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How to tailor progestin use to individual needs in the post-menopause

R Sitruk-Ware (US) [1]

Progesterone and progestins have been approved for the prevention of endometrial hyperplasia in postmenopausal hormonal replacement therapy (HRT) regimens. Since the publication of the Women's Health Initiative (WHI) study the role of hormonal therapy in postmenopausal women (PMW) has been further challenged. The risks attributed to the progestins have been overestimated and wrongly extrapolated to the whole class of compounds. A trend is now observed to use non-oral estradiol and natural progesterone, based on the assumption that a neutral metabolic profile would be more favorable on cardiovascular and venous risk.

Non-oral routes of administration may avoid some side-effects of systemic administration of progestins. P can be delivered vaginally from a gel or a ring. A first uterine pass effect of vaginal delivery of P results in high local uterine concentration with little systemic distribution. Levonorgestrel delivered at low doses from an intra-uterine system (IUS) targets also a local endometrial effect.

Although guidelines recommend P use only in women with a uterus, other reasons justify its use also for women without uterus. Indeed, Progesterone and Nestorone induced neuroregeneration, myelin repair and neurosteroids are currently studied for prevention or repair of Alzheimer's disease. Tailoring P use to women's preferences and estrogen therapy doses is recommended.

[1] Population Council, NEW YORK