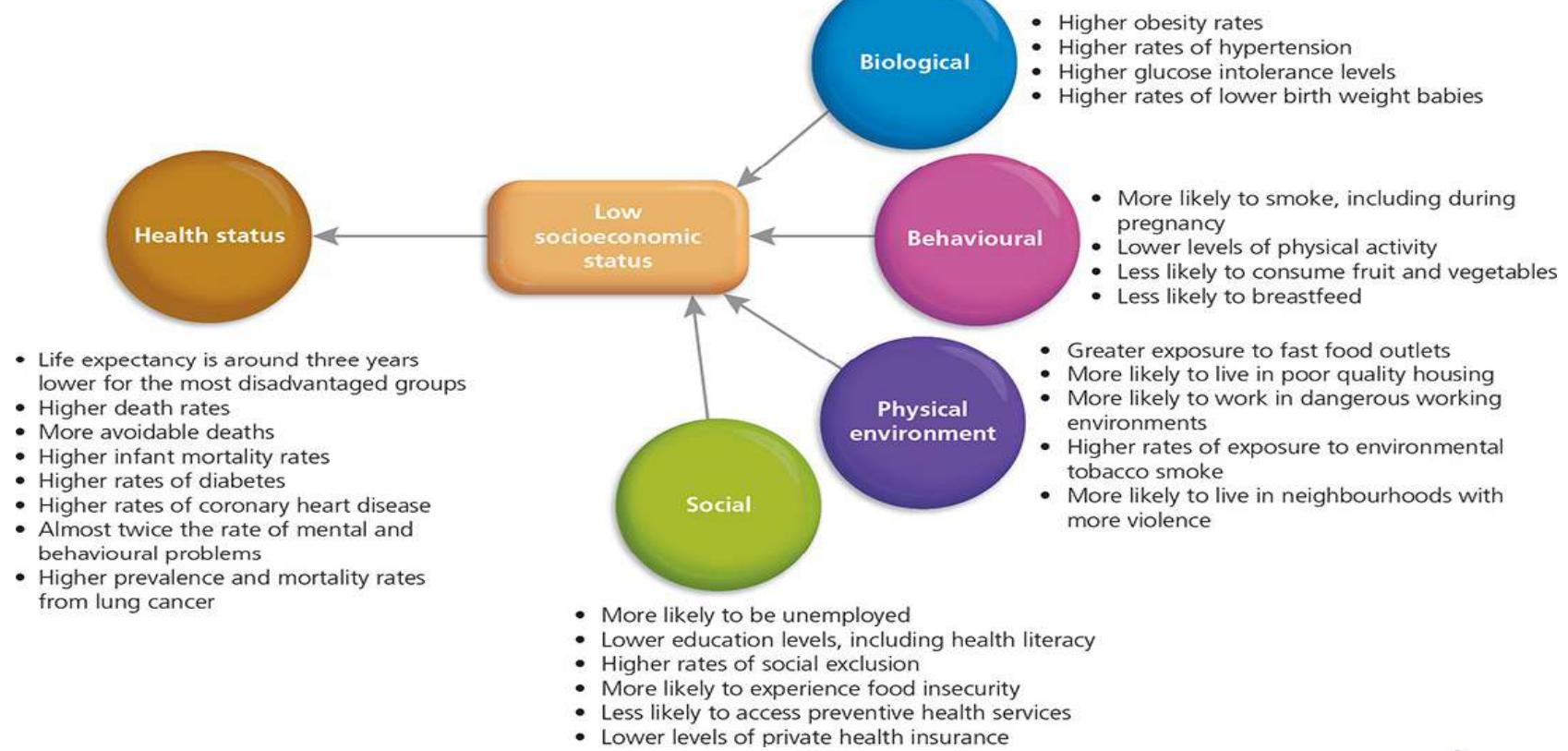
- General terminology and definitions
- Conceptual problem in Latin America
- Statistics in Latin America
- Conclusions



I.Blas, E. II.Sivasankara Kurup, A. Equity, social determinants and public health programs. World Health Organization. 2010

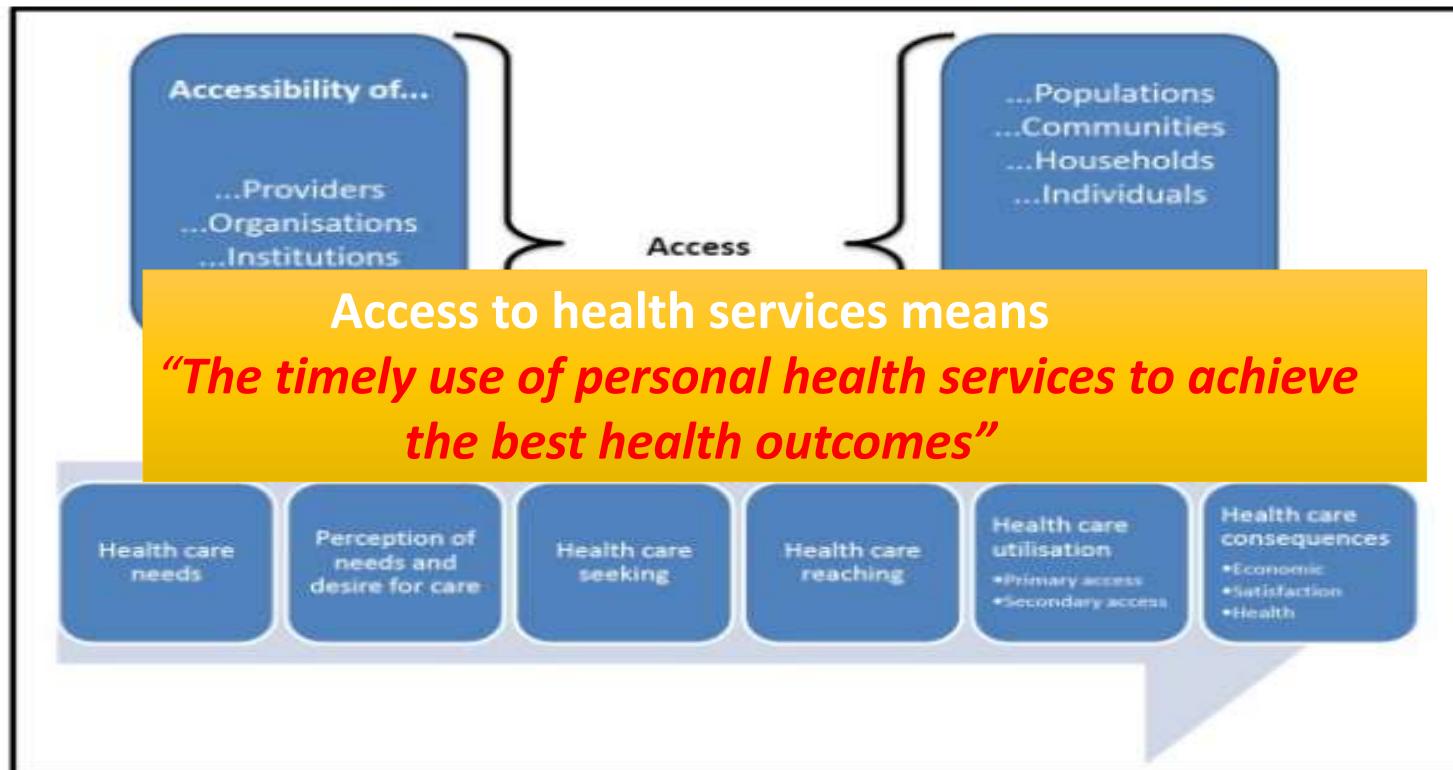
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Source: Key Concepts in Health & Human Development Third Edition - Units 3 & 4

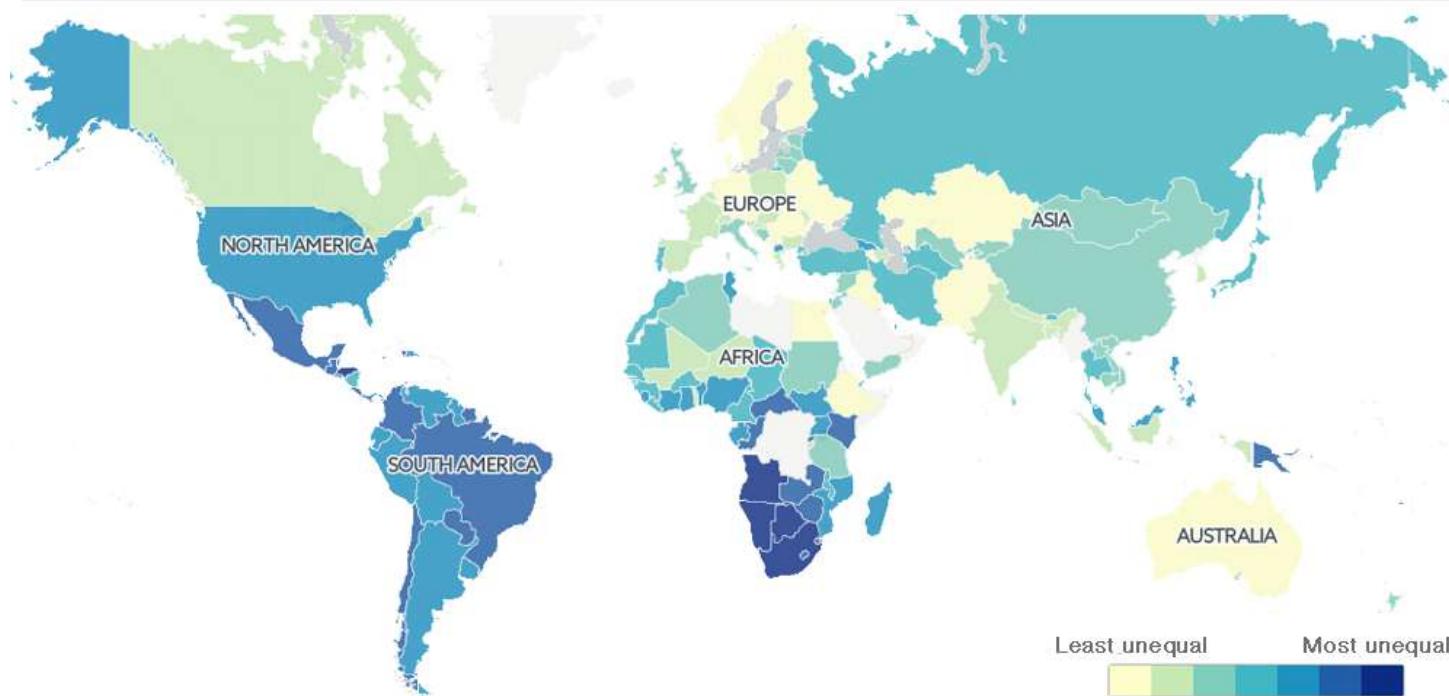
Access to health care: Definition



National Healthcare Quality Report, 2013. Chapter 10: Access to Healthcare. Rockville (MD): Agency for Healthcare Research and Quality; May 2014.

The most unequal regions in the world

GINI index measure of inequality



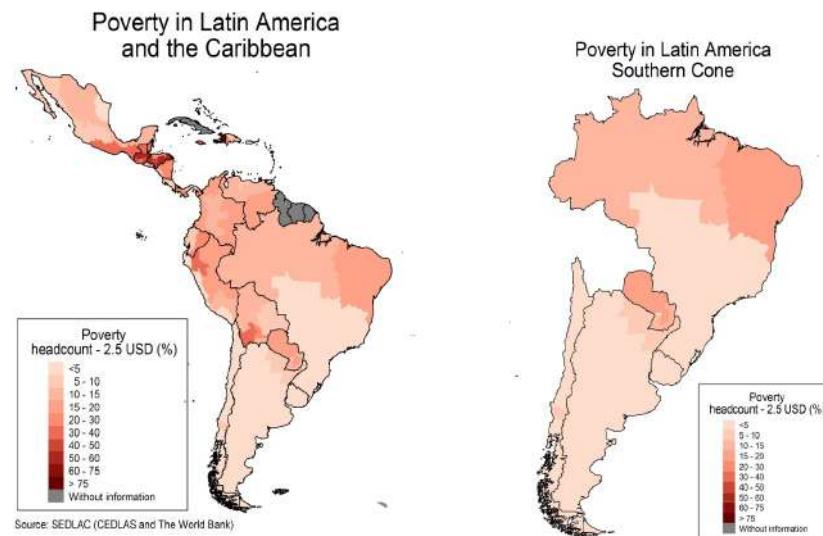
Source: GINI Index (World Bank estimate)

January's World Economic Forum Annual Meeting Davos.2016



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Poverty correlates with health outcomes



Poverty	Population %	Million people	Extreme Poverty
2014	28.5	168	8.2% 48 million
2015	29.8	178	
2016	37.7	186	10% 61 million

Economic Commission for Latin America and the Caribbean (ECLAC) Dic 2017

"Source: Socio-Economic Database for Latin America and the Caribbean (CEDLAS and The World Bank)." 2016

Global Extreme Poverty by [Max Roser and Esteban Ortiz-Ospina](#)^[cite]
 World Bank Publications. Available from <https://openknowledge.org/> First published in 2013; substantive revision March 27, 2017.

