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Rates of bone loss in postmenopausal women randomly assigned to one of two dosages of vitamin D

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AM. J. CLIN. NUTR. 1995 61/5 (1140–1145)

We conducted a study to determine whether increasing vitamin D intake above the recommended dietary allowance (RDA) of 5.0 g (200 IU)/day reduces bone loss in healthy postmenopausal women residing at latitude 42 N. In this double-blind, randomized 2-year trial, we enrolled 247 healthy, ambulatory, postmenopausal women who consumed an average of 2.5 g (100 IU) vitamin D/day in their usual diets. The women were given either 2.5 g (100 IU) or 17.5 g (700 IU) vitamin D/day. All women received 500 mg supplemental calcium per day as citrate malate. Duplicate hip and spine and single whole-body scans were performed by dual-energy X-ray absorptiometry at 6-month intervals selected to flank the periods when 25-hydroxycholecalciferol (calcidiol) concentrations are highest (summer/fall) and lowest (winter/spring). Plasma calcidiol and serum osteocalcin were measured in these seasons in year 1. Both treatment groups lost bone mineral density from the femoral neck, but the 17.5 g group lost less (-1.06, 0.34%;-x SE) than the 2.5 g group (2.54, 0.37%, $P = 0.003$). Seasonally, 70% of the benefit each year occurred in winter/spring and 30% in summer/fall. Changes in spinal and whole-body bone densities did not differ by treatment group and were minimal after 2 years. Serum osteocalcin and plasma calcidiol (2.5 g group only) fluctuated with season. In conclusion, in healthy, calcium-supplemented, postmenopausal women residing at latitude 42 N, an intake of 5.0 g (200 IU) vitamin D/day is sufficient to limit bone loss from the spine and whole body but it is not adequate to minimize bone loss from the femoral neck. We recommend that postmenopausal women at this latitude increase their vitamin D intake above the current RDA of 5.0 g/day to reduce bone loss from the hip. Although an intake as high as 20 g (800 IU)/day may not be needed, this amount is safe and effective.

95132782

Estrogen replacement therapy and fatal ovarian cancer

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AM. J. EPIDEMIOL. 1995 141/9 (828–835)

The authors examined the relation between use of estrogen replacement therapy and ovarian cancer mortality in a large prospective mortality study of 240 073 peri- and postmenopausal women, none of whom had a prior history of cancer, hysterectomy, or ovarian surgery at enrollment in 1982. During 7 years of follow-up, 436 deaths from ovarian cancer occurred. Cox proportional hazard regression was used to adjust for other risk factors. Ever use of estrogen replacement therapy was associated with a rate ratio for fatal ovarian cancer of 1.15 (95% confidence interval (CI) 0.94–1.42). The mortlity rate ratio increased with duration of use prior to entry to this study to 1.40 (95% CI 0.92–2.11) with 6–10 years of use and 1.71 (95% CI 1.06–2.77) with 11 years of use. The increase in mortality associated with 6 years of use was observed in both current users (rate ratio (RR) = 1.72, 95% CI 1.01–2.90) and former users at study entry (RR = 1.48, 95% CI 0.99–2.22), relative to never users. Risk associated with use was not modified by any of the other risk factors. These data suggest that long-term use of estrogen replacement therapy may increase the risk of fatal ovarian cancer.

95140224

The uncertain fate of ovaries at the time of hysterectomy

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ITAL. J. GYNAECOL. OBSTET. 1994 6/4 (75–84)

Objective: The aim of this review was to analyse the current opinions on the practice of prophylactic oophorectomy at the time of hysterectomy according to the patient's age. Methods: All publications regarding the role of prophylactic oophorectomy at the time of hysterectomy indexed on CANCER-CD TIM from 1984 –1994 have been revised. Recent data on the reduction of ovarian cancer incidence and on the risk/benefit assessment of hormonal deprivation compared with hormonal replacement therapy (HRT) following ovarian ablation were also examined. Results: Prophylactic oophorectomy is considered the most effective way of avoiding ovarian cancer and it is widely performed in post-menopausal women. Uncertainty remains for younger women: the use of HRT allows the unfavourable metabolic effects caused by early hormonal deprivation, to be overcome for the most part in those patients who have undergone oophorectomy. Furthermore, preserved ovaries do not ensure their regular activity after hysterectomy and sometimes have to be removed due to the 'residual ovary syndrome'. Nevertheless, a good compliance with estrogen therapy is necessary to avoid the situation where the drawbacks of oophorectomy (higher incidence of coronary heart disease and osteoporosis) exceed the benefits (lower incidence of ovarian and breast cancer). Conclusions: There is general agreement on preserving ovaries in women under 40 years of age and performing prophylactic oophorectomy on women over 50 years of age at the time of hysterectomy. For patients in the fifth decade of life, risk factors for ovarian cancer and the effectiveness of HRT should be considered; any decision must be taken in accordance with the patient's opinion, adequately informed of the potential risks and benefits of therapeutic options.

