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“Hot topics” na saúde da mulher

Terapêutica hormonal, fragilidade óssea
e outros assuntos candentes

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Sharon tem indicação para terapêutica hormonal porque tem sintomas vasomotores, a menopausa é recente e tem <60 anos. Adicionalmente, a TH reduzir-lhe-á o risco de osteoporose e de doença coronária.

Indicações para tratamento hormonal (TH)

1. Alívio dos sintomas vasomotores
2. Alívio da sintomatologia urogenital (requer tratamento de longo prazo)
3. Prevenção da osteoporose

- ✓ Idade inferior <60 anos
- ✓ Menopausa há <10 anos

Contra-indicações relativas para tratamento hormonal

1. Passado de cancro da mama
2. Passado de cancro do endométrio
3. Porfíria
4. Doença hepática activa
5. Hipertrigliceridémia
6. Doença tromboembólica
7. Hemorragia vaginal não esclarecida
8. Endometriose
9. Fibromiomas uterinos

**Avaliação do risco fracturário nas
mulheres na pós-menopausa**

FRAXPOR

Idade ≥ 60 anos

**1.5 milhões de mulheres em Portugal
com ≥ 60 anos**

Score T

Compara a densitometria de um dado indivíduo com o valor médio de indivíduos jovens normais. A diferença, o Score-T, representa o número de desvios-padrão acima ou abaixo da média do adulto jovem.

Ex: um score de -3.2 significa que a DMO do doente está 3.2 desvios-padrão abaixo do valor médio de adultos jovens. O limite da normalidade é um desvio-padrão abaixo do valor médio.

Categoria	Score-T
Normal	-1.0 ou menos
Baixa massa óssea	-1.0 a -2.5
Osteoporose	-2.5 ou mais
Osteoporose grave ou estabelecida	-2.5 ou mais e fratura por fragilidade óssea

Vitamin D and calcium supplementation in primary care: an update

KEY PRACTICE POINTS

- Most people can achieve adequate levels of vitamin D through exposure to sunlight
- Vitamin D supplementation should be reserved for frail older people or those at risk of deficiency; routine supplementation for the general population is not recommended
- There is no evidence of vitamin D toxicity at doses recommended to treat mild deficiency, although this practice may increase the risk of renal tract stones
- Testing vitamin D levels is rarely beneficial for patients, is expensive and often unreliable; in most cases deficiency is likely to be a consequence of poor health rather than a cause
- Encourage an increase in dietary calcium before considering calcium supplementation, i.e. two to three serves of dairy products a day

In 2011, bpac^{nz} produced guidance on vitamin D supplementation for primary care. In the past five years vitamin D use has risen substantially and it is now the 12th most frequently prescribed medicine in New Zealand. Previously, prescribing vitamin D on the basis of deficiency risk was recommended, without testing. This is still broadly considered best practice, however, it is now more evident which groups of patients are likely to benefit from supplementation. Dietary calcium should be optimised in people taking vitamin D supplements, but routine supplementation with calcium is not recommended. Despite the growing number of studies reporting associations between vitamin D deficiency and non-skeletal diseases, there remains no convincing evidence of a causal link from meta-analyses or randomised controlled trials.



For further information on vitamin D, see: www.bpac.org.nz/BPJ/2011/june/vitamin-d.aspx

Sunlight is the preferred source of vitamin D

People derive approximately 80% of their circulating vitamin D from the ultraviolet B (UV-B) rays in sunlight.¹ Most healthy people can achieve adequate vitamin D levels by spending time outdoors during the day. Skin needs to be exposed to direct sunlight to allow the synthesis of vitamin D to occur as glass blocks UV-B rays.

How much sunlight is enough?

To prevent vitamin D deficiency, a daily walk in the early morning or late afternoon from September to April in the Southern hemisphere with face, arms and hands exposed is recommended.¹ At the height of summer as little as six to eight minutes of sun exposure may be sufficient to produce 1000 IU of vitamin D.² From May to August outdoor activity is best scheduled around noon as approximately 30 – 50 minutes of sun exposure is required to produce the same amount of vitamin D.^{1, 2} Dark skin pigmentation is correlated with decreased rates of vitamin D production and people with darker skin may require three to six times more sun exposure to achieve equivalent levels of vitamin D production.² It is not possible to develop vitamin D toxicity due to exposure to sunlight.¹

Risk factors for vitamin D deficiency

Groups considered to be at high risk of vitamin D deficiency and who may benefit from supplementation include people:¹

1. With very dark skin pigmentation
2. Who completely avoid the sun for medical reasons, e.g. they have had skin cancer or are using photosensitising medicines long-term
3. With reduced mobility who are frail or housebound and at risk of musculoskeletal pain and osteomalacia

Oral calcium supplements may be associated with adverse effects

Serum calcium levels are slightly elevated in the short term by taking oral calcium supplements.⁷ People who ingest an equivalent amount of calcium from their diet do not experience the same elevations in serum calcium.⁷ Since vascular calcification is an established risk factor for cardiovascular disease it has been suggested that calcium supplementation may increase cardiovascular risk.⁷

Calcium supplementation is known to be associated with increased rates of:²⁰

- Renal tract stone formation
- Constipation
- Gastrointestinal symptoms
- Cardiovascular events, including myocardial infarction

A 2015 meta-analysis concluded that due to the limited benefits of calcium supplementation and the increased risk of relatively serious adverse events, calcium supplements should not be recommended for individuals or at a population level.²⁰

The benefits of supplementation on bone health and falls prevention have been overstated

More than 50 meta-analyses have examined the effects of vitamin D on falls or fractures.⁶ This research now confirms that vitamin D supplementation for the general population provides no benefit and is a waste of resources. Key findings from studies include:

- The United States Preventative Services Task Force concluded, in 2013, that daily supplementation with 400 IU (10 micrograms) of vitamin D₃ and 1000 mg of calcium has no effect on fracture incidence in post-menopausal women.⁷
- A meta-analysis involving more than 50 000 participants concluded that vitamin D taken without calcium has no effect on fracture incidence and that vitamin D taken in combination with calcium has weak and inconsistent effects on fracture risk; benefits were restricted to frail, older females living in institutions.⁸
- Analyses of randomised controlled trials involving almost 30 000 participants found that vitamin D with or without calcium has no effect on the risk of falls.⁸