Latin America and the Caribbean by estimated GDP (Nominal)^[1]

Rank	Country	GDP (Nominal) in millions USD	GDP (Nominal) per capita USD
1	Brazil	2,138,918	10,224.03
2	Mexico	1,212,831	9,723.04
3	Argentina	625,921	14,043.67
4	Colombia	327,978	6,581.38
5	Chile	280,289	15,087.31
6	Peru	231,567	7,198.64
7	Ecuador	106,621	6,263.19
8	Venezuela	100,845	3,168.41
9	Guatemala	82,356	4,770.73
10	Dominican Republic	80,413	7,830.20
11	Panama	66,711	16,040.89
12	Uruguay	63,370	18,074.85
13	Costa Rica	61,287	12,188.70
14	Bolivia	40,737	3,621.79
15	Paraguay	32,291	4,578.32

16	El Salvador	29,407	4,596.22
17	Honduras	24,024	2,051.21
18	Trinidad and Tobago	22,158	16,083.43
19	Jamaica	15,258	5,334.53
20	Nicaragua	14,532	2,309.74
21	The Bahamas	12,318	32,714.93
22	Haiti	9,417	847.09
23	Barbados	5,317	18,882.00
24	Suriname	3,857	6,534.36
25	Guyana	3,747	4,849.83
26	Belize	1,912	4,830.01
27	Saint Lucia	1,755	9,937.37
28	Antigua and Barbuda	1,612	17,476.74
29	Grenada	1,180	10,924.70
30	Saint Kitts and Nevis	972	16,878.30
31	Saint Vincent and the Grenadines	835	7,569.71
32	Dominica	476	6,722.24
	Total	5,600,887	10,193.78



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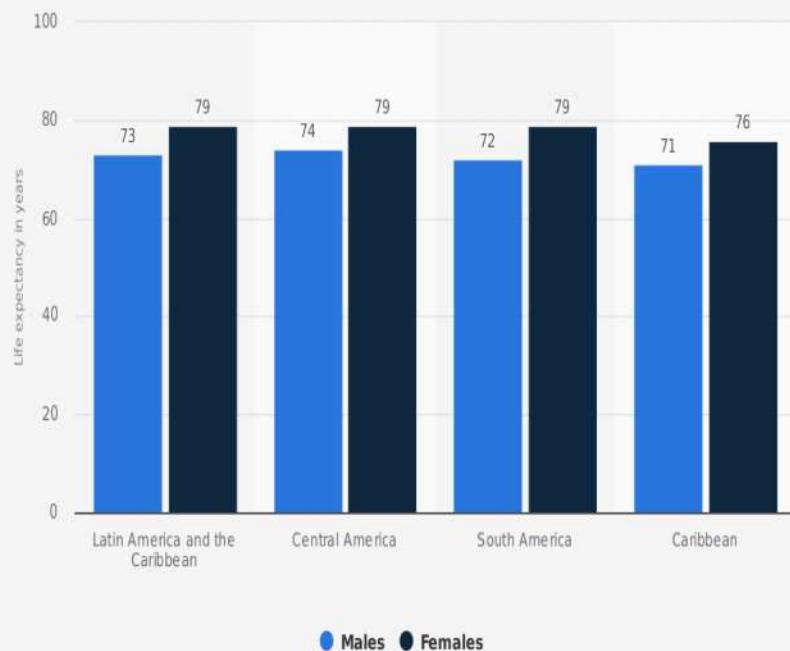
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LA-Caribbean Region

- A complex region of 600 million people, 33 countries and 14 territories
- 320 million (54%) have no health-care coverage
- Factors behind exclusion from health care: language barriers, unemployment, underemployment, geographic isolation, low educational levels and health illiteracy
- For the poorest populations: even in the context of free health care, limited access by the inability to pay medication costs, lack of affordable transportation, inconvenient clinic operation and long waiting times



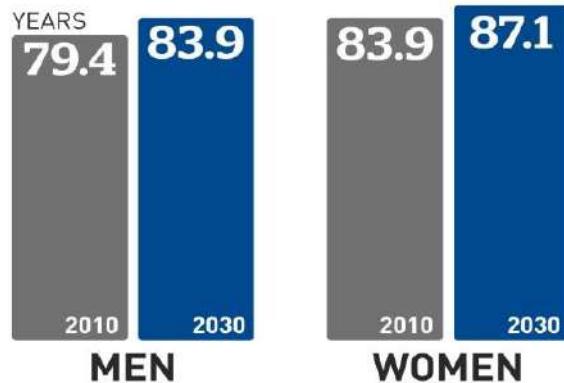
Average life expectancy* in Latin America and the Caribbean for those born in 2017, by gender and region (in years)



Source
Population Reference Bureau
© Statista 2018

Additional Information:
Central and South America

Life expectancy at birth in Canada 2010 AND 2030



CBC NEWS

Source: The Lancet

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Summary of comments from 11 Latin American and Caribbean countries

On young children	On education	On socioeconomic status
<ul style="list-style-type: none"> Difficulties registering children at birth, which have a long-term impact on access to social protection programs Violations of the marketing code for breast-milk substitutes Permanent institutionalization of children with different mental or intellectual abilities Malnutrition rates 	<ul style="list-style-type: none"> Lack of access to differentiated education programs and curricula, when appropriate, for children with disabilities Lack of access by indigenous communities to intercultural bilingual education Banning of pregnant girls or adolescent mothers from the school system Presence of bullying and sexual violence in schools 	<ul style="list-style-type: none"> Limited financial protection for the health of disabled children Legal and political barriers to family planning, sex education, and emergency contraceptives Trafficking of adolescent girls for sex work and sexual exploitation
On access to work and employment conditions	On housing and living conditions	On disease prevention systems
<ul style="list-style-type: none"> Discrimination against migrant workers in access to social protection programs and the social security system Child labor High accident and occupational death rates In some cases, the civil code requires women to obtain their husband's permission to participate in the workforce 	<ul style="list-style-type: none"> Forcible eviction of people and households from marginalized or underprivileged populations, especially migrant, Afro-descendant, and indigenous groups Declaring "mental illness" affects a person's right to a home Intensive and disproportionate use of water by the mining industry, limiting access to safe drinking water and sanitation 	<ul style="list-style-type: none"> Absence of legal mechanisms and policies to ensure that women, adolescents, older persons, and persons with disabilities can give their free and informed consent for medical treatment (legal capacity) Lack of comprehensive strategies to replace institutional care with community-based services

Source: PAHO. The social determinants of health in selected countries in Latin America and the Caribbean 2016 .

Note: The review included Argentina, Belize, Brazil, Chile, Costa Rica, Cuba, El Salvador, Jamaica, Mexico, Peru, and Suriname.

Reproductive health care is often lacking in Latin America and the Caribbean



22% of women at risk of unintended pregnancy (23 million) are not using an effective contraceptive method

ONLY **3%** of women of reproductive age live in countries where abortion is broadly legal

AT LEAST **10%** of maternal deaths are due to unsafe abortion.

54% of women do not receive needed care for pregnancy complications

55% of newborns do not receive needed care for major health complications

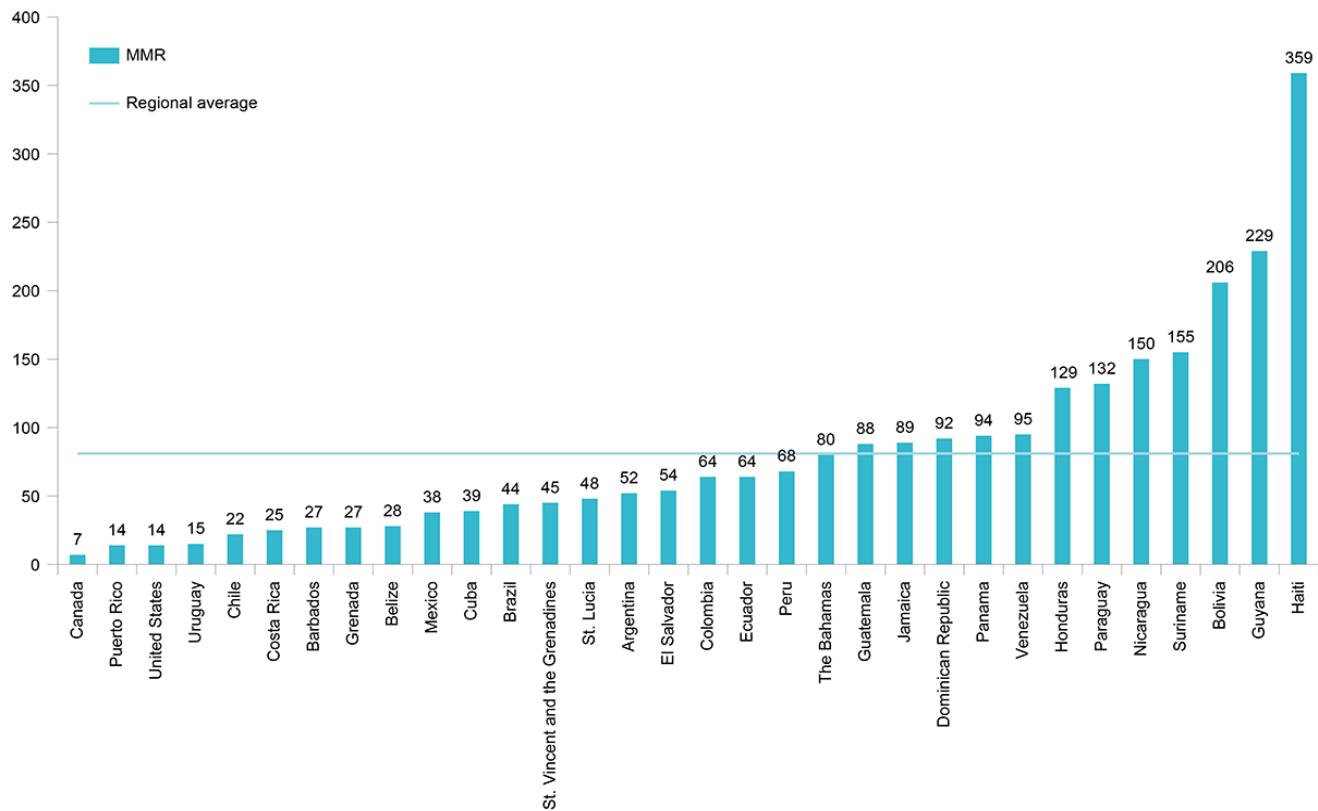
Source: Guttmacher Institute.

www.guttmacher.org

Guttmacher Institute, Investing in sexual and reproductive health in Latin America and the Caribbean, *Fact Sheet*, New York: Guttmacher Institute, 2014, <http://www.guttmacher.org/fact-sheet/investing-sexual-an>

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Maternal mortality rate (per 100,000 live births), 2015



Source: World Health Organization, United Nations Children's Fund, United Nations Population Fund, World Bank Group, United Nations Population Division. *Trends in maternal mortality: 1990 to 2015*. Geneva: WHO; 2015.

HEALTH STATUS INDICATORS

Maternal mortality



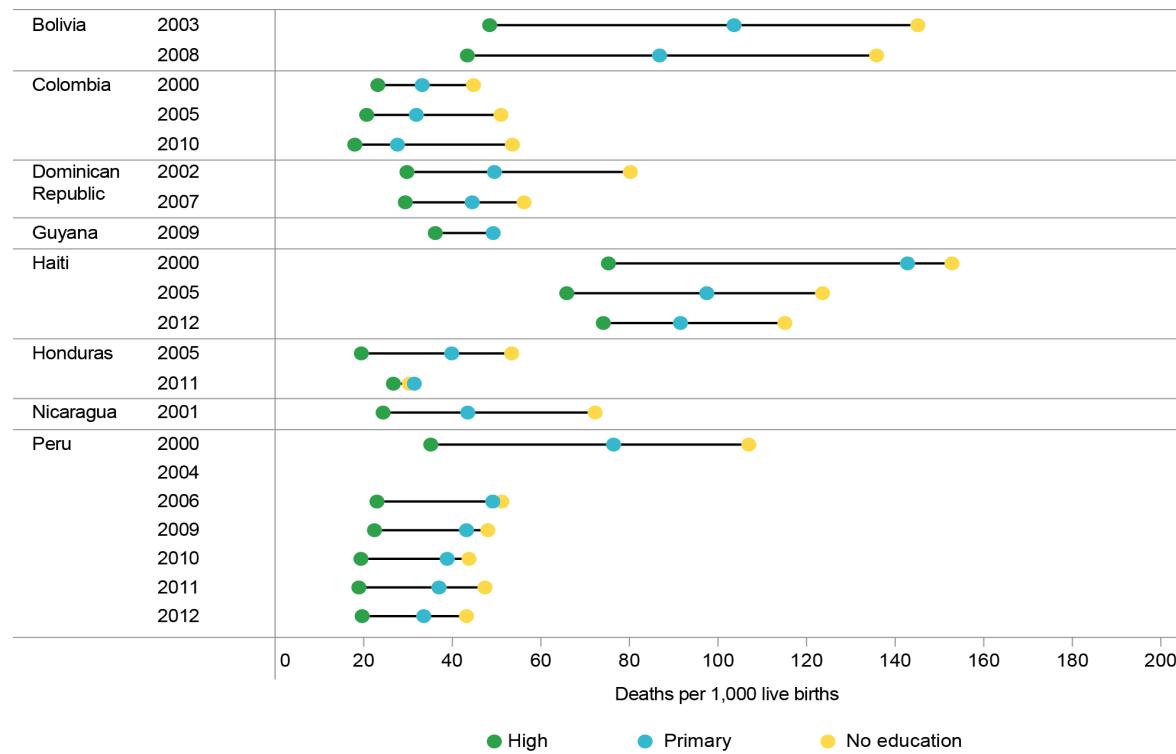
	<i>SDG: 3.1.1</i> 17	<i>SDG: 3.1.1</i> 18	<i>SDG: 3.1.1</i> 19		<i>SDG: 3.2.2</i> 20	<i>SDG: 3.2.2</i> 21	<i>SDG: 3.2.2</i> 22	<i>SDG: 3.2.2</i> 23		<i>SDG: 3.2.1</i> 24	<i>SDG: 3.2.1</i> 25
	Maternal mortality ratio reported (100,000 lb)	Maternal deaths reported	Maternal mortality ratio estimated (*) (100,000 lb) 2015		Infant mortality rate reported (1,000 lb)	Infant deaths reported	Neonatal mortality rate reported (1,000 lb)	Under-five mortality reported (1,000 lb)		Under-five deaths due to 2015	
	year		(80 UHC)		year				year	ADD (%)	ARI (%)
The Americas	44.2	6,297	52		13.0	157,002	8.0	15.8		1.9	4.7
North America	12.1	571	13		5.7	25,101	3.9	6.7		0.9	1.3
Bermuda	2016	-	-	---	2016	3.4	2	3.4	3.4	-	-
Canada	2013	6.1	23	7 (5-9)	2013	5.0	1,884	3.8	5.8	2013	0.3
United States of America	2007	12.7	548	14 (12-16)	2014	5.8	23,215	3.9	6.8		0.9
Latin America & the Caribbean	58.0	5,726	68		16.1	131,901	9.9	19.7		2.4	6.2
Latin America	57.6	5,657	67		16.0	130,154	9.9	19.7		2.4	6.2
Mexico	2015	34.6 ^c	778	38 (34-41)	2015	12.5 ^c	28,149	7.9	15.1		2.4
Central American Isthmus	76.0	600	95		18.2	10,902	10.4	23.0		6.0	14.4
Belize	2016	83.2	6	28 (20-36)	2016	14.3	103	11.2	16.5	2014	0.9
Costa Rica	2016	27.1	19	25 (20-29)	2016	7.9	555	6.1	9.3	2014	1.5
El Salvador	2016	27.4 ^a	31	54 (40-69)	2016	9.8 ^a	1,107	5.6	11.9	2014	4.5
Guatemala	2013	113.4 ^a	452	88 (77-100)	2015	21.0 ^a	8,202	10.0	27.0		8.4
Honduras	2010	74.0 ^b	...	129 (99-166)	2007-12	24.0 ^b	...	18.0	30.0 ^b 2015
Nicaragua	2016	37.8 ^{a,b}	52	150 (115-196)	2005-10	17.0	...	8.0	21.0		3.6
Panama	2015	52.7 ^a	40	94 (77-121)	2015	12.3 ^a	935	7.2	16.2		3.5
Latin Caribbean	66.5	249	187		32.3	5,176	18.6	48.7		1.5	3.8
Cuba	2016	41.9	49	39 (33-47)	2016	4.3	497	2.4	5.5	2013	0.9
Dominican Republic	2016	90.0	177	92 (77-111)	2016	22.2 ^c	4,360	16.0	35.0 ^b 2015	2013	1.6
French Guiana	2010-12	42.2 ^f	8 ^f	...	2012-14	8.2 ^f	53 ²⁰¹³	5.4	12.8 ²⁰¹¹	2014	-
Guadeloupe	2014	17.3	1	...	2013-15	8.9 ^f	44 ²⁰¹⁴	6.9	10.6 ²⁰¹⁴	2014	-

