 **Selección de Resúmenes de Menopausia**

Semana del 1 al 7 de Julio de 2015

Juan Enrique Blümel. Departamento Medicina Sur. Universidad de Chile

**Psychoneuroendocrinology. 2015 Jun 17;60:96-104. doi: 10.1016/j.psyneuen.2015.06.005. [Epub ahead of print]**

**Insomnia in women approaching menopause: Beyond perception.**

Baker FC, Willoughby AR, Sassoon SA, Colrain IM, de Zambotti M.

The menopausal transition is marked by increased prevalence in disturbed sleep and insomnia, present in 40-60% of women, but evidence for a physiological basis for their sleep complaints is lacking. We aimed to quantify sleep disturbance and the underlying contribution of objective hot flashes in 72 women (age range: 43-57 years) who had (38 women), compared to those who had not (34 women), developed clinical insomnia in association with the menopausal transition. Sleep quality was assessed with two weeks of sleep diaries and one laboratory polysomnographic (PSG) recording. In multiple regression models controlling for menopausal transition stage, menstrual cycle phase, depression symptoms, and presence of objective hot flashes, a diagnosis of insomnia predicted PSG-measured total sleep time (p<0.01), sleep efficiency (p=0.01) and wakefulness after sleep onset (WASO) (p=0.01). Women with insomnia had, on average, 43.5min less PSG-measured sleep time (p<0.001). There was little evidence of cortical EEG hyperarousal in insomniacs apart from elevated beta EEG power during REM sleep. Estradiol and follicle stimulating hormone levels were unrelated to beta EEG power but were associated with the frequency of hot flashes. Insomniacs were more likely to have physiological hot flashes, and the presence of hot flashes predicted the number of PSG-awakenings per hour of sleep (p=0.03). From diaries, women with insomnia reported more WASO (p=0.002), more night-to-night variability in WASO (p<0.002) and more hot flashes (p=0.012) compared with controls. Women who develop insomnia in the approach to menopause have a measurable sleep deficit, with almost 50% of the sample having less than 6h of sleep. Compromised sleep that develops in the context of the menopausal transition should be addressed, taking into account unique aspects of menopause like hot flashes, to avoid the known negative health consequences associated with insufficient sleep and insomnia in midlife women.

**Atherosclerosis. 2015 Jun 19;241(2):743-751. doi: 10.1016/j.atherosclerosis.2015.06.032. [Epub ahead of print]**

**Associations between calcium and vitamin D supplement use as well as their serum concentrations and subclinical cardiovascular disease phenotypes.**

Thiele I, Linseisen J, Meisinger C, Schwab S, Huth C, Peters A, Perz S, Meitinger T, Kronenberg F, Lamina C, Thiery J, Koenig W, Rathmann W, Kääb S, Then C, Seissler J, Thorand B.

BACKGROUND: Supplementation of calcium (Ca) and vitamin D for the prevention of osteoporosis is frequently found in Western countries. Recent re-analyses of clinical trials observed a higher risk of myocardial infarction and stroke in subjects taking Ca (+vitamin D) supplements, although the underlying mechanisms are not clear. OBJECTIVE: Thus, we analyzed the associations between Ca and vitamin D supplementation as well as serum concentrations of Ca and 25-hydroxyvitamin D (25(OH)D) and subclinical cardiovascular disease (CVD) phenotypes, namely intima-media thickness, ankle-brachial-index (ABI), intermittent claudication, and atrial fibrillation (AF). DESIGN: Data of 1601 participants aged 50-81 years of the population-based cross-sectional Cooperative Health Research in the Region of Augsburg (KORA) F4 study in Germany were analyzed. Logistic and linear regression models were used to estimate odds ratios (OR) (95% confidence intervals (CI)) and β-estimates (p-values), respectively. RESULTS: Regular Ca supplementation showed a significant positive association with the presence of AF after multivariable adjustment (OR = 3.89; 95% CI 1.28-11.81). Higher serum 25(OH)D concentrations were independently associated with a lower prevalence of asymptomatic peripheral arterial disease as assessed by ABI measurements (β = 0.007; p = 0.01). No other significant associations between supplementation or serum concentrations of Ca or vitamin D and CVD phenotypes were identified. CONCLUSIONS: Although based on few cases the finding of a significant higher prevalence of AF in Ca supplement users hints at one possible mechanism that may contribute to an increased risk of myocardial infarction and stroke. The observed association between serum 25(OH)D and ABI supports results from other studies.

