

Think Androgen Excess in Women With Hirsutism

BY DAMIAN McNAMARA
Miami Bureau

SAN ANTONIO — Address the underlying androgen excess when a woman presents for correction of cutaneous effects of hyperandrogenism, Dr. Ellen E. Wilson said at a meeting of Skin Disease Education Foundation.

Polycystic ovary syndrome (PCOS) is the most common etiology of hyperandrogenism. "Dermatologic manifestations include hirsutism, acne, acanthosis nigricans, and androgenetic alopecia—in that order," said Dr. Wilson, a reproductive endocrinologist at the University of Texas Southwestern Medical Center in Dallas.

PCOS affects an estimated 6%-10% of women in their reproductive years. The excess male hormone production or action can cause infertility. About 25% of women of reproductive age have polycystic ovaries but not the syndrome.

Patients must meet two out of three criteria for diagnosis: polycystic ovaries on ultrasound (more than 12 cysts per ovary);

Hirsutism is the main symptom of hyperandrogenism, but physicians may not be able to see it because patients will often self-treat by plucking or shaving.

oligoanovulation; or clinical or biochemical evidence of hyperandrogenism. A testosterone level of 50-80 ng/dL is the upper range of normal for women, she said. Hirsutism is defined as male pattern hair growth in a female. Rapid onset of hair growth, deepening of the voice, and temporary balding can produce emotional anguish in patients from a presumptive loss of femininity.

Although hirsutism is the leading dermatology-related symptom of hyperandrogenism, physicians may not see it "because patients are self-treating for this—plucking, shaving, etc.," Dr. Wilson added. "So make sure to ask about this."

Cancer can also cause virilization, so androgen levels should be measured in the tests to rule out a tumor. "If someone has a testosterone level over 200 ng/dL we are going to look for a tumor, especially ovarian," she noted.

Irregular cycles from menarche or shortly thereafter that do not normalize suggest PCOS. If a patient's cycle is irregular for more than a year, do an endometrial biopsy because she is at risk for hyperplasia or uterine cancer, Dr. Wilson said at the meeting. SDEF and this news organization are wholly owned subsidiaries of Elsevier.

An endocrinologist can address the long-term consequences of PCOS, which include endometrial cancer, diabetes mellitus, and cardiovascular disease. Dr. Wilson said that "there is a big overlap with metabolic syndrome. We don't know what the cause of PCOS is. We know there is a platform of insulin resistance."

Endocrinologists are starting to prescribe metformin in PCOS patients because of these long-term risks. Metformin

is the most popular and well-studied insulin sensitizer in PCOS patients, she said, but start slow to minimize side effects. "There is a big controversy in the pediatric realm [about] whether or not to put adolescents on metformin."

A contraceptive pill, patch, or ring regimen can regularize periods and treat the effects of hyperandrogenism. Low-dose oral contraceptives lower free testosterone levels, with the progestins desogestrel, gestodene, and norgestimate being associated

with greater reductions. "The bottom line is probably any low-dose formulation producing an overall similar clinical response."

Treatment with hormonal suppression will be necessary for at least 6 months before there is an observable difference. "It takes time," Dr. Wilson said. "For hirsutism, often I recommend they go to a dermatologist for hair removal, and I tell them there should be no new growth."

Patients with PCOS may remain on oral contraceptives through their 30s and 40s,

often until they are menopausal.

If oral contraceptives are not enough, "we will supplement with spironolactone," Dr. Wilson said. "Spironolactone is a potential teratogen, so we feel more comfortable if they are already on an oral contraceptive." Spironolactone is effective in doses of 100-200 mg/day.

Vaniqa (eflornithine) is approved for hirsutism as a twice-a-day local treatment. "It is expensive and works in one-third to two-thirds of women," she said. ■



Discover Levemir®:
a long-acting basal insulin
with a light touch

Levemir: for your patients who need a safe and effective way to improve A1C control

With proven reductions in A1C and FPG levels over time, Levemir can help your patients get to goal with up to 24 hours of glycemic control. Patients with diabetes can experience a consistent blood glucose response from injection to injection. Less weight gain was observed with Levemir in 12 of 12 clinical trials.* And Levemir is available in the Levemir® FlexPen®. FlexPen® is the world's #1 selling prefilled insulin pen.† So start your patients with diabetes on Levemir, and help them experience the light side of basal insulin.

Levemir is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information
Levemir should not be diluted or mixed with any other insulin preparations. Levemir is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Levemir is not to be used in insulin infusion pumps. Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir from other intermediate or long-acting insulin preparations. The dose of Levemir may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation. *Whether these observed differences represent true differences in the effects of Levemir and NPH insulin is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

Reference: 1. IMS Health, IMS MIDAS [12 months ending September 2005]. Please see brief summary of Prescribing Information on adjacent page. FlexPen and Levemir are registered trademarks of Novo Nordisk A/S. © 2006 Novo Nordisk Inc. 131007 September 2006

Levemir®
insulin detemir (rDNA origin) injection
Lighter years ahead