Core indicators. Health Situation in the Americas. 2017. Pan American Health Organization and World Health Organization

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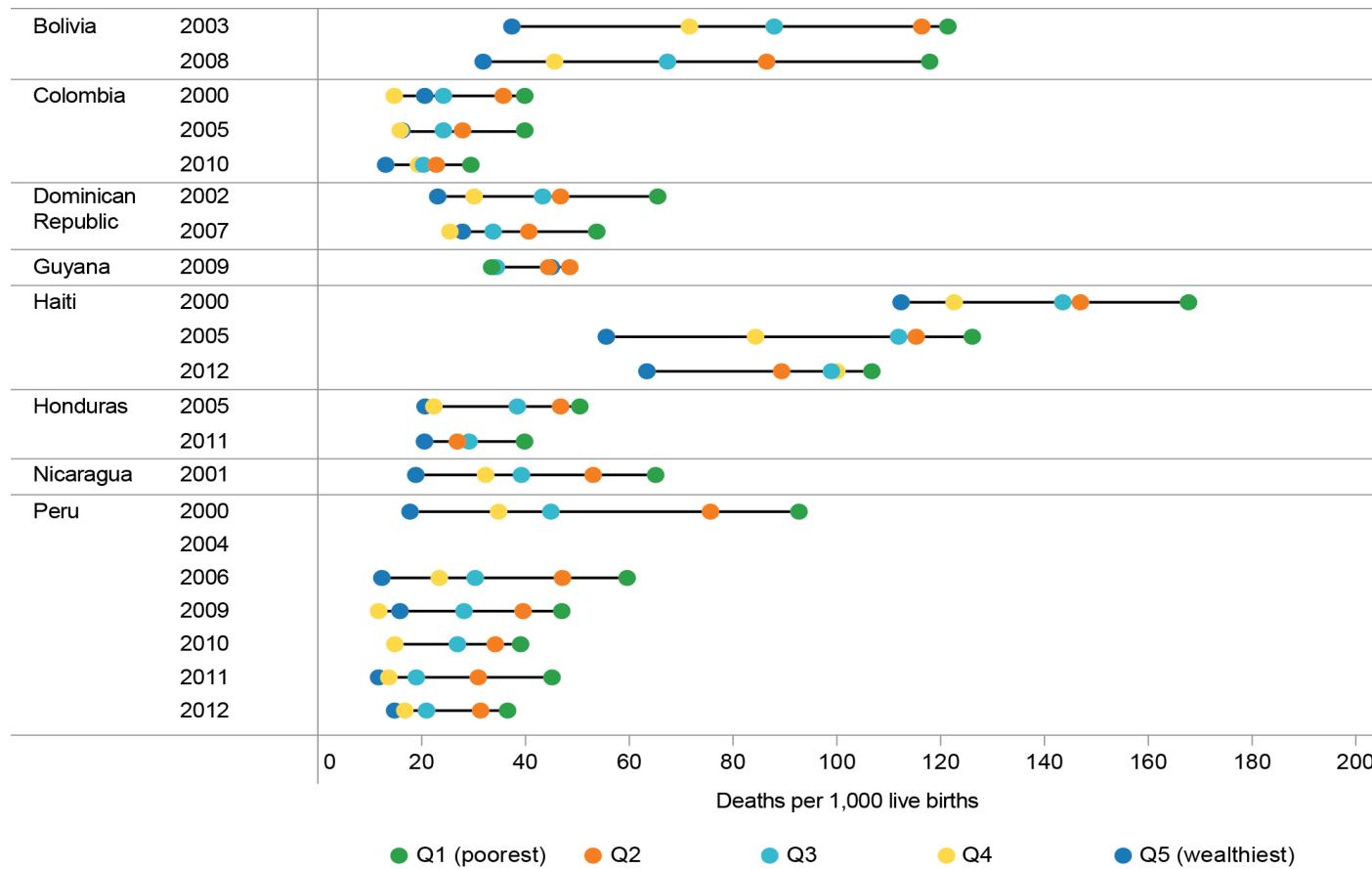
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Mortality in children under 5 by maternal educational level



Hosseinpoor et al. Data Resource Profile: WHO Health Equity Monitor (HEM). Int J Epidemiol 2016 Oct ;45(5): 1404-1405

Mortality in children under 5 by income level



Hosseinpour et al. Data Resource Profile: WHO Health Equity Monitor (HEM). Int J Epidemiol 2016 Oct ;45(5): 1404-1405

HEALTH STATUS INDICATORS

Diseases

SDG: 3.3.3 26	27	28	29	30	31	SDG: 3.3.1 32	SDG: 3.3.1 33	SDG: 3.3.2 34
Selected diseases, reported cases						HIV diagnoses		Tuberculosis incidence rate
Malaria 2015	Dengue 2016	Cholera 2016	Measles 2016	Yellow fever 2016	Leprosy 2016	Rate (100,000 pop) year	Sex Ratio (Male : Female) 2016	(100,000 pop) 2015
454,311	2,276,803	42,622	93	111	33,312	13.7	3.3	22.2
2,174	343	15	92	-	266	11.7	4.3	3.0
- 2012	2 ^H	-	-	-	- ^L	8.5	5.3	-
447 ^H 2014	-	1 ^H	12 ^J	-	...	2014	7.2	4.6
1,727 ^H 2014	341	14 ^H	80 ^J	-	266	2015	12.2	2.8
452,137	2,275,050	42,607	1	111	33,046	14.9	2.8	32.9
441,755	2,265,787	42,607	1	111	32,892	14.3	2.8	33.1
551	130,069	1	-	-	451	2014	4.1	17.0
12,012	159,595	-	-	-	40	12.9	2.8	29.2
13	192	-	-	-	- ^L 2012	61.3	1.1	21.7
8	22,605	-	-	-	24	20.2	7.4	8.8
9	8,789	-	-	-	9 ^L 2015	18.8	2.7	40.0
5,538	8,844	-	-	-	1	2015	6.8	2.2
3,575	22,961	-	-	-	2	3.7	2.0	36.0
2,307	88,320	-	-	-	2	18.1	2.4	40.5
562	7,884	-	-	-	2	2015	28.4	2.7
18,754	9,497	42,605	-	-	672	20.3	2.8	60.2
71 ^H 2016	1,836	25	-	-	213	20.2	4.3	6.1
661	6,645	1,159	-	-	266	21.4	0.7	42.8
434	522	-	-	-	20	2012	78.9	0.9



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Core indicators. Health Situation in the Americas. 2017. Pan American Health Organization and World Health Organization

Conclusions

- The distributions of health status and access to health services among different socioeconomic groups in LAC ,follow patterns that place the most vulnerable groups in situations of continuing and often growing disadvantage.
- The relationships between socioeconomic conditions and health in LAC find large health differentials between the upper and lower levels of well-being
- Poverty is a difficult cycle to break, often passed from one generation to the next.



PANAMA

Thanks for your attention

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Unmet needs in cancer prevention



**Dr. Carlos Rencoret
Chile**

Financial Disclosures

**Dr. Carlos Rencoret
Chile**

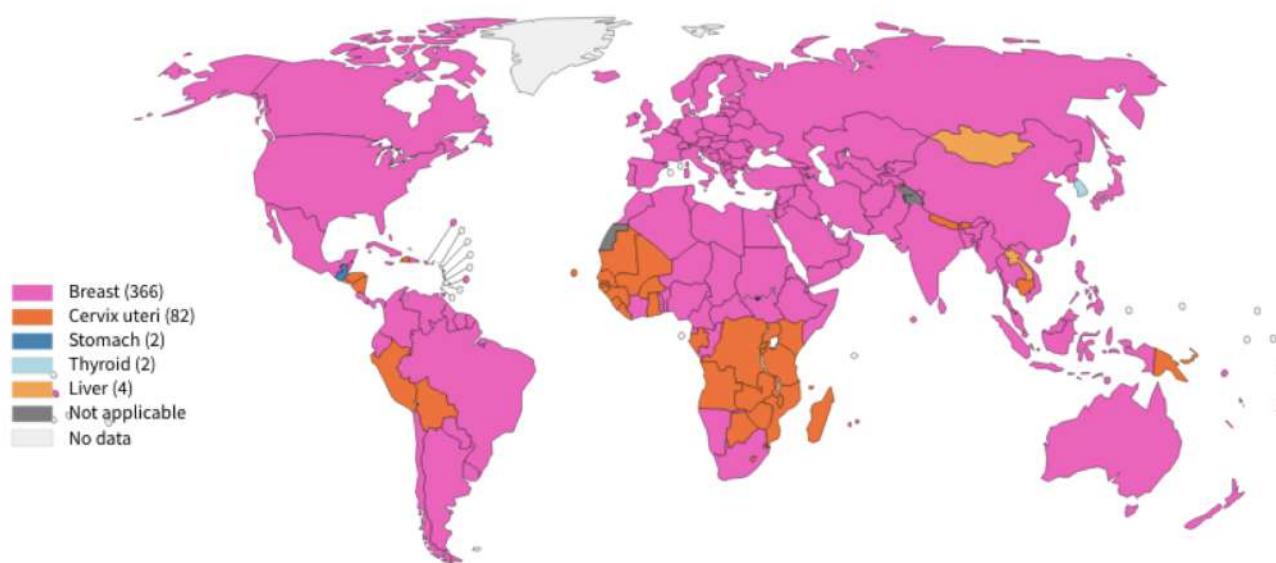
I have financial relationships to disclose.

Speaker and/or advisor for the following companies:

**CHILE/TEVA, MERCK, PFIZER, ABBOT, ANDROMACO,
SAVAL, SILESIA, TECNOFARMA, GRUNENTHAL.**



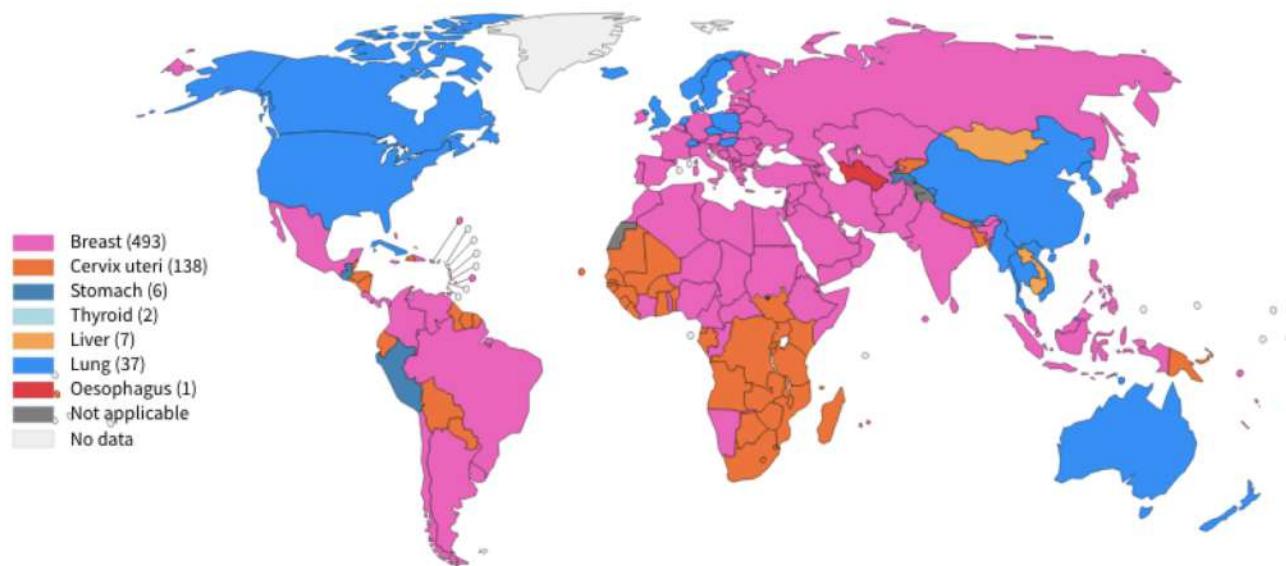
Top cancer per country Estimated age-standardized rates (World) of incident cases, Latin America and the Caribbean + North America in 2012



GLOBOCAN 2012

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Top cancer per country Estimated age-standardized rates (World) of deaths, Latin America and the Caribbean + North America in 2012



GLOBOCAN 2012

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CANCER PREVENTION

Prevention, screening and early detection have overlapping goals:

-Either avoiding cancer altogether or treating it when the odds of success are highest.