**Appl Physiol Nutr Metab. 2015 Jul;40(7):741-8. doi: 10.1139/apnm-2014-0453.**

**Food group preferences and energy balance in moderately obese postmenopausal women subjected to brisk walking program.**

Garnier S, Vallée K, Lemoine-Morel S, Joffroy S, Drapeau V, Tremblay A, Auneau G, Mauriège P.

The objective of the study was to examine the effects of a 16-week walking program on food group preferences and energy balance of sedentary, moderately obese (body mass index, 29-35 kg/m(2)), postmenopausal Caucasian women, aged 60 ± 5 years old. One hundred and fifty-six volunteers were subjected to 3 sessions/week of 45 min of walking at 60% of heart rate reserve. Total energy intake (TEI) and food group preferences (3-day dietary record), total energy expenditure (TEE, 3-day physical activity diary), cardiorespiratory fitness (2-km walking test), anthropometry, and body composition (bioelectrical impedance) were measured before and after walking. Data were statistically analyzed using an ANOVA with repeated measures on 1 factor (time). The modest increase in TEE of 151 ± 24 kcal/day (p < 0.0001) leads to body weight, fat mass losses, and waist girth reduction (p < 0.0001). TEI remained unchanged despite a slight decrease in carbohydrate intake and a minor increase in protein intake (p < 0.05). Analysis of food records revealed a decreased consumption of fruits (p < 0.05) and sweet and fatty foods (p < 0.01), but an increase in oil consumption (p < 0.0001) after walking. Women with the highest body weight loss showed the greatest reduction in the consumption of fruits, sugar, sweet foods, and fatty foods (p < 0.05). Women with the greatest fat mass loss showed the highest decrease in fatty food intake (p < 0.05). In conclusion, although our walking program changed some food group consumption patterns, body weight loss was primarily because of the increased TEE.

**Maturitas. 2015 Jun 16. pii: S0378-5122(15)00730-6. doi: 10.1016/j.maturitas.2015.06.026. [Epub ahead of print]**

**Anti-mullerian hormone (AMH) is associated with natural menopause in a population-based sample: The CARDIA Women's Study.**

Nair S, Slaughter JC, Terry JG, Appiah D, Ebong I, Wang E, Siscovick DS, Sternfeld B, Schreiner PJ, Lewis CE, Kabagambe EK, Wellons MF.

OBJECTIVE: AMH is associated with menopausal timing in several studies. In contrast to prior studies that were restricted to women with regular cycles, our objective was to examine this association in women with either regular or irregular menstrual cycles. METHODS: CARDIA is a longitudinal, population-based study that recruited adults ages 18-30 when it began in 1985-1986. AMH was measured in serum stored in 2002-2003. Natural menopause was assessed by survey in 2005-2006 and 2010-2011. RESULTS: Among 716 premenopausal women, median [25th, 75th] AMH was 0.77 [0.22-2.02]ng/dL at a median age of 42 [39-45] years. Twenty-nine percent of the women (n=207) reported natural menopause during 9 years of follow up. In fully adjusted discrete-time hazard models, a 0.5ng/dL AMH decrement was associated with higher risk of menopause (p<0.001). Hazard ratios varied with time since AMH measurement. The HR (95% CI) for menopause was 8.1 (2.5-26.1) within 0-3 years and 2.3 (1.7-3.3) and 1.6 (1.3-2.1) for 3-6 and 6-9 years, respectively. When restricted to women with regular menses, results were similar (e.g., HR=6.1; 95% CI: 1.9-20.0 for 0-3 years). CONCLUSION: AMH is independently associated with natural menopause. AMH appears most useful in identifying women at risk of menopause in the near future (within 3 years of AMH measurement).

**Menopause. 2015 Jun 29. [Epub ahead of print]**

**Armodafinil for fatigue associated with menopause: an open-label trial.**

Meyer F, Freeman MP, Petrillo L, Barsky M, Galvan T, Kim S, Cohen L, Joffe H.

