

Don't Miss the Diagnosis in Cases of Excess Hair

Women who seek laser hair removal should be screened for systemic disease.

BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE FLORIDA SOCIETY OF DERMATOLOGY & DERMATOLOGIC SURGEONS

NAPLES, FLA. — Many women with hirsutism have already removed their excess, unwanted hair before they present. Look beyond the shaving, bleaching, plucking, and waxing, Dr. Elise A. Olsen said, to identify important medical conditions associated with excess hair growth.

"Patients seen for the cosmetic treatment of hirsutism provide an opportunity to screen for [other] common findings." Accurate diagnosis also optimizes dermatology treatment. "Most of your patients with hirsutism will be coming in for laser hair removal. Evaluation for hirsutism will affect your [result]," Dr. Olsen said at the meeting.

Polycystic ovarian syndrome, adrenal abnormalities, and drug reactions are important considerations in a differential diagnosis. Rule out these and other causes of hirsutism, as well as acromegaly and premature ovarian failure, Dr. Olsen said.

Hirsutism is a common problem that affects at least 5% of the female population, said Dr. Olsen, director of the Duke Dermatopharmacology Study Center and

professor of dermatology at Duke University Medical Center in Durham, N.C.

Begin your evaluation with patient and family history. Ask about history of menses, acne, and how often the woman removes unwanted hair. Note affected anatomic sites during your physical examination, and use the Ferriman-Gallwey hirsutism index to score results, Dr. Olsen said. Also perform a pelvic examination and order ultrasound if you suspect a tumor or other abnormality.

Measurement of serum levels of dehydroepiandrosterone sulfate (DHEAS), androstenedione, prolactin, and sex-hormone-binding globulin (SHBG) can facilitate diagnosis. Other helpful laboratory assays include luteinizing hormone/follicle stimulating hormone (LH/FSH) levels, a glucose tolerance test with insulin levels, and a fasting lipid panel.

Simple blood work includes a check of testosterone levels, Dr. Olsen said. "You will catch 40% [of hyperandrogenemia in hirsutism] with elevated testosterone alone and 60% with elevated free testosterone." In addition, she added, "I have started to do DHT or dihydrotestosterone because it can catch idiopathic cases."

Polycystic ovarian syndrome (PCOS)

affects an estimated 3%-11% of women of reproductive age. Keep in mind that Rotterdam consensus criteria do not apply to adolescent girls, women on oral contraceptive pills, or postmenopausal women, Dr. Olsen said.

"One of the most important things I will talk about is that 50%-60% of these women with PCOS have insulin resistance. They have a three to seven times increased risk of type 2 diabetes, decreased fertility, and increased risk of cardiovascular disease," Dr. Olsen said. Risk of endometrial cancer is also elevated.

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Part of ruling in PCOS is ruling out congenital adrenal hyperplasia, which can be challenging because many symptoms overlap, Dr. Olsen said.

To diagnose congenital adrenal hyperplasia, look for premature pubarche with early pubic hair, cystic acne, and accelerated growth in girls.

These girls also will have advanced bone age but premature closure of epiphyses, "so, ultimately, they have short adult stature," she said. In adult women,

it is important to include amenorrhea, anovulation, oligomenorrhea, and infertility in your differential diagnosis.

Tumors that cause hirsutism are rare, Dr. Olsen said. "If someone is suddenly developing hirsutism, that should be in the back of your mind."

Not surprisingly, androgen medications can cause excess hair growth in women. Danazol (Danocrine, Sanofi-Synthelabo Inc.; plus generics), valproate sodium (Depacon, Abbott; plus generics), and valproic acid (Depakene, Abbott; plus generics) are other common drug-related causes. Take a thorough medication history that includes these agents as well as progesterone.

There is no drug specifically indicated to treat hirsutism approved for marketing by the U.S. Food and Drug Administration. One agent, eflornithine (Vaniqa, SkinMedica Inc.) is approved only for reduction of unwanted facial

hair.

