

Hirsutism Often Not Skin Deep; Look for Disorders

Women can pluck hairs on the chin and the belly, so be sure to do an undressed, full-body exam.

BY TIMOTHY F. KIRN
Sacramento Bureau

LOS ANGELES — Hirsutism may be the most reliable way to recognize polycystic ovary syndrome because excess hair is so common with the condition.

But be sure that the patient truly has hirsutism and not just hypertrichosis, Dr. Ricardo Azziz said at a meeting of the Obstetrical and Gynecological Assembly of Southern California.

Hirsutism is more than a cosmetic problem. It is a sign of the single most common endocrine abnormality today, polycystic ovary syndrome (PCOS), a condition with significant morbidity and mortality, he said.

"There is a myth that perhaps the most common cause of hirsutism is idiopathic hirsutism, and that is incorrect," said Dr. Azziz of the Center for Androgen-Related Disorders at Cedars-Sinai Medical Center, Los Angeles. "The vast majority of women with hirsutism will have a disorder."

Hirsutism affects 7% of women, Dr. Azziz said. He reviewed records for 873 untreated women with known androgen excess and 659 untreated women who presented with hirsutism. Among the women with androgen excess, 76% had hirsutism, and 85% of those presenting with hirsutism had a defined androgen disorder. The most common androgen disorder, found in 78% of the 659 women who presented with hirsutism, was PCOS.

PCOS is a diagnosis of exclusion, Dr.

Azziz said. Fortunately, tumors of the adrenal glands and the ovaries only occur in hirsute women at about the same rate as in the general population, according to his large series of patients.

Ninety-five percent of tumors are detected clinically, not by androgen testing, he said.

For ruling out other conditions, the history—Are the signs and symptoms new or established?—and physical examination—Is the patient cushingoid?—are key, he said.

Hirsutism needs to be distinguished from hypertrichosis, he said. Many women have fine, downy, villous hairs. But hirsutism requires terminal hairs—hairs more than 5 mm in length, with a hard core, often curly or pigmented—arranged in a male pattern.

If one looks for terminal hairs only on the chin and the belly, one will miss many cases of hirsutism. That's in part because those are the areas many women can see and pluck or shave, Dr. Azziz said.

"The most common mistake examiners make is that they don't do an undressed full-body exam," he said.

He uses a modified Ferriman-Gallwey scale to rate hairiness in male-pattern areas, which does not include the lower arms and legs, where many nonhirsute women are hairy.

Once a physician gets acquainted with

using the scale, it can be quite helpful, particularly since laboratory measurements of androgen levels are quite unreliable because the normal range is so great, he said.

"If you do it in all the patients, over time, your data will be reliable within your practice," he said.

Medical therapy generally needs two arms, blocking androgen production and blocking its activity, according to Dr. Azziz.

The best approach to blocking androgen production is an oral contraceptive.

Many endocrinologists recommend metformin for hirsutism. But metformin has a less direct effect on androgen production than an oral contraceptive, and its efficacy for hirsutism is "modest" at best, Dr. Azziz said.

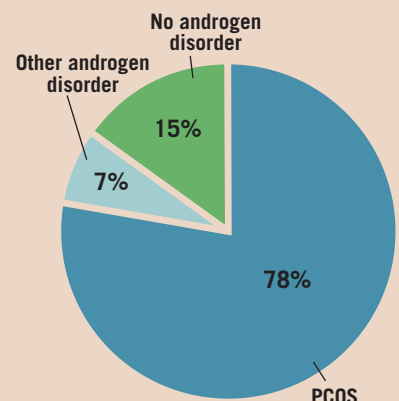
Glucocorticoids should not be used because they induce insulin insensitivity and therefore can worsen the metabolic profile of patients with hirsutism.

In addition to inhibiting androgen production, treatment should block androgen activity also, because the hair follicles are already sensitized. Available medications include spironolactone, flutamide, and finasteride.