OBJECTIVE: This study aims to obtain preliminary data on the efficacy of armodafinil for improving menopause-related fatigue and quality of life. METHODS: Women (aged 40-65 y) experiencing menopause-related fatigue received open-label armodafinil therapy (up to 150 mg/d) for 4 weeks. Changes from baseline in Brief Fatigue Inventory score and Menopause-Specific Quality of Life (MENQOL) physical domain score were examined using the Wilcoxon signed rank test. Exploratory analyses examined the effects of armodafinil on hot flashes, overall quality of life, insomnia, depression, anxiety, and perceived cognitive performance. After open-label treatment, participants were randomized to double-blind continuation of armodafinil versus placebo for 2 weeks to examine whether treatment discontinuation would precipitate symptom recurrence. RESULTS: Of 29 eligible participants, 20 women (69.0%) completed the trial. During treatment with armodafinil (mean dose, 120 mg/d), median Brief Fatigue Inventory scores decreased by 57.7% from 5.2 (interquartile range [IQR], 4.6-6.2) to 2.2 (IQR, 1.1-4.4; P = 0.0002), and median MENQOL physical domain scores decreased by 51.3% from 3.9 (IQR, 2.3-4.8) to 1.9 (IQR, 1.3-2.7; P = 0.0001). Median hot flashes for 24 hours decreased by 48.3% from 2.9 (IQR, 1.1-4.6) to 1.5 (IQR, 0.4-2.4; P = 0.0005). Improvements in MENQOL total score (49%; P = 0.0001), cognitive function (59.2%; P = 0.0002), depressive symptoms (64.7%; P = 0.0006), insomnia (72.7%; P = 0.0012), and excessive sleepiness (57.1%; P = 0.0006) were noted. Randomized continuation (n = 10) or discontinuation (n = 10) did not indicate group differences. Armodafinil was well-tolerated; three women (12%) were withdrawn for adverse events. CONCLUSIONS: These preliminary results suggest a therapeutic effect of armodafinil on fatigue affecting quality of life during menopause, and a potential benefit for other menopause-related symptoms.

**Int J Womens Health. 2015 Jun 18;7:615-24. doi: 10.2147/IJWH.S50804. eCollection 2015.**

**Critical appraisal of paroxetine for the treatment of vasomotor symptoms.**

Carroll DG, Lisenby KM, Carter TL.

BACKGROUND: Vasomotor symptoms (VMS), characterized by hot flashes and night sweats, are the most commonly reported symptoms associated with estrogen deficiency during menopause and occur in up to 70% of women. The goal of treatment is to reduce the frequency and severity of symptoms. Although hormone therapy (HT) is generally recommended as first-line treatment, it is not appropriate for all patients. Antidepressants, specifically selective serotonin reuptake inhibitors, have been evaluated and utilized internationally for alternative treatment for VMS. In 2013, paroxetine mesylate (Brisdelle(®)) received a US Food and Drug Administration-labeled indication for moderate-to-severe hot flashes, making it the first nonhormonal treatment for VMS associated with menopause. The objective of this review is to critically evaluate available clinical data regarding the efficacy and safety of paroxetine for the treatment of VMS in menopausal women. METHODS: MEDLINE, PubMed, and Google Scholar were searched using the keywords paroxetine, vasomotor symptoms, hot flashes, and menopause. Searches were limited to humans, English language, and clinical trial design with a primary outcome of hot flash/vasomotor changes. RESULTS: Paroxetine (hydrochloride and mesylate) has been associated with a 33%-67% reduction in hot flash frequency with 6-12 weeks of treatment compared to 13.7%-37.8% reductions with placebo in patients both with and without a history of breast cancer. It was also associated with significant reductions in hot flash severity. Benefits of treatment persisted through 24 weeks in the study of the longest duration. Most adverse effects reported were of mild-to-moderate severity, with improved tolerability associated with lower doses (7.5-12.5 mg/day). CONCLUSION: Paroxetine is a safe and effective therapy for the treatment of VMS during menopause. Paroxetine (7.5-12.5 mg/day) should be considered a first-line therapy option for VMS in patients when HT is either inappropriate or intolerable.