CANCER PREVENTION

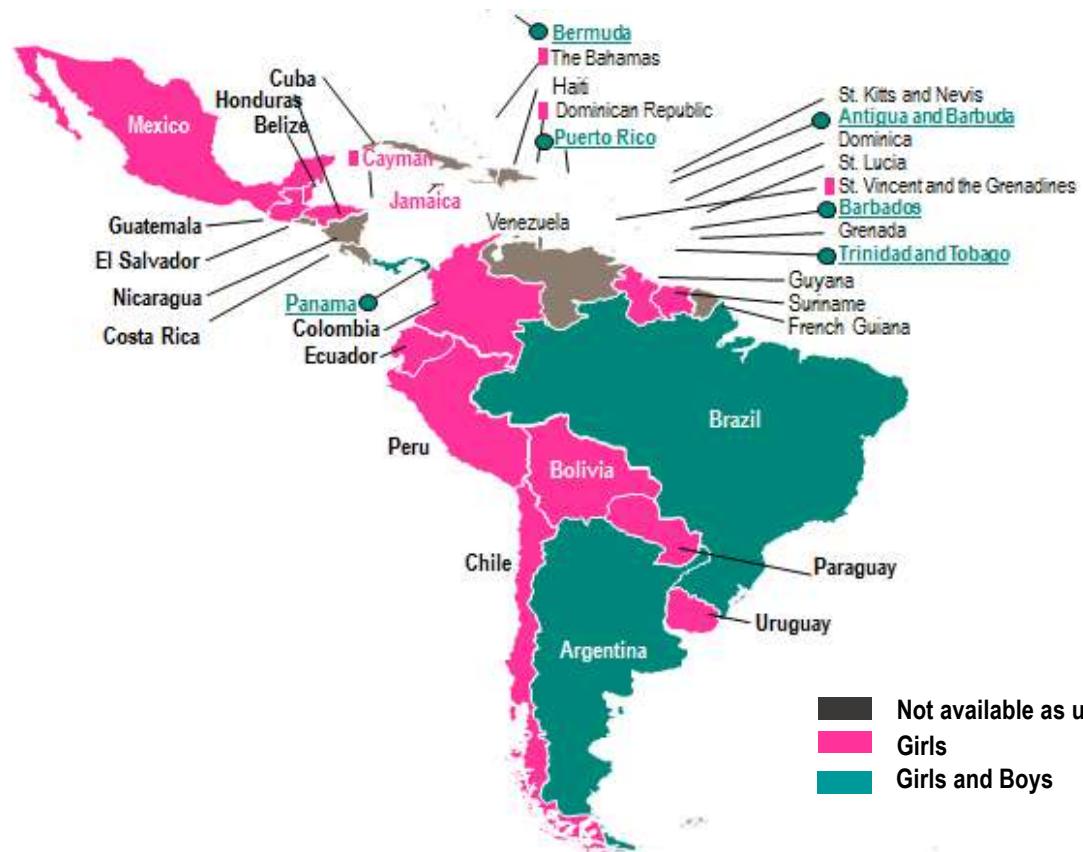
- Prevention can be primary, to stop the disease from beginning to develop, or secondary, to eliminate known cancer precursors.
- Similarly, screening can be for early changes that can develop into cancer or for the disease itself.

CERVICAL CANCER

PRIMARY PREVENTION

- The potential impact of vaccines against HPV is far greater. Cervical cancer remains the second biggest killer cancer among women in Latin America, and this intervention could prevent the HPV genotypes which cause 70% of this burden.

Figure 1. Map of HPV vaccination considering target population in National Immunization Programs in Latin America & Caribbean



Not available as universal vaccination
Girls
Girls and Boys

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CERVICAL CANCER

PRIMARY PREVENTION

HPV Vaccine.

- Where countries have data, the percentage of the target population receiving the first dose of the vaccine is very high, usually over 90%. By the third dose, however, it drops significantly, to around 50-67%.

CANCER CONTROL, ACCESS AND INEQUALITY IN LATINAMERICA.
The Economist Intelligence Unit Limited 2017



HPV vaccination coverage 2014

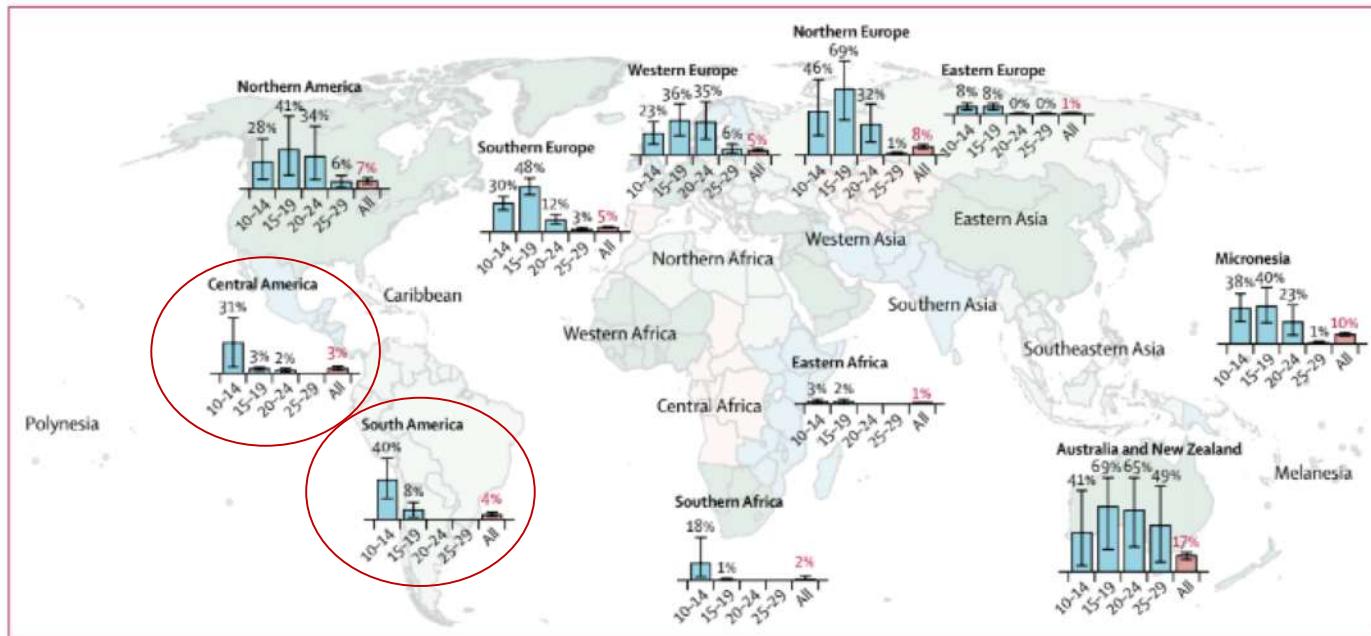


Figure 4: Estimated full-course coverage of human papillomavirus vaccine by 2014, by age group and geographical region

AMERICA CENTRAL-MEXICO 34% (10-19a)
SUDAMERICA 48% (10-19a)

Bruni L et al. Lancet Glob Health 2016; 4: e453–63

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SCREENING

- “You can’t ensure early diagnosis without some type of screening.”
- Screening is expensive, and we have to base its use on cost/effectiveness. Some screening methods that are valuable in high-income countries simply cannot be applied in settings of limited resources. (e.g Latin America).
- In practice, screening in Latin America largely relates to cancer of the cervix.

SCREENING. CERVICAL CANCER

- Studies from specific institutions in Brazil, Colombia and Chile found that the proportion of women presenting cervical cancer at stage 1 (when treatment outcomes are best) was typically around 20%, equivalent to about one-half of the global figure of 42%.
- The traditional screening technique is the Papanicolaou test.

SCREENING. CERVICAL CANCER

- On average in the study countries, only about one-half (51%) of the target population has been screened in recent years. In four study countries (Bolivia, Costa Rica, Ecuador and Panama) coverage is just 35% or less.*
- More striking is the impact of poor integration within health systems. For example, Colombia has almost 80% Pap smear coverage, but about 30-40% of lesions are not treated because the women do not have access to confirmatory diagnosis or treatment.

CANCER CONTROL, ACCESS AND INEQUALITY IN LATINAMERICA.
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BREAST CANCER

- The issues around breast-cancer screening differ in detail, but the big picture is similar. In all 12 study countries mammography guidelines exist. Such screens are free in all but Panama and Paraguay.
- (Access to a mammography is NOT the same as a breast cancer screening program).

BREAST CANCER

- Among those study countries where data is available, none comes close to the minimum 70% accepted by the WHO. In Colombia the figure is 54%, but in Chile, Costa Rica and Argentina it is between 32% and 46%, while in Mexico it is just 22%
- **IN REALITY, THERE IS NO REAL BREAST CANCER SCREENING PROGRAM IN ANY LATIN AMERICAN COUNTRY.**

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The Economist Intelligence Unit Limited 2017



BREAST CANCER

- As with cervical cancer, the rest of the health system responds slowly to breast-cancer screening: in both Mexico and Brazil the median waiting time between the first contact with the health service and the initial treatment is seven months, with most of that time taken up by waiting for confirmation of the diagnosis.

BREAST CANCER

- Several studies in Brazil, Chile and Colombia have found that around 20% of women or fewer present breast cancer at stage 1. In Mexico, the figure is roughly 10%. In developed countries it is typically 40-50%.

CANCER CONTROL, ACCESS AND INEQUALITY IN LATINAMERICA.
The Economist Intelligence Unit Limited 2017



CONCLUSIONS

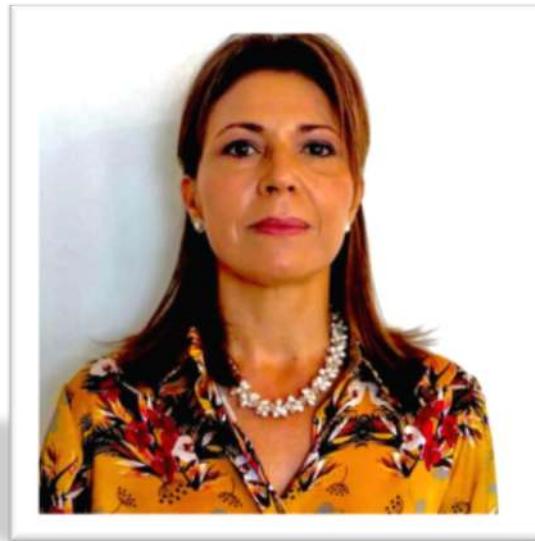
LATIN AMERICA:

- Cancer prevention is more theoretical than real.
- Only cervical cancer prevention exists:
 - Primary prevention (HPV vaccine)
 - Secondary prevention (Papanicolaou test)
- VPH vaccine coverage:
 - Great variation between countries (but low %)
- Papanicolaou coverage :
 - 20-70% (partial information obtained only from public health systems)

CONCLUSIONS(2)

- Breast cancer: We've only got at our disposal mammographies of uncontrolled check (real mammographic screening does not exist)
- Since there doesn't exist adequate prevention programs, cancer diagnosis in Latin America is late in comparison to developed countries (higher mortality and higher cost of the treatment)

Limitations in the preventive strategies of cardiometabolic diseases



**Dr. Sonia Cerdas
Costa Rica**



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Financial Disclosures

**Dr. Sonia Cerdas
Costa Rica**

- I am member of an advisory board for NovoNordisk, Sanofi and MSD.
for Educational Programs in Latin America.
- I am Member of a speakers' bureau for NovoNordisk, Sanofi, MSD
and Boeringer Ingelheim .
- I have participated in Phase III clinical trials within the past two years
with MSD and Janssen Cilag as a Principal Investigator.

Cardiovascular diseases remain the biggest cause of deaths worldwide.

- > 17 million people died from CVDs in 2015.
 - > 3 million of these deaths occurred before the age of 60.
- 7.4 million were due to coronary disease
- 6.7 million were due to stroke

Figure ④ Distribution of CVD deaths due to heart attacks, strokes and other types of cardiovascular diseases, males (1).

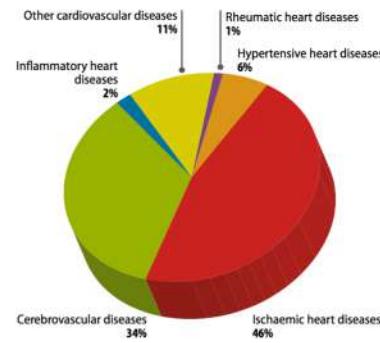
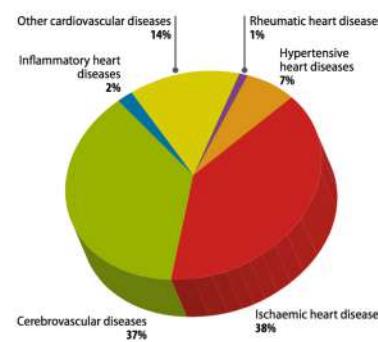


Figure ⑤ Distribution of CVD deaths due to heart attacks, strokes and other types of cardiovascular diseases, females (1).



Adapted from WHO 2004, 2014, 2011 reports. The Burden of disease.

http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004_update_part4.pdf



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Different Types of CVDs

1. CVDs due to atherosclerosis:

- ischaemic heart disease or coronary artery disease (e.g. heart attack)
- cerebrovascular disease (e.g. stroke)
- diseases of the aorta and arteries, including hypertension and peripheral vascular disease.

2. Other CVDs

- congenital heart disease
- rheumatic heart disease
- cardiomyopathies
- cardiac arrhythmias.



CV Factor Risks

1. tobacco use
2. physical inactivity
3. unhealthy diet (rich in salt, fat and calories)
4. harmful use of alcohol.