Of those, Dr. Azziz said he most often uses spironolactone, starting at a dose of 25 mg/day and escalating, if necessary, up to a maximum of 200 mg/day. Most patients will adjust and become tolerant to the diuretic effect of the medication.

Treated individuals need to have patience, he noted. When patients are treat-

Most Women With Hirsutism Have an Androgen Disorder



Note: Based on a study of 659 untreated women with hirsutism.
Source: Dr. Azziz

ELSEVIER GLOBAL MEDICAL NEWS

'There is a myth that perhaps the most common cause of hirsutism is idiopathic The vast majority of women with hirsutism will have a disorder.'

Awaited Bone Guidelines Target Broader Group for Therapy

BY BARBARA J. RUTLEDGE
Contributing Writer

Updated guidelines slated for release this year should make it easier for physicians and patients to manage osteoporosis and make informed treatment decisions, according to Dr. Bess Dawson-Hughes, director of the bone metabolism laboratory at Tufts University, Boston.

"We are under increasing pressure to develop ways to better identify those patients who will benefit most from treatment," Dr. Dawson-Hughes said at the annual meeting of the International Society for Clinical Densitometry in Tampa.

The National Osteoporosis Foundation (NOF) is revising its Physician's Guide to Prevention and Treatment of Osteoporosis to incorporate a new World Health Organization (WHO) algorithm that evaluates absolute fracture risk.

Absolute fracture risk is easier for patients to understand than are T scores or z scores, so the phrase "Know your fracture risk" will replace "Know your T score" as the message for patients. The use of absolute fracture risk should allow patients to consider



'We are under increasing pressure to develop ways to identify patients who will benefit from treatment.'

DR. DAWSON-HUGHES

their osteoporosis risk in the context of other chronic disease risks, and to facilitate better decision making concerning osteoporosis treatment, she said.

The need for the updated algorithm is largely to expand treatment to those women who do not clearly have osteoporosis and for whom there has not been

a consensus about when to treat—that is, primarily those postmenopausal women whose dual-energy x-ray absorptiometry (DXA) T score is between -1.5 and -2.5. Dr. David L. Kendler, president of the International Society for Clinical Densitometry, explained at the annual meeting of the American Association of Clinical Endocrinologists.

Evidence shows that half or more of low-impact fractures actually occur in this group, he said. In the current NOF guide, treatment is recommended for all postmenopausal women with prior fracture; for postmenopausal women with a T score below -2 and no risk factors; and for postmenopausal women with a T score below -1.5 if they have at least one risk factor.

By comparison, "the [draft] WHO algorithm accounts for

the impact of risk factors and for the interactions among risk factors. This is a sophisticated and advanced use of risk factor information," Dr. Dawson-Hughes said, adding that an advantage of the upcoming NOF guide is that it will better utilize the individual's risk profile to predict fracture.

The new algorithm is based on data from 60,000 subjects. It will enable a physician to estimate a woman's 10-year risk of fracture on the basis of her femoral-neck T score and/or body mass index, together with a number of risk factors. So far, a 12% 10-year risk warrants treatment, although the exact percentage risk that will be used will probably vary by country, Dr. Kendler said.

Corticosteroid use and other secondary causes of osteoporosis are included in the new NOF guide; they are not in the current one, which was issued in 1999. The risk factors are also handled differently, explained Dr. Daw-

son-Hughes, who is the immediate past president of the NOF.

A case in point: A 60-year-old woman who went through menopause at age 52 and who was not on hormone therapy would have a femoral-neck T score of -1.6.

According to most current osteoporosis guidelines, treatment would not be advised. However, according to the draft WHO algorithm, because she is a smoker and her mother had a hip fracture, her 10-year risk of fracture is actually 15%, and therefore treatment would be warranted, Dr. Kendler said.

The algorithm, which is being developed by Dr. John Kanis of the WHO Collaborating Centre for Metabolic Bone Diseases at the University of Sheffield (England), is expected to be finalized and released this year, Dr. Kendler added.

Timothy F. Kirn of the Sacramento Bureau contributed to this report.