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Insomnia and menopause: a narrative review on mechanism and treatment

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Increased frequency of sleep disturbances was noted in perimenopausal transition. Among these, insomnia is one of the most common symptoms. According to its pathogenetic model (3-P Model), different predisposing factors (i.e. a persistent condition of past insomnia and aging) increase the risk of insomnia during menopause. There are multiple precipitating and perpetuating factors favoring perimenopausal insomnia, like hormonal changes, menopausal vasomotor symptoms, and will be reviewed here.

Since perimenopausal insomnia is associated with several underlying factors, management would rely on meticulous evaluation of the psychological and somatic symptoms of the individual menopausal woman. Drugs and behavioral interventions will be options of therapeutic strategies. Cognitive behavioral therapy represents the first-line treatment of insomnia patients and its efficacy in the general population is well known from multiple controlled trials. Drugs as antidepressants, BZDs, Gabapentin are shown helpful in insomnia severity. However, when vasomotor symptoms are present, menopausal hormone therapy should be considered in the treatment of related insomnia taking into account the risk-benefit profile. Finally, given its good tolerability, safety, and efficacy on multiple sleep and daytime parameters, prolonged-released melatonin should represent a first-line drug in women aged ≥ 55 years.

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The Association between Hormone Therapy and Sarcopenia in Postmenopausal Women

Sarcopenia is defined as the presence of low muscle quantity or quality and low muscle strength. Sarcopenia is associated with aging process and significantly increases the risks of falls, fractures, disability, functional impairments, and mortality. The etiology of sarcopenia is multifactorial, such as the aging process, nutrients, social and lifestyle behaviors, and age-related hormonal, neurological, immunological and metabolic factors. The prevalence of sarcopenia in women increases around the age of 50. Thus, the role of menopause in the development of sarcopenia can be hypothesized. Postmenopausal hormone therapy is also considered to play a protective role in the development and progression of sarcopenia.

The aim of this presentation is to discuss the following issues:

1. Definition, prevalence, and influence of sarcopenia.
2. The role of menopause in the development of sarcopenia.
3. Effect of menopausal hormone therapy on muscle mass and muscle strength.
4. Prevention Strategies for Sarcopenia during the Perimenopause & Postmenopause.

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Management of urinary incontinence in postmenopausal women: An EMAS clinical guide

The prevalence of urinary incontinence and of other lower urinary tract symptoms increases after the menopause and affects between 38 % and 55 % of women aged over 60 years. While urinary incontinence has a profound impact on quality of life, few affected women seek care.

Healthcare professionals should consider urinary incontinence a clinical priority and develop appropriate diagnostic skills. They should be able to identify and manage any relevant modifiable factors that could alleviate the condition. A wide range of treatment options is available. First-line management includes lifestyle and behavioral modification, pelvic floor exercises and bladder training. Estrogens and other pharmacological interventions are helpful in the treatment of urgency incontinence that does not respond to conservative measures. Third-line therapies (e.g. sacral neuromodulation, intravesical onabotulinum toxin-A injections and posterior tibial nerve stimulation) are useful in selected patients with refractory urge incontinence. Surgery should be considered in postmenopausal women with stress incontinence. Midurethral slings, including retropubic and transobturator approaches, are safe and effective and should be offered.

Successful treatment depends on accurate diagnosis of the type of incontinence, identification and treatment of any modifiable contributing factors and a personalized therapeutic approach. Specialist referral is mandatory for the management of complex cases. Effective and personalized care of urinary incontinence should be a healthcare priority so that women do not suffer unnecessarily from this common debilitating condition.

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Managing vasomotor symptoms effectively without hormones

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Approximately 80% of women experience vasomotor symptoms (e.g., hot flashes and night sweats) during the menopause transition, which can affect quality of life. In women who require relief from these symptoms, systemic estrogen-containing products remain the therapeutic standard for moderate to severe symptoms. However, some clinical trials have associated ET/EPT with adverse effects, including breast cancer, stroke, and thromboembolism. Clinicians are advised to involve women in the decision-making process when weighing the benefits, harms, and scientific uncertainties of therapeutic options. Clinical trial results for nonprescription remedies, such as soy foods and isoflavone supplements, are insufficient to either support or refute their efficacy; however, no serious side effects have been associated with the short-term use of these therapies. Recommended options for women with concerns or contraindications relating to estrogen-containing treatments include prescription progestogens, venlafaxine, paroxetine, fluoxetine, and gabapentin. Oxybutynin chloride is an antimuscarinic, anticholinergic agent with antispasmodic activity and is known to cause urine incontinuity. In a randomized, double-blind clinical trial of vasomotor symptoms in women with or without breast cancer, Oxybutynin is an effective and relatively well-tolerated treatment option. Fezolinetant is a neurokinin 3 receptor antagonist that blocks neurokinin B (NKB) signaling, thereby normalizing the dynorphin (KNDy neurons) activity in the thermoregulatory center of the brain. In a phase 2b, dose-ranging clinical trial (VESTA), Fezolinetant significantly reduced the frequency and severity of moderate-to-severe vasomotor symptoms compared with a placebo in postmenopausal women. This talk reviews evidence regarding the efficacy of nonhormonal treatments for vasomotor symptoms, including pharmacological and nonpharmacological approaches. We also provide clinical suggestions for symptom management.