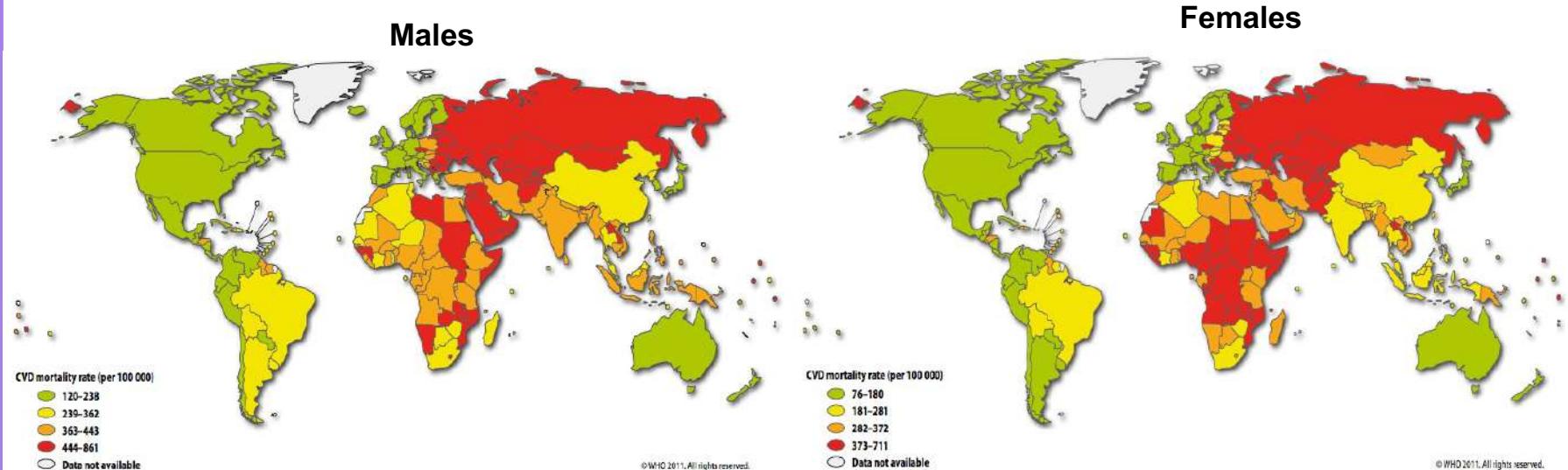
Metabolic Risk Factors:

5. Hypertension
6. Diabetes
7. Hypercholesterolemia
8. Overweight and Obesity

Other risk factors:

9. poverty and low educational status
10. advancing age
11. gender
12. inherited (genetic) disposition
13. psychological factors (e.g. stress, depression)
14. other risk factors (e.g. excess homocysteine).

Global Distribution of CVD mortality Rates (age standardized, per 100.000)



Adapted from WHO 2004, 2014, 2011 reports. The Burden of disease.
http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004_update_part4.pdf

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Significant Social Challenges in most Countries in Latin America

Rank #	Country	Gross Domestic Product (GDP)Millions \$	Gross Domestic Product (GDP)Per capita \$
1	Brazil	3,330,461	15,919.48
2	Mexico	2,498,202	20,027.63
3	Argentina	952,464	21,370.26
4	Colombia	747,024	14,992.54
5	Chile	472,413	25,425.40
6	Peru	449,153	13,962.69
8	Ecuador	193,221	11,350.31
9	Dominican Republic	186,128	18,124.19
10	Guatemala	145,712	8,440.81
11	Panama	107,037	25,737.47
12	Costa Rica	90,157	17,930.48
13	Bolivia	88,529	7,870.77
14	Uruguay	82,405	23,504.44
15	Paraguay	72,137	10,227.86
16	El Salvador	59,226	9,256.86
17	Honduras	48,238	5,725.55
18	Trinidad and Tobago	44,416	32,194.28
19	Nicaragua	38,514	6,121.24
20	Jamaica	27,332	9,557.15
21	Haiti	20,876	1,877.88
22	The Bahamas	9,758	25,916.16
23	Suriname	8,176	14,123.87
24	Guyana	6,724	8,702.53
25	Barbados	5,041	17,902.88
26	Belize	3,368	8,444.40
27	Antigua and Barbuda	2,510	27,215.35
28	Saint Lucia	2,497	14,137.79
29	Grenada	1,658	15,352.83
30	Saint Kitts and Nevis	1,612	27,986.57
31	Saint Vincent and the Grenadines	1,342	12,163.20
32	Dominica	892	12,612.08
Total		10,070,343	Av. 15,492.84



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Life expectancy in Latin America



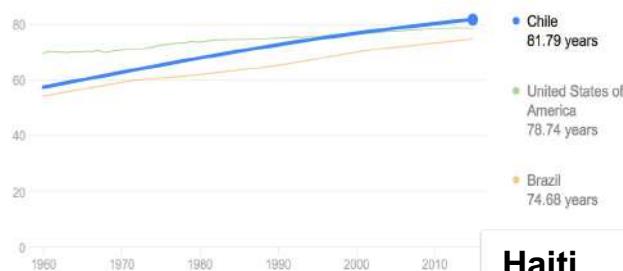
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Life expectancy in Latin America

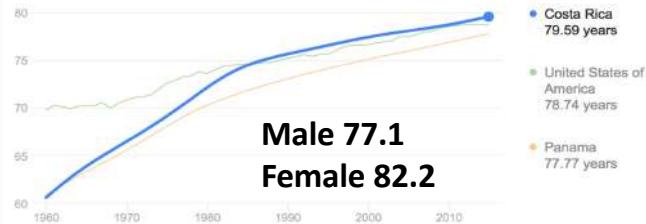
Chile

81.79 years (2015)



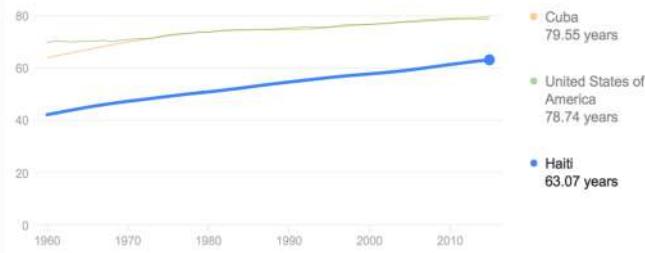
Costa Rica

79.59 years (2015)



Haiti

63.07 years (2015)



According to the latest WHO data published in 2015
Source World Bank

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Heart diseases, Stroke, Cancer and Diabetes, are associated In Latin America 75% of deaths and 3 DALYS lost

The disability-adjusted life year (**DALY**) is a measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.
It was developed in the 1990s as a way of comparing the overall health and life expectancy of different countries.

Growing inequalities between countries and populations

- **4%** Premature deaths from **high-income countries**
- **42%** in **low-income countries**

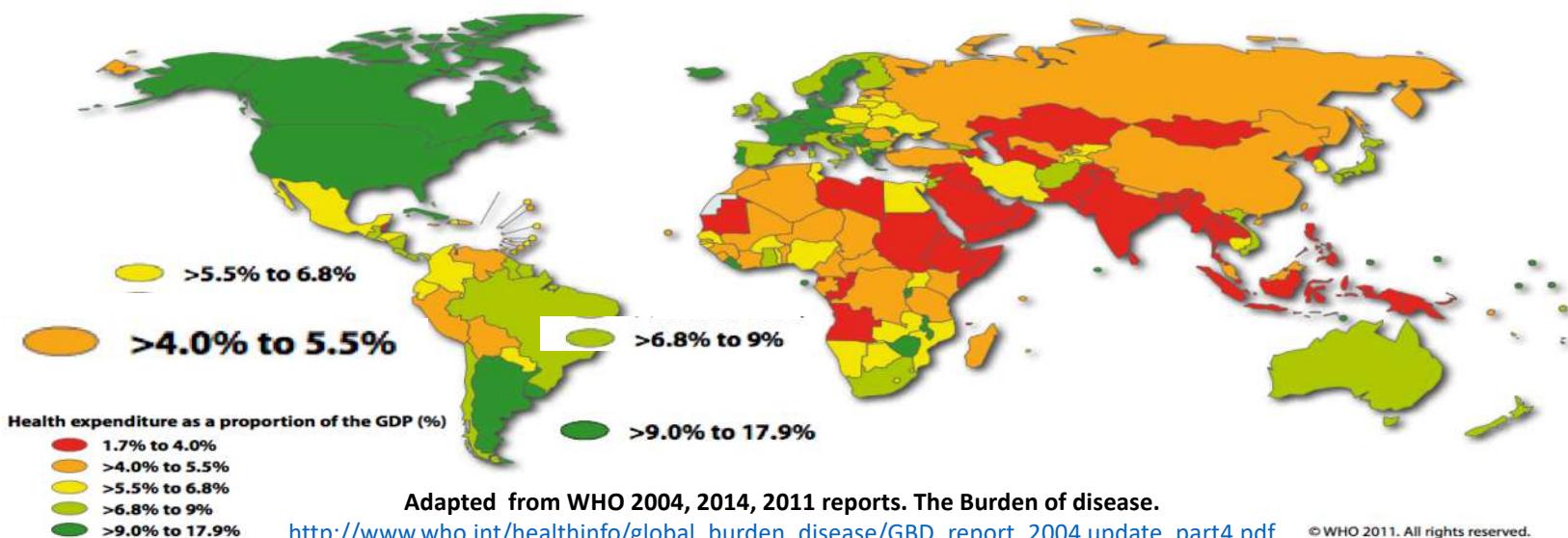


Adapted from WHO 2004, 2014, 2011 reports. The Burden of disease.
http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004_update_part4.pdf

Investing on health is key to promote development

Diabetes in Latin America is 65 billion USD annually,
representing 2% to 4% of GDP

Health Expenditure as a percentage of Gross Domestic Product (GDP)



Cardiovascular diseases could have largely been prevented.

BUT in LA

A large proportion of people with high CV risk remain undiagnosed

Even those diagnosed have insufficient access to treatment at the primary health-care level

We need wide measures

which are cost effective evidence based in order to

- Improve access to individual health
- Modify CVDs risk factors

Premature deaths from CVD:

- Reduce productivity
- Curtails economic growth and
- Pose a significant social challenge in most countries.



Global Atlas on cardiovascular disease prevention and control



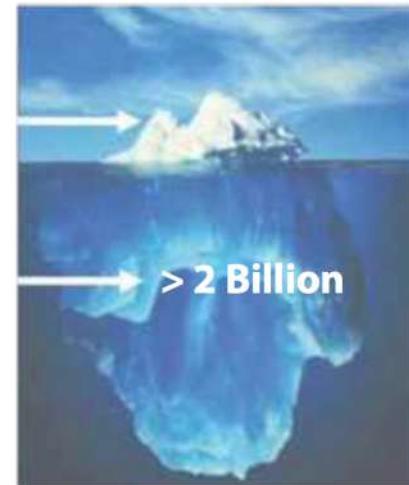
Published by the World Health Organization
in collaboration with the World Heart Federation
and the World Stroke Organization.

Public health burden hidden and underestimated

Heart attacks and strokes are only
the tip of the iceberg

Risk factor burden; unrecognised

- Obesity
- Physical activity
- Unhealthy diet
- Tobacco use
- Raised blood pressure
- Raised blood sugar
- Raised blood lipids
- Air pollution
- Poverty



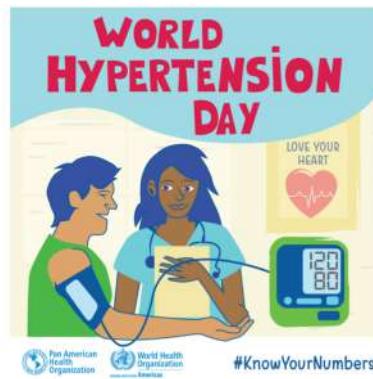
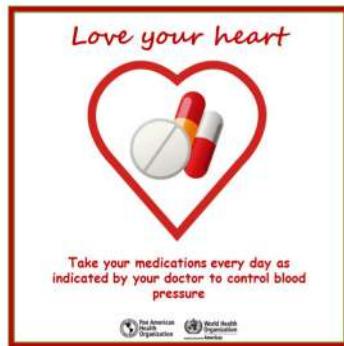
Global Atlas on Cardiovascular Diseases Prevention and Control

25

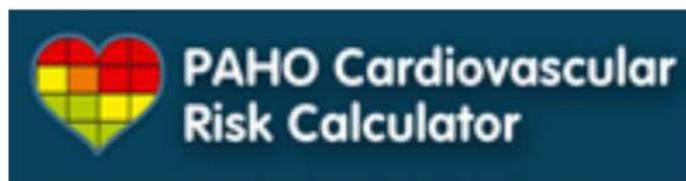


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WHO Goal: “To reduce CV morbidity and mortality: by 25% by 2025”



Tools



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WHO Goal: “To reduce CV morbidity and mortality: by 25% by 2025”

Two types of interventions are recommended

Population-wide interventions:

- comprehensive tobacco control policies
- taxation to reduce the intake of foods high
 - fat
 - sugar
 - salt
- building walking and cycle paths
- strategies to reduce harmful use of alcohol
- providing healthy school meals to children.



