Think Androgen Excess in Women With Hirsutism

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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); 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.

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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. ■