"It decreases the rate of hair growth and amount of shaving a woman has to do," Dr. Olsen said. "It's a decrease in the rate of hair growth only" and not the amount of hair, so patient education and realistic expectations are important. ■

Disclosures: Dr. Olsen said she is a consultant for Merck & Co., an investigator for Eisai Pharmaceuticals, and she receives research support from both companies.

CDC Guideline Ranks Contraceptives' Efficacy and Risks

BY MICHELE G. SULLIVAN

FROM MORBIDITY AND MORTALITY WEEKLY REPORT

A new guideline issued by the Centers for Disease Control and Prevention aims to help physicians balance the safety and efficacy of different contraceptive methods for all women, whether they are healthy or have an illness that may preclude the use of a specific method.

The Medical Eligibility Criteria for Contraceptive Use 2010 is adapted from a similar evidence-based guideline created by the World Health Organization. The U.S. document, however, includes information on disorders that were not included in the international guideline and updated scientific evidence. It was also formulated to agree with practice guidelines endorsed by U.S. health provider organizations.

A multispecialty board reviewed the WHO document and the extant literature to develop the new guideline. Dr.

Robert W. Rebar, the executive director of the American Society for Reproductive Medicine, was a member of the panel. "The [Centers for Disease Control and Prevention] also asked us to recommend some particular diseases that were not covered by the WHO document, but which are relevant in the United States, among them obe-

Each of the contraceptive methods is examined in light of its effect on different groups of patients, and the conditions are ranked according to the related risk.

sity and arthritis," Dr. Rebar said in an interview.

"Our intent was to provide guidance for physicians as to what kind of contraception appears to be safe and appropriate for these patients," he said.

The new guideline addresses the use of hormonal contraceptives, emergency contraceptive pills, intrauterine devices for both pregnancy prevention

and emergency contraception, barrier methods, sterilization, and "natural methods," including coitus interruptus, lactational amenorrhea, and fertility awareness. Each method is examined in light of its effect on different groups of patients, and the conditions are ranked according to the related risk (MMWR 2010;59[RR-4]:1-86):

1. A condition for which there is no restriction for the use of the contraceptive method.
2. A condition for which the advantages of using the method generally outweigh the theoretical or proven risks.
3. A condition for which the theoretical or proven risks usually outweigh the advantages of using the method.
4. A condition that represents an unacceptable health risk if the contraceptive method is used.

The guideline takes into account not only the safety of each method, but its efficacy as well, Dr. Rebar said. "We attempted to balance the risks of

pregnancy—which are not inconsiderable—and the risks of contraception. In each case, physicians can use the guideline to provide patients with an evaluation of the risk, so they can choose" the method that best fits their particular situation and personal needs.

For example, while coitus interruptus is a safe method for any woman, regardless of her physical state, its relative ineffectiveness may not make it a good choice.

"Coitus interruptus is unforgiving of incorrect use, and its effectiveness depends on the willingness and ability of the couple to use withdrawal with every act of intercourse. Women with conditions that make pregnancy an unacceptable risk should be advised that [coitus interruptus] might not be appropriate for them because of its relatively higher typical-use failure rates," according to the document.

The document also includes a summary of the evidence about potential drug interactions between hormonal contraceptives and antiretroviral therapy. Al-

though there are limited data on the topic, those that do exist suggest that some antiretroviral drugs—particularly the ritonavir-boosted protease inhibitors—can suppress contraceptive steroid blood levels and increase the chance of pregnancy. Other studies suggest that oral contraceptives can increase the likelihood of antiretroviral drug toxicity.

The final pages are devoted to a chart of physical conditions that must be considered when recommending contraceptives, and the possible implications of each method for each reproductive age group. Health care providers can use the summary table as a quick reference guide to the classifications for hormonal contraceptive methods and intrauterine contraception and to compare classifications across these methods. ■

Disclosures: No conflicts of interest were reported.

The MMWR document is available for free at www.cdc.gov/mmwr/pdf/rr/rr59e0528.pdf.