95133444

An audit of oestradiol levels and implant frequency in women undergoing subcutaneous implant therapy

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CLIN. ENDOCRINOL. 1995 42/5 (445–450)

Objectives: The aim of the study was to review our long-term use of subcutaneous oestradiol (E2) implant therapy for the treatment of climacteric symptoms in postmenopausal women. On the grounds that the aim is to restore premenopausal serum E2 levels, our declared clinical policy is not to repeat implants even in the presence of symptoms if serum E2 levels are > 400 pmol/l. Therapy was with 50 mg E2 implants inserted subcutaneously in the lower abdominal wall. Design: All women who had attended the gynaecological/endocrinological clinic and had received subcutaneous E2 implants for the relief of climacteric symptoms between December 1981 and December 1992 were included. Results: Between December 1981 and December 1992, 275 women received a total of 759 50 mg E2 implants. The median length of implant therapy was 34.2 months (range 3.7–109.5 months), and the median number of implants per patient was 4 ranging from 1–13. One-hundred and twenty-nine women had more than four implants and their mean recorded serum E2 level was 425 187 pmol/l; the mean level over the first 24 months of therapy was 408 157 pmol/l. This was not different from the mean value of the remaining period of therapy (439 158 pmol/l). Following the second implant there was no significant progressive rise in serum E2 with time and implant number and the mean E2 level per patient was no higher in those patients who received implants more frequently. The mean time between the first two implants was 9.7 0.4 months and between subsequent ones was 11.7 0.5 months. After the first two implants there was no progressive change in this interval with time. Conclusion: This study shows that effective, safe and sympathetic management of women with oestrogen deficiency symptoms may be achieved by use of two criteria to determine retreatment; the return of symptoms, and a serum E2 level no higher than 400 pmol/l. Once therapy is established, E2 implants may need to be prescribed only on an annual basis. There appears to be no justification for giving E2 implants more frequently as this policy achieves satisfactory (physiological) premenopausal E2 levels and good symptomatic relief without any evidence for accumulation of E2 or 'tachyphylaxis'.

95131388

Menopause in women with learning disabilities

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J. INTELLECT. DISABIL. RES. 1995 39/2 (137–139)

A brief questionnaire concerning previous and current menstrual status was sent to 280 women over the age of 35 on the Wandsworth Register for People with Learning Disabilities: 196 questionnaires (70.4%) were returned. Of the 171 questionnaires used in the analyses, 45 were from women with Down's syndrome. The results suggested that, compared with data for normal women, menopause may occur earlier in women with learning disabilities and earlier still in women with Down's syndrome.

95181345

Association of medically treated depression and age at natural menopause

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AM. J. EPIDEMIOL. 1995 141/12 (1170–1176)

Between October 1989 and November 1992, the authors surveyed approximately 10 000 women between 45 and 54 years of age residing in western metropolitan Boston and selected as cases all women naturally menopausal before age 40 and a sample of women naturally menopausal between 40 and 46 years of age. Controls were a random sample of women who were premenopausal or naturally menopausal after age 47. Based on the results of an in-person interview to assess past reproductive and medical history, 14% of 344 cases compared with 6% of 344 controls reported a history of medically treated depression at least 1 year prior to menopause or comparable reference age in controls (adjusted odds ratio (OR) = 1.9, 95% confidence interval (CI) 1.1–3.3). The association of medically treated depression and early menopause was greatest in women naturally menopausal before age 40 compared with their age- and residence-matched controls (OR = 6.6, 95% CI 0.7–58.9) and in women who reported a history of medically treated depression that required more than 3 years of treatment (OR = 4.0, 95% CI = 1.3–12.0). This is the first study to suggest a link between a self-reported history of medically treated depression and early menopause. Additional studies are necessary to clarify the basis for this association.