Individual interventions:

For prevention of first heart attacks and strokes:

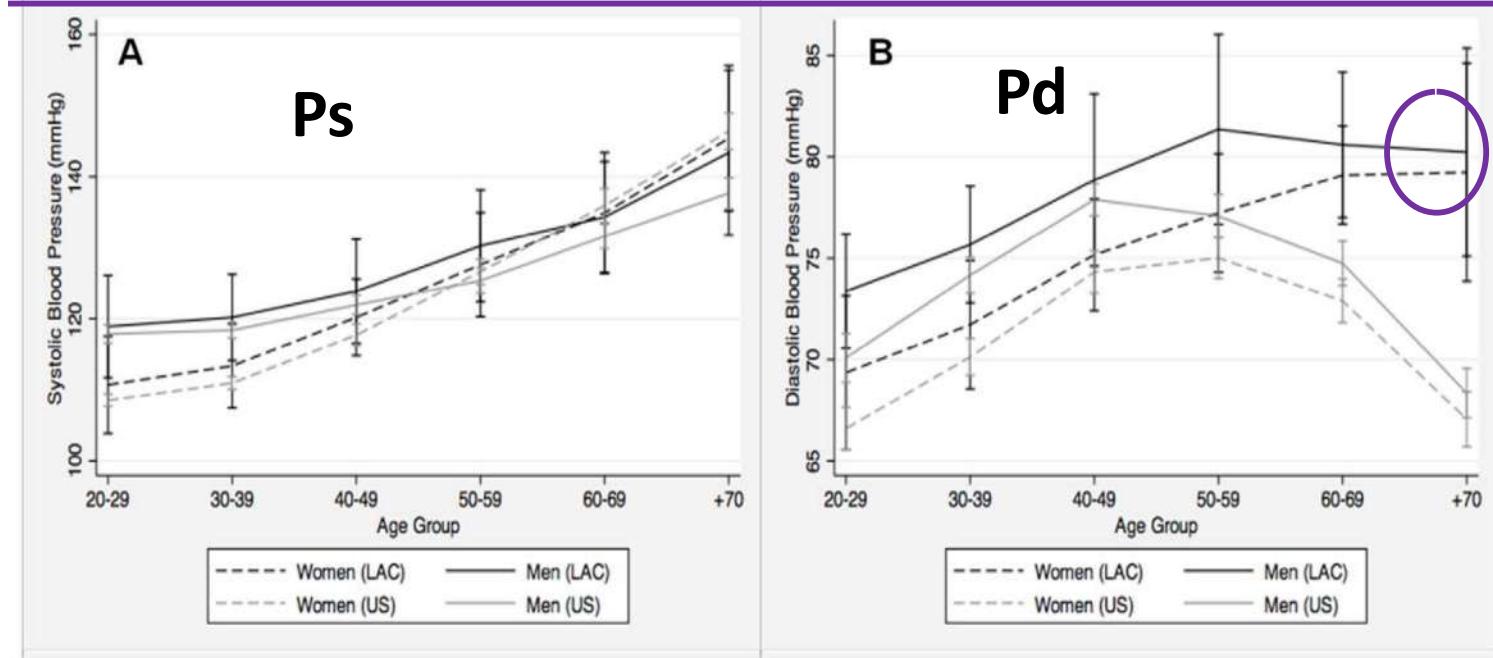
- individual health-care interventions
need to be targeted to those at high
total CV risk or those with single risk factor

- Hypertension
- Hypercholesterolemia.
- Diabetes Mellitus
- Obesity

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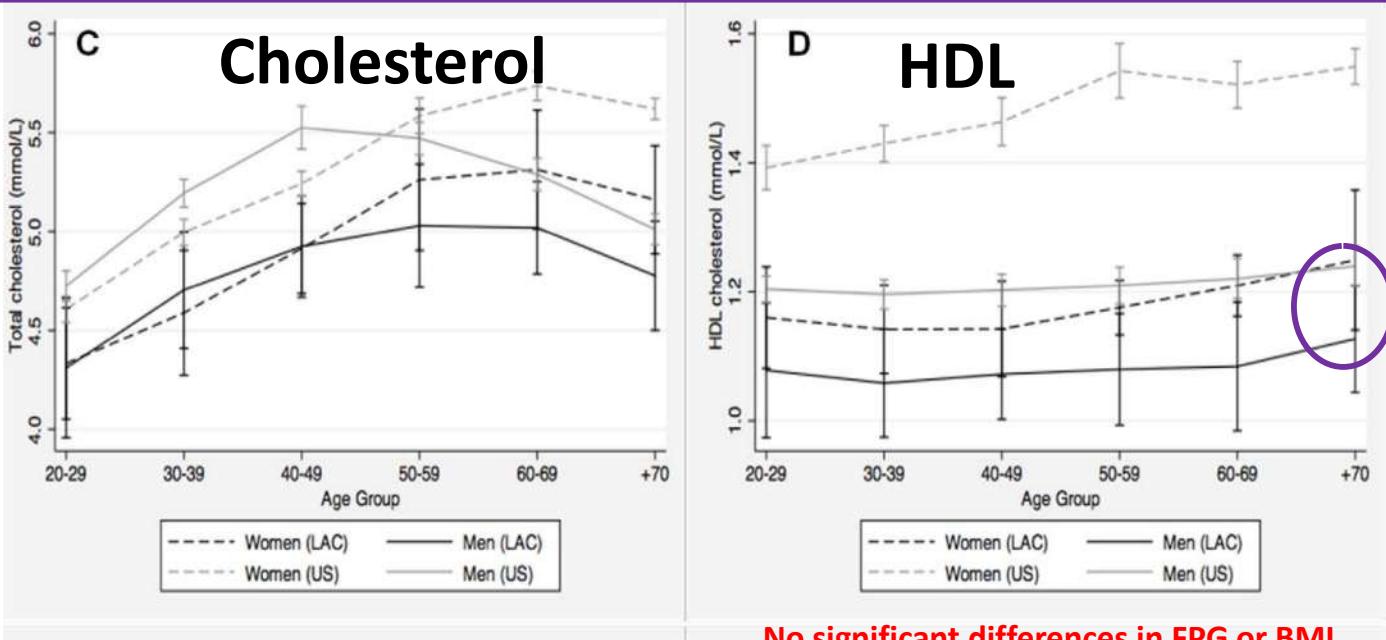
Prevalence of CVD Risk Factors in LA and USA



Adapted from Major Cardiovascular Risk Factors in Latin America: A Comparison with the United States. Consortium of Studies in Obesity (LASO). Miranda J.J., et al. Plos one 2013, 8:1-10

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Gender differences in metabolic control and complication rates in a cohort of type 2 diabetic patients from Central America

Chih Hao Chen-Ku¹, Julio Palencia-Prado², César Ponce Puerto³, Leonel Rivera Ochoa⁴, Carlos Alvayero⁵, Luis Alberto Ramírez⁶, Sonia Cerdas Pérez⁷, José Napoleón Alvarado⁸

¹ Clínica Los Yoses, Costa Rica. ² Prevención en Salud S.A., Guatemala. ³ Honduras Medical Center, Honduras. ⁴ Clínica de Diabetes Dr. Rivera Ochoa, El Salvador. ⁵ Instituto Salvadoreño del Corazón, El Salvador. ⁶ Hospital Privado Herrera Berardi, Guatemala. ⁷ Hospital CIMA, Costa Rica. ⁸ Centro Panamericano de Ojos, El Salvador.

Corresponding author: Dr. Chih Hao Chen-Ku, email chenku2409@gmail.com

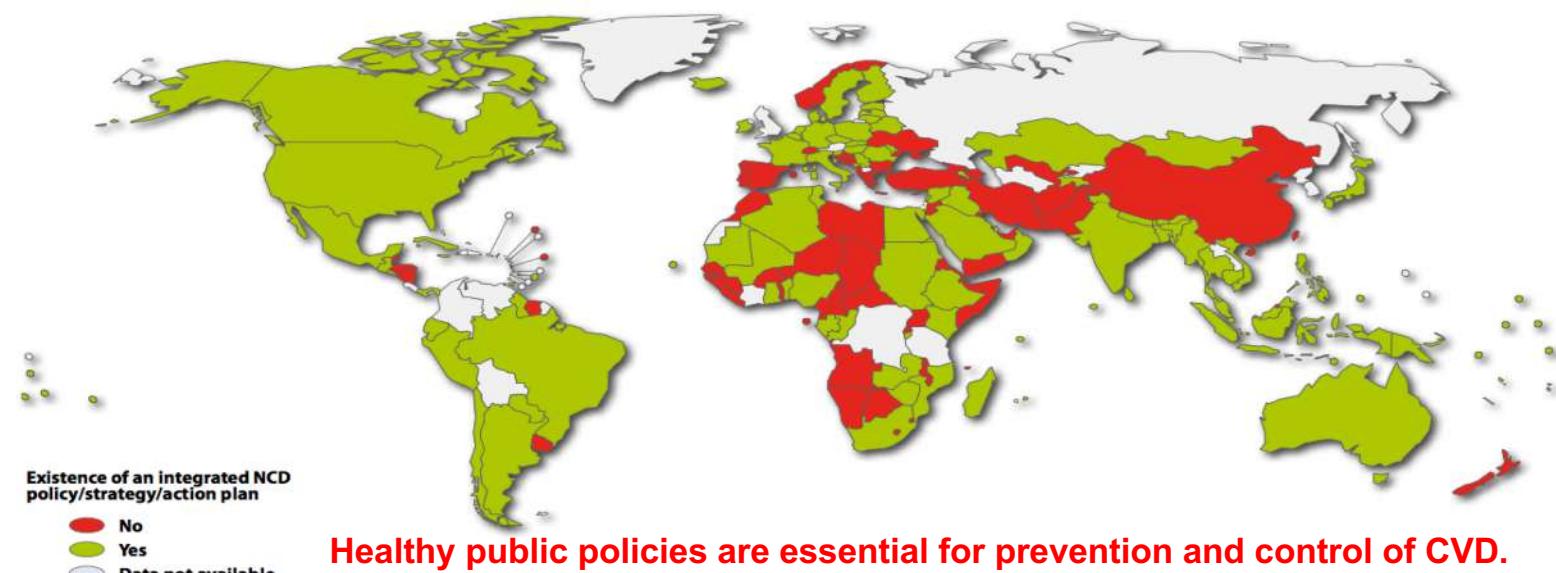
Porcentaje de pacientes en meta de A1C < 7%, de LDL <100mg/dl y de PA <140/90
n 253

Year	Hba1c <7%	SBP <140 mm Hg	DPB <90 mm Hg	LDL <100 mg/dl	All targets
Baseline	29.4%	82.1%	93.9%	35.1%	4.34%
2010	64.1%	94.6%	98%	59.5%	24.6%
2011	71.3%	94.4%	96.3%	65.8%	25.8%
2012	73.1%	94.0%	98.5%	67.9%	30.0%
2013	66.4%	95.3%	98.4%	70.4%	32.07%
2014	57.6%	94.3%	98.4%	70%	26.97%
Promedio:	60.33 %	92.45 %	97.25%	61.45 %	24 %

½ Hipoglicemias

Codhy, Marzo 2017

Existence of an Integrated Policy/Strategy/Action Plan for CVD Prevention (WHO)



Healthy public policies are essential for prevention and control of CVD.

© WHO 2011. All rights reserved.



Adapted from WHO 2004, 2014, 2011 reports. The Burden of disease.
http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004_update_part4.pdf

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Healthy public policies are essential for prevention and control of CVD

Mexico:

The importance of CV prevention programs starting from **early childhood** through multidisciplinary interventions in **children 3 to 5 years old**. and in secondary prevention the introduction of "**The polypill measure**" by the Mexican Institute of Social Security (70 million affiliates) into their global strategy called "A todo corazón"



Adapted from Prevalence of cardiovascular risk factors in Latin America:
a review of the published evidence 2010-2015.

Pereira-Rodríguez J., et al. Rev Mex Cardiol 2015, 26: 125-139

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Conclusions

Prevention is better than cure:

the proverb remains as important as it has been for decades and centuries.
CVD remains the most common cause of death worldwide

- ✓ The prevalence of unmet needs for cardiovascular care is considerable in LA
- ✓ Inequality persists as a factor in meeting needs for cardiovascular care.
- ✓ We need to work all together to achieve the Goal of the WHO to reduce the CV morbimortality: **25% /2025**

**Healthy public policies
And education
of health professionals and patients**



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**IX Congreso de la Federación Latinoamericana
de Sociedades de Climaterio y Menopausia**

**XIX Congreso de la Asociación Costarricense
de Climaterio, Menopausia y Osteoporosis**

**III Congreso de Ginecología
Endocrinológica**

26-29 de Marzo del 2019
Hotel Real Intercontinental,
San José, Costa Rica

Curso Precongreso:
Manejo Básico del Climaterio

Actualización en:

- Síndrome Vasomotor
- Riesgo Cardiovascular y Climaterio
- Síndrome Metabólico
- Diabetes Mellitus y Manejo de la Obesidad en el Climaterio
- Metabolismo Fosfocálcico y Vitamina D
- Terapia de Reemplazo Hormonal
- Uroginecología
- Andropausia
- Oncología y Climaterio

Organizan:

Información e Inscripción
flascym2019.com

Produce:

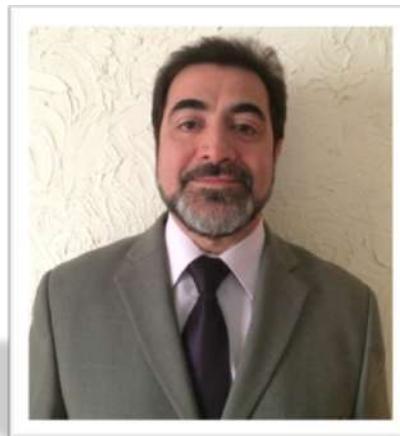


Intercontinental Hotel
26-29 March 2019
San José, Costa Rica

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Current challenges for Postmenopausal Osteoporotic fracture prevention



**Dr. Victor Mercado Cárdenas
México**



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Financial Disclosures

**Dr. Victor Mercado
México**

I have no financial relationships to disclose

Abstract

- In Mexico, osteoporosis is a public health problem that is expected to increase in prevalence in the decades ahead.
- Therapeutic management with pharmacological and non-pharmacological approaches, and the important role that the patient plays in the consulting room and in daily life.
- The usage of calcium and vitamin D supplement use as an effective, safe, and cost-effective initiative to prevent low bone mass, in all the population.

Preface

- As part of its efforts to reduce the clinical and epidemiological burden of disease and delay the onset of bone mass loss, it is primordial to offer health care professionals up-to-date evidence related to primary prevention activities for population groups at risk.
- Most research and clinical practice related to osteoporosis have focused on diagnosis and treatment, but it is necessary to produce general measures for primary prevention based on modifiable risk factors.

Introduction

- Osteoporosis is defined as a skeletal disease characterized by diminished bone strength that predisposes the individual to greater risk of fractures.
- Bone strength reflects the integration of bone density and the quality of the bone.
- The clinical consequence of osteoporosis are fragility fractures, which occurs in 50% of women and 25% of men over 50 years of age.
- The most common prevalent fractures involve the spine, wrists, forearms (distal radius), hip, humerus, and pelvis, commonly occurring after a fall.
- In Mexico, 1 of every 12 women, and 1 of every 20 men, 50 and over, will sustain a fracture in their remaining time.

