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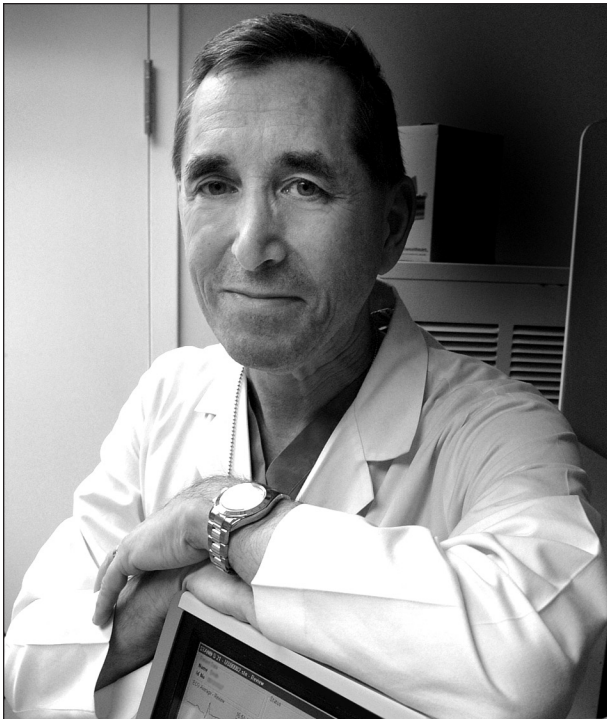
*The Journal of
Reproductive Medicine[®]*

Volume 62, No. 7-8/July-August 2017

A Note from the Editor-in-Chief

Lawrence D. Devoe, M.D.

Welcome to the July-August 2017 Editor-in-Chief's page. This editorial column focuses on two reports included in this issue that share a common theme: the impact of obesity on reproduction.



Lawrence D. Devoe, M.D., Editor-in-Chief

In This Issue

- ***Changes in Menstrual Cycle in Patients Undergoing Bariatric Surgery***
S. Bhandari, P. Agrawal, I. Ganguly, A. Singh, and M. Bhandari

This study addresses the postoperative impact of bariatric surgery on menstrual function in morbidly obese (≥ 35 kg/m²) women. After 1 year's follow-up 42% of reproductive-aged women noted a return to regular menses, while only 7% experienced irregular cycles. The authors opine that, for a select group of morbidly obese women seeking restoration of regular menses, bariatric surgery may be an effective option and constitute another indication for such procedures.

- ***Body Mass Index Does Not Affect Suppression of Hyperandrogenism but Does Impact Carbohydrate Metabolism During Low-Dose Folate-Supplemented Ethinyl Estradiol/Drospirenone Oral Contraceptive Therapy in Women with Polycystic Ovary Syndrome***
K. E. Elkind-Hirsch, M. Paterson, E. Seidemann, and H. Gutowski

The authors studied a small group of patients with polycystic ovary syndrome (PCOS) divided into normal BMI, overweight (BMI ≥ 25 and < 30),

and obese (BMI ≥ 30). Before and 24 weeks after administering a course of folate-supplemented ethinyl estradiol–drospirenone (EE/DRSP), the patients had a battery of serum analytes determined: DHEAS, T, SHBG, free androgen index, lipids, folate, and glucose levels (after a standard glucose load). The results indicate that after receiving oral contraceptives (OCs), BMI was not related to the normalization of the menstrual cycle or effects on androgen levels. Obese subjects experienced decreased insulin sensitivity and β -cell function as compared to nonobese PCOS subjects. This study suggests that, regardless of BMI, while PCOS patients with irregular menses may benefit from OC administration, such treatments should be applied more cautiously in obese patients due to observed effects on glucose metabolism.

Editorial Comment

For more than two decades the obgyn community has expanded its focus on the growing rate of obesity and its impact on women's health. Management of obesity is problematic because there are many contributing factors including genetic predisposition (e.g., leptin resistance), unhealthy diet and lifestyle, and acquired medical conditions that can alter carbohydrate and lipid metabolism. Preventive measures have been shown to have had limited effects to stem the tide of this widespread public health problem. Conversely, there has been considerable attention paid to after-the-fact medical and surgical management. Typically, patients seeking to lose weight and improve their health status are directed to conservative approaches that include specialized dietary programs coupled with exercise routines, support groups, and regular monitoring of patient progress to specific weight-loss goals. While conservative approaches work for some patients, the aggregate of prospective studies show that long-term results, i.e., the degree and maintenance of weight loss, have been disappointing for many.

Surgical approaches to weight loss have been employed with increasing success and decreasing

ing morbidity, making them safer and more effective for more patients. Although those considering gastric bypass or sleeve procedures must undergo extensive counseling and demonstrate that more conservative measures have failed, the general eligibility criteria have been expanded, most recently to include type II diabetes coupled with BMI > 35 . As the first manuscript suggests, bariatric surgery may address a significant issue for obese patients, i.e., menstrual irregularities that may also be associated with involuntary infertility. While it is quite premature to consider such procedures as frontline treatment for this indication alone, as such surgeries still carry significant perioperative risks, they are often associated with other obesity-related medical problems that bariatric surgery can improve. The second article looks at a different aspect of obesity, in this case, its association with the polycystic ovary syndrome that confers a significantly increased risk for this condition. Even in patients not seeking pregnancy, irregular menses associated with infrequent ovulation may result in a higher risk for unopposed estrogen exposure that, in turn, increases the risk for endometrial hyperplasia and cancer. An important takeaway is that a program of oral contraceptives may effectively return obese patients to "regular" menses and reduce the risk associated with higher levels of naturally occurring estrogens. This approach should be tempered by the impact of oral contraceptives on the metabolic profile of such patients and possible increased risk of venous thromboembolism.

In summary, there is definitely no one-size-fits-all approach to preventing obesity or managing this condition once it is established. It is becoming more obvious that the earlier in the life cycle that susceptible individuals can be identified, the greater the potential for interventions now and in the future that may stem the tide of what, with two-thirds of our population overweight or obese, has now become the biggest health problem for our patients.