Hirsutism Often Not Skin Deep; Look for Disorders

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 an- drogen 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 a 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 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 their overall condition in the context of other chronic disease risks, and to facilitate better de- cision making concerning osteo- porosis treatment, she said.

The need for the updated al- gorithm 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 bone mineral density test (DEXA) T score is between –1.5 and –2.5, Dr. David L. Kendler, president of the Inter- national Society for Clinical Den- trosclerosis, explained at the annual meeting of the American Associa- tion of Clinical En- docrinologists.

Evidence shows that half or more of low-im- pact fractures actually occur in this group, he said. In the current NOF guide, treatment is rec- ommended 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 fac- tors. This is a sophisticated and advanced use of risk factor in- formation,” Dr. Dawson-Hughes said.

Dawson-Hughes added that an advantage of the upcoming NOF guide is that it will better utilize the in- dividual’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 algorithm, which is being developed by Dr. John Kanis of the WHO Collaborating Centre for Metabolic Bone Diseases at the University of Sheffield (Eng- land), is expected to be finalized and released this year, Dr. Kendler added.

About 15% of patients will have a good response with combination therapy.

In the meantime, good options for the patient include shaving and eflornithine HCL (Vaniqa), although eflornithine is approved only for use on the face, and it is not known what effect greater application might have.

Plucking is probably not a good idea, said Dr. Azziz, because it can cause folliculitis. Waxing removes hair, but it is essentially like plucking and does not de- stroy the hair follicle, except when it is used long term.