Introduction

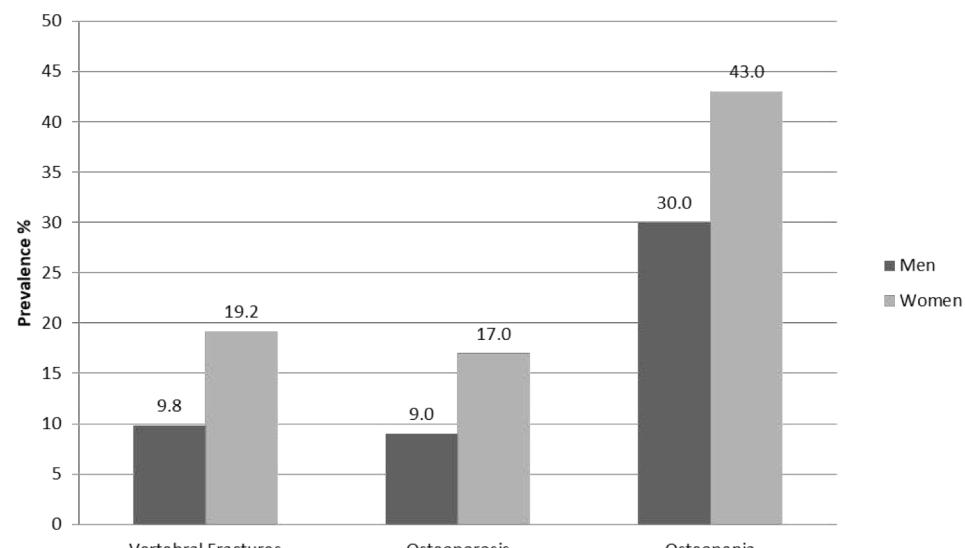


Figure 1. Prevalence of vertebral fractures, osteoporosis, and osteopenia in Mexico.
Adapted from Clark, et al., 2005 and 2009.

Nutrition and Bone Health

- Different micronutrients are important to maintain bone health. Two of them, calcium (Ca) and vitamin D (VD) are essential and needed in large amounts, while others can be obtained from dietary sources and are required only in small quantities.
- The most abundant mineral in the skeleton is Ca (approximately 99% is deposited in bone), it performs an important biological role as enzymatic factor in multiple hormonal processes and essential activities for maintaining the body's integrity.

Prevention of low bone mass to achieve high bone density in Mexico:
Position of the Mexican Association for Bone and Mineral Metabolism

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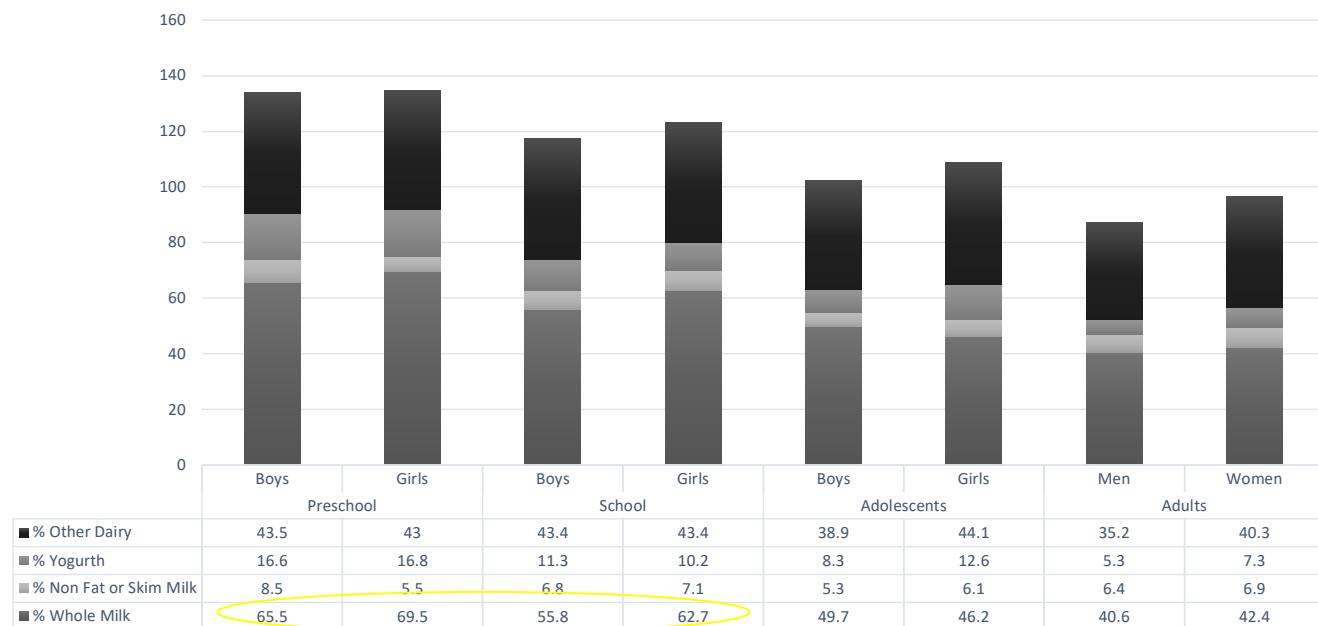
Nutrition and Bone Health

- The principal sources of Ca in foods include dairy products, fish, and some fruits and vegetables.
- In Mexico, the 2012 National Health and Nutrition Survey (ENSANUT 2012) reported that 70.3% of the population consumes some form of dairy products, mainly whole milk, and 43.4% of total Ca intake comes from this food group.
- School age children are the population segment with the highest consumption of dairy products.

Prevention of low bone mass to achieve high bone density in Mexico:
Position of the Mexican Association for Bone and Mineral Metabolism



Nutrition and Bone Health



Consumption of dairy products in Mexican population.
With permission of Rivera-Dommarco, et al. 2014.

Nutrition and Bone Health

- Another fundamental nutrient for bone health is vitamin D (VD), which has a significant effect on intestinal absorption of Ca through synthesis of a Ca carrier protein, moreover, other extra-skeletal functions have also been described.
- Even though few foods contain VD, the primary sources are some types of fatty fish and their oils (salmon, sardine, tuna), products derived from meat (liver), dairy products, eggs, and certain varieties of mushrooms.
- Exposure to the sun is an other way to obtain VD since it helps to convert the inactive VD into active. In all the countries that sun exposure is limited, there for diet is the most important source of VD or the supplementation.

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Nutrition and Bone Health

Table 2. Usual intake and prevalence of inadequate intake of calcium in the Mexican population

	Calcium (mg/day) ¹				Population below EAR ²	
	Men		Women		Men	Women
1–4 years³	828 (6.93)				25.6 (2.97)	
5–11 years	866	(6.74)	816	(8.34)	62.7	(3.88)
12–19 years	921	(11.8)	786	(7.39)	71.8	(3.69)
≥ 20 years	819	(7.01)	723	(5.58)	54.5	(2.82)
					74.2	(4.61)

¹Values are presented as means and (standard errors)

²Values are presented as percentages and (standard errors)

³For children 1–4 years, average consumption was calculated for men and women jointly.

Data taken from Sanchez-Pimienta, et al. 2016 (28).

Table 3. Usual intake and prevalence of inadequate intake of vitamin D in the Mexican population

	Vitamin D (μg/day) ¹				Population below EAR ²	
	Men		Women		Men	Women
1–4 years³	4.82 (0.06)				95.7 (2.13)	
5–11 years	4.78	(0.08)	4.56	(0.07)	94.5	(4.92)
12–19 years	4.84	(0.10)	3.90	(0.07)	93.0	(7.45)
≥ 20 years	3.77	(0.07)	3.25	(0.05)	96.5	(2.44)
					98.0	(1.61)

¹Values are presented as means and (standard errors)

²Values are presented as percentages and (standard errors)

³For children age 1–4 years, average consumption was calculated for men and women jointly.

Data taken from Pedroza-Tobias, et al. 2016 (29).



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Physical Activity, Exercise and Bone Health

- Physical activity should be included in osteoporosis prevention programs.
- Low intensity exercise in adult women stimulates anabolic hormones and prevents muscular atrophy through strengthening and hypertrophy of muscles.
- In response to exercise, muscles and fatty tissue secrete molecules involved in the regulation of bone metabolism and production of energy, causing a response to interleukin 6 (IL-6) and insulin growth factor 1 (IGF-1), which are related to inflammation and resorption.
- As leptin levels fall, positive effects are observed in body composition.

Physical Activity, Exercise and Bone Health

- Recommended exercises are aerobic, eccentric, progressive resistance, and with resistance to the force of gravity or articular reaction, muscle stretching, and posture control.
- The objectives of rehabilitation of patients with osteoporosis are to reduce risk of fracture; increase peak bone mass; increase bone strength; reduce pain; improve posture, balance, and walking; reduce the risk of falls; maintain functionality in everyday activities; manage psychological well-being; and prevent disability after fractures.

Physical Activity, Exercise and Bone Health

Table 4. Recommended behavior based on bone mineral density.

Normal	Osteopenia	Osteoporosis
No treatment	Antiresorptive treatment	Antiresorptive treatment
Education	Patient	Pain management
Spinal hygiene	Pain	Joint mobility, muscle strength, proprioception
Diet	Strengthening spinal erector muscles	Thermotherapy, massage, muscle strengthening
Walking	Training, weights	Strengthening spinal erector muscles
Weight training	Aerobics, walking 40 min/day	Walking 40 min/day, strength exercises
Aerobics	Strengthening with weights	Aquatic exercises 2–3 times a week
Strengthening of abdominal and spine erector muscles	Postural exercises	Prevention of falls
	Frenkel exercises, prevention of falls	Postural exercises
	Tai-chi	Prevention of compression fractures, orthotics
		Balance, walking
	Yoga	Progressive strength exercises

Physical Activity, Exercise and Bone Health

Table 5. Recommended exercise plans for persons with osteoporosis.

Activity	Exercise	Function
Walking	Aerobic	Increase of bone mineral density
Reaction exercise on the floor	Closed chain exercises	Increase of bone mineral density
Strengthening with progressive resistance	Weight training (progressive resistance)	Increase of bone mineral density
Selection of specific muscles	Trabecular thickening	Increase of bone mineral density
SPEED Dr. Sinaki	Proprioception of spinal extensor muscles	Prevention of kyphosis
Orthotics	Proprioception of spinal extensor muscles	Prevention of kyphosis
Pain	Muscle stretching and strengthening, aqua aerobics	Reduction of pain and increasing muscle strength
Posture	Stretching of pectoral, psoas, ischiotibial, soleus, and calf muscles	Improvement in relation to axis of gravity, falls
Mobility	Frenkel Joint	Prevention of joint stiffness and falls
Strength	Progressive resistance	Increase of bone mineral density and strength, prevention of falls
Proprioception	Exercises on receptors, ligaments, and tendons	Falls
Balance and foot deformity	Tai-chi, yoga, special footwear	Falls
Aids: cane, eyeglasses, hearing aids, etc.	Use	Falls

Hormone Replacement Therapy for Preventing poor Bone Quality

- Estrogens prevent osteoporosis by three routes:
 - Maintain bone mass at the skeletal level.
 - Reduce tissue-level bone remodeling.
 - They have an indirect effect on bone, which alters the balance of both calcitonin and VD and its metabolites.

Hormone Replacement Therapy for Preventing poor Bone Quality

- In the PEPI (Postmenopausal Estrogen/Progestin Interventions) study, for three years, with or without progestagen, significantly increased spinal BMD by 1.5% and hip BMD by 1.7%.
- The Women's Health Initiative (WHI) study, showed a significant increase in spinal BMD of 4.5% and in hip BMD of 3.7% following administration of conjugated equine estrogens and medroxyprogesterone acetate.

Hormone Replacement Therapy for Preventing poor Bone Quality

- Clinical studies have shown that hormone replacement therapy along with estrogens influences BMD and prevents osteoporosis by lowering the risk of fracture by 27%.
- MHT is effective in prevention of fractures related to osteoporosis in at-risk women aged under 60 or up to 10 years after menopause.
- The dose and duration of MHT should be individualized based on treatment objectives, always assessing safety-related aspects, and should be monitored by a gynecologist.

Prevention of low bone mass to achieve high bone density in Mexico:
Position of the Mexican Association for Bone and Mineral Metabolism



Conclusions

- (1) Pharmacological treatment of osteoporosis with HMT has proved to be suitable for preventing fractures.
- (2) The design of a plan for prevention and treatment of osteoporosis should include exercise or physical activity suited to each patient clinical conditions.
- (3) Patients should participate actively in choosing the therapeutic approach to adopt.
- (4) The literature has shown that Ca and VD supplementation in adults has numerous beneficial effects on bone health by improving bone mineral density and reducing the risk and incidence of fractures.

Thank you



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Genitourinary Syndrome and Sexual Health Care Needs



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Financial Disclosures

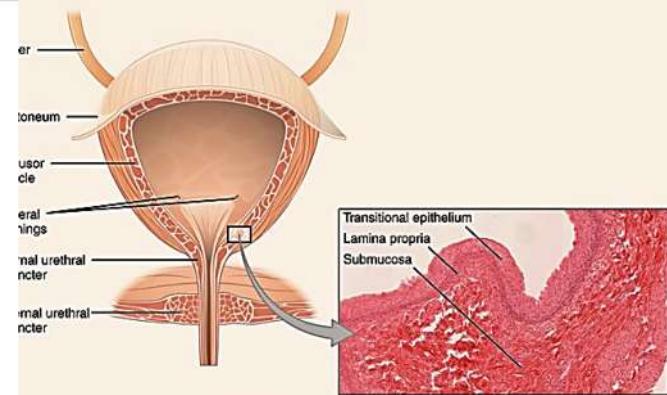
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I have no financial relationships to disclose



Genitourinary Syndrome of Menopause

- GSM is a medically more accurate all-encompassing and publicly acceptable term than Vulvovaginal Atrophy
- GSM is defined as a collection of Symptoms and Signs associated with a ↓ in Estrogen and other Sex Steroids involving changes:
 - **Labia Majora - Minora**
 - **Clitoris**
 - **Vestibule - Introitus**
 - **Vagina**
 - **Urethra**
 - **Bladder**



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Genitourinary Syndrome of Menopause



- The syndrome may include but is not limited to genital symptoms:
 - Dryness
 - Burning
 - Irritation
- Sexual symptoms:
 - Lack of Lubrication
 - Discomfort
 - Pain
 - Impaired Function
- Urinary symptoms:
 - Urgency
 - Dysuria
 - Recurrent Urinary Tract Infections



Urogenital Changes

- Anatomic Changes include:
 - ↓ Collagen Content and Hyalinization
 - ↓ Elastin
 - ↓ Thinning of the Epithelium
 - ↓ Appearance and Function of Smooth Muscle Cells
 - ↑ Density of Connective Tissue
 - ↓ Blood Vessels



Tan O, et al. Management of vulvovaginal atrophy-related sexual dysfunction in postmenopausal women: an up-to-date review. Menopause 2012;19:109-117

Nappi RE, Palacios S. Impact of vulvovaginal atrophy on sexual health and quality of life at postmenopause. Climacteric 2014;17:3-9

MacBride MB, Rhodes DJ, Shuster LT. Vulvovaginal atrophy. Mayo Clin Proc 2010;85:87-94

Urogenital Changes

- Labia Minora thin and regress
- The Introitus retracts
- The Hymenal Carunculae involute and lose elasticity → often leading to significant **Entry Dyspareunia**
- The Urethral Meatus appears prominent relative to the Introitus and becomes vulnerable to Physical Irritation and Trauma



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Urogenital Changes

- Physiologic Changes:

- ↓ Vaginal Blood Flow
- ↓ Lubrication
- ↓ Flexibility and Elasticity of the Vaginal Vault
- ↑ Vaginal pH

↓ in Vaginal Tissue strength and ↑ friability may predispose to epithelial damage with vaginal penetrative sexual activity, leading to vaginal:

- Pain
- Burning
- Fissuring
- Irritation
- Bleeding after Sex



MacBride MB, et al. Vulvovaginal atrophy. Mayo Clin Proc 2010;85:87-94

Kingsberg S, et al. Treating dyspareunia caused by vaginal atrophy: a review of treatment options using vaginal estrogen therapy. Int J Womens Health 2010;1:105-111

**Menopause-related Genitourinary
Symptoms affect up to 50 %
of Midlife and Older Women**



Management of symptomatic vulvovaginal atrophy: 2013 Position Statement of The NAMS. Menopause 2013;20:888-902

Parish SJ, Nappi RE, et al. Impact of vulvovaginal health on postmenopausal women: a review of surveys on symptoms of vulvovaginal atrophy. Int J Women's Health 2013;5:437-447

Genitourinary and Sexual Symptoms

3520 women (55-65 years of age) UK, USA, Sweden, Finland, Denmark and Norway

The Vaginal Health: Insights Views and Attitudes (VIVA) study an estimated:

- 45% Postmenopausal Women reported that they experienced Vaginal Symptoms
- 4% Were able to identify these symptoms as VVA related to Menopause

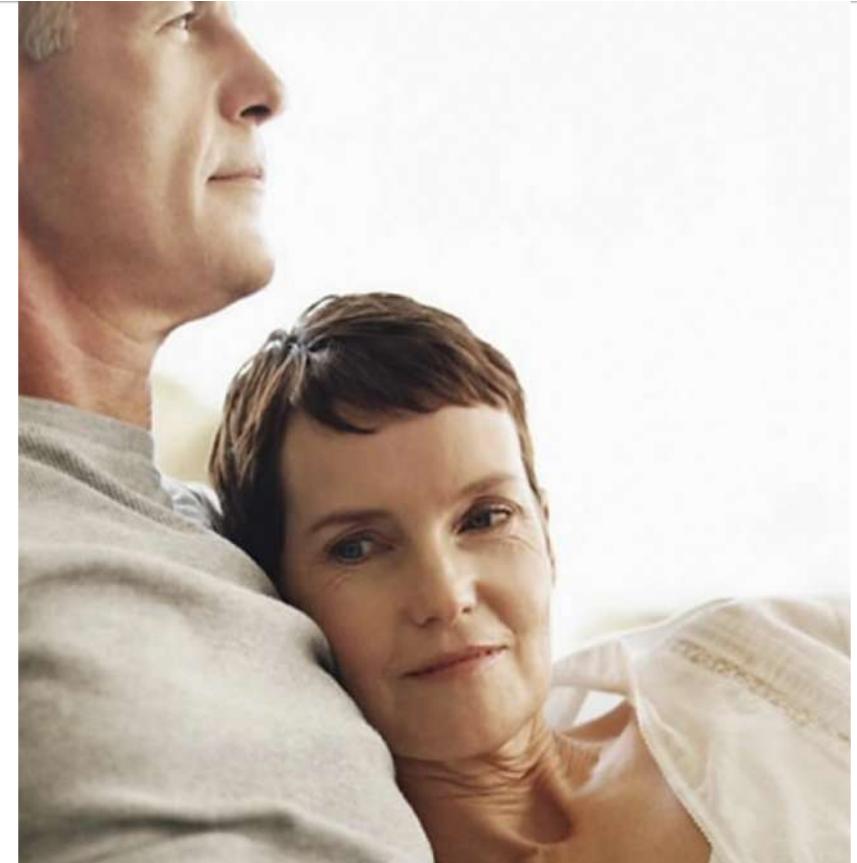
Nappi RE, Kokot-Kierepa Vaginal Health: Insights, Views & Attitudes (VIVA): results from an international survey.
Climacteric 2012;15:36-44

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The relationship between Genitourinary Symptoms and Sexuality is complex as:

- ✓ Physiologic and Psychologic Factors
- ✓ Interpersonal Relationships
- ✓ Sociocultural Influences



All play a role in Sexual Function

Genitourinary and Sexual Symptoms

- Urinary Frequency and Urgency are common midlife complaints
- Incontinence occurs in 15 - 35% of women > 60 years of age
- Women with Lower Urinary Tract Symptoms have a:
 - 7 fold greater risk of Sexual Pain Disorders
 - 4 fold greater risk of Sexual Arousal Disorders



Constantine GD, et al. Incidence of genitourinary conditions in women with a diagnosis of vulvar/vaginal atrophy
Curr Med Res Opin 2014;30:143–8

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Genitourinary and Sexual Symptoms

GSM may also occur in induced hypoestrogenic states including:

- ✓ Surgical Menopause
 - ✓ Use of GnRH Agonists
 - ✓ Hypothalamic Amenorrhea
 - ✓ Cancer Treatments → Chemotherapy - Pelvic Radiation or Endocrine Therapy
-
- Since the Genitourinary Symptoms related to an abrupt Menopause in these patients tend to present in relatively younger women and cause greater **Sexual Dysfunction** and **poorer QOL outcomes**

Management of symptomatic vulvovaginal atrophy: 2013 position statement of The North American Menopause Society **Menopause** 2013;20:888–902

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Public Perception

- The *Real Women's Views of Treatment Options for Menopausal Vaginal Changes (REVIVE)* survey → postmenopausal women reported that only **19%** of Healthcare Professionals addressed their Sexual Lives

The Vaginal Symptoms negatively affected enjoyment

- ❖ **59 %** Sexual Activity
- ❖ **24 %** Sleep
- ❖ **23 %** Overall enjoyment of Life

- Only **13%** specifically raised the issue of Genitourinary Symptoms, despite the fact that **40% of women** expected their HCP to initiate discussions related to Menopausal Symptoms

Kingsberg SA, et al. Vulvar and vaginal atrophy in postmenopausal women: findings from the REVIVE (REal Women's VIews of Treatment Options for Menopausal Vaginal ChangEs) survey. J Sex Med 2013;10:1790-1799



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Public Perception

- Societal views about women's sexuality at older ages are essentially negative and sexual problems are often considered to be part of normal ageing leading to many women not seeking help for their symptoms
- There is a disparity between the number of women who experience bothersome symptoms and those who are treated
- Women are unwilling shy or embarrassed to discuss their symptoms with their HCP especially if:
 - The Healthcare Professional is young and male
 - The patient has had a previous negative experience with a Healthcare Professional
 - The patient regards her symptoms as a natural part of ageing that she should "put up with"
- Women often wait for their Healthcare Professional to ask the questions



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Lindau ST, et al. A study of sexuality and health among older adults in the United States. *N Engl J Med* 2007;357:762-774

Public Perception

- The Healthcare Professional may be embarrassed or reluctant to ask appropriate questions (especially about Sexual Function) dismiss the symptoms as part of normal ageing or feel pressured for time
- Healthcare Professionals may also be unaware of available treatments or their recommended doses and may treat inadequately and in the short term



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Archer DF. Efficacy and tolerability of local estrogen therapy for urogenital atrophy. *Menopause* 2010;17:194–203

Public Perception

- In the *Clarifying Vaginal Atrophy's Impact on Sex and Relationships (CLOSER)* online survey → less than half of US respondents were aware of available treatments (Nonhormonal or Hormonal) to improve Vaginal Discomfort
- Collectively these findings serve to highlight the lack of discussion, the under-diagnosis, and the under-treatment of vulvar, vaginal, sexual, and urinary symptoms associated with Menopause



Simon J, Nappi R, et al. Clarifying Vaginal Atrophy's Impact on Sex and Relationships (CLOSER) survey: emotional and physical impact of vaginal discomfort on North American postmenopausal women and their partners. *Menopause* 2014;21:137-142

The vaginal discomforts negatively Sexual Function in Postmenopausal Women

- *Levine et al.* reported that Postmenopausal Sexually Active women with Sexual Dysfunction were nearly 4 times more likely to have Vulvovaginal Symptoms than those **Without Sexual Dysfunction**

- Among women with Vulvovaginal Symptoms:

- 40 % Reported Sexual Dysfunction
- 24 % Lack of Desire
- 34 % Arousal difficulties
- 19 % Orgasm difficulties



- *The Study of Women's Health Across the Nation (SWAN)* in the USA reported that women with Sexual Dysfunction considered Vaginal Dryness to be an important factor associated with:
 - Masturbation
 - Pain
 - Arousal
 - Physical Pleasure
 - Emotional Satisfaction

Levine KB, et al. Vulvovaginal atrophy is strongly associated with female sexual dysfunction among sexually active postmenopausal women. Menopause. 2008;15:661–666

Avis NE, et al. Longitudinal changes in sexual functioning as women transition through menopause: results from the Study of Women's Health Across the Nation. Menopause. 2009;16:442–452

Megan E. McCoo, et al. Prevalence of Female Sexual Dysfunction Among Premenopausal Women: A Systematic Review and Meta-Analysis of Observational Studies. Sex Med Rev 2016;1-16

- This systematic review of the literature (2000 - 2014) and meta-analysis of 95 international studies showed that **41%** of Premenopausal Women report FSD

Prevalence of the individual Disorders of Sexual Dysfunction in Premenopausal Women

28 % Hypoactive Sexual Desire Disorder

23 % Female Sexual Arousal Disorder

21 % Lubrication Difficulties

26 % Female Orgasmic Disorder

21 % Pain Disorders



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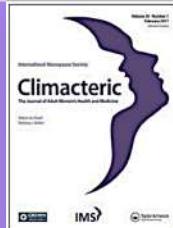
Blümel JE, et al. Collaborative Group for Research of the Climacteric in Latin America (REDLINC). Sexual dysfunction in middle-aged women: a multicenter Latin American study using the Female Sexual Function Index

Menopause 2009;16:1139–48

**In the countries of Latin America a
prevalence of Sexual Dysfunction
has been described**

56,8 %





Climacteric

ISSN: 1369-7137 (Print) 1473-0804 (Online) Journal homepage: <http://www.tandfonline.com/loi/icmt20>

Vaginal Health: Insights, Views & Attitudes (VIVA-LATAM): results from a survey in Latin America

R. E. Nappi, N. R. de Melo, M. Martino, C. Celis-González, P. Villaseca, S. Röhrich & S. Palacios

- 57% reported experiencing symptoms of vaginal atrophy
- 6% of the overall cohort attributed symptoms of vaginal atrophy directly to the condition
- 71% did not consider the condition to be chronic, resulting in many women not accessing effective therapy
- 49% affected by vaginal atrophy had used lubricating gels and creams
- 36% had used some form of local hormone treatment
- To understand symptoms/treatment options for vaginal discomfort: 92% were willing to seek advice from HCP
- 61% felt/would feel comfortable talking to their doctor about this

2509 postmenopausal women aged 55–65 years

Resident in:

Argentina, Brazil, Chile, Colombia, Mexico

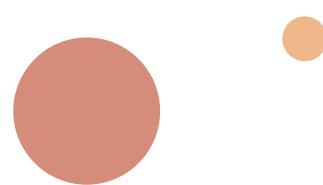
Published online: 09 May 2018

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Sexual Dysfunction

- Management → requires a **complex and multidisciplinary approach**
- **Lubricants and Moisturizers** may be recommended initially for dryness and loss of lubrication with intercourse
- **Vaginal Estrogens** are prescribed when Atrophic Changes are present
- Pelvic Floor Dysfunction - Pelvic Pain - Urinary Symptoms referral to a **Pelvic Floor Physiotherapist** for pelvic floor training and relaxation will help to ↓ symptoms

- Sometimes **vaginal trainers** will help dilate the vaginal introitus
- Consider changing regular medications that affect Sexual Function (Antidepressants) and referral to a **Sexual Therapist** and/or **Couple Counseling** may be necessary



Sexual Dysfunction

- Preparations that improve Atrophic Symptoms are:
 - ✓ Ospemifene
 - ✓ Oral SERM
 - ✓ Vaginal Gel of DHEA
- Research is ongoing into new and improved Vaginal Estrogen Preparations
 - ✓ Estradiol - Estriol Cream
 - ✓ Conjugated Equine Estrogens Cream
 - ✓ Estradiol Vaginal Tablets
 - ✓ Estradiol Vaginal Ring
- Intravaginal CO₂ Laser therapy - *MonaLisa Touch™*
- Dynamic Quadripolar Radiofrequency device
- Vaginal Erbium Laser (VEL) the 2nd Generation Thermotherapy





G M S

- A multidisciplinary approach may be necessary where there are complex problems: including Sexual Dysfunction
- The Healthcare Professional is in a unique position to sensitively discuss symptoms:

- ✓ Incontinence
- ✓ Sexual Pain
- ✓ Prolapse
- ✓ Vaginal Irritation
- ✓ Dryness

The Healthcare Professional should advise, educate and manage accordingly, providing long-term follow-up



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Thanks for your help

Sincerely: your Patients



Unmet Health care needs in Latinoamerican Postmenopausal Women

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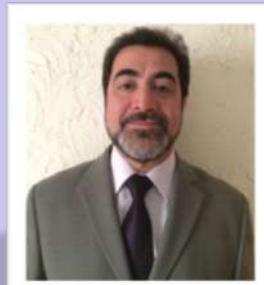
Closing remarks and questions



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