

**INV23****Cardiovascular health management: preventive assessment**

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Cardiovascular disease (CVD), the leading cause of death among men and women, represents a significant women's health concern. While the majority of cardiovascular prevention guidelines are similar for men and women, there is growing appreciation that there may be sex differences in the magnitude of relative and absolute benefits and harms of preventive interventions. For instance, while aspirin is associated with a reduction in the risk of CVD events in both men and women, the specific types of benefit appear to differ by sex, with some evidence that aspirin therapy lowers myocardial infarction risk in men (but not women), and ischemic stroke risk in women (but not men). Sex-specific risk assessment may be particularly well established in a primary prevention setting. Race, education, waist circumference, waist/hip ratio, typical angina, family history of CAD, high stress, lipids, fasting blood sugar, anemia, insulin, insulin resistance (Homeostasis Model Assessment, HOMA) are particularly important in women together with peculiar risk factors related to pregnancy, early menopause, autoimmune diseases and hypoestrogenism. Comparing to men the most predicting CV risk factors appear to be older age, hypertension, history of diabetes, history of smoking, higher triglycerides, and lower Glomerular filtration rate. Regarding Lipoprotein A in the Women's Health Initiative and the Juppiter trial cohorts of women Lp(a) was associated with CVD only among those with high levels of total cholesterol. Further, improvement in risk prediction was minimal in independent validation samples, suggesting that routine screening for Lp(a) may have limited utility in women in primary prevention. The carotid intima-media thickness (cIMT) is widely used to define vascular age. The cIMT tends to be thinner in women than in men, although the evidence to support this finding is controversial. Unfortunately it is only a surrogate marker for atherosclerosis, whereas CT derived coronary calcification as well as, also in our experience, breast artery calcifications, appear to be a valid index of early atherosclerosis. Finally C Reactive Protein appear to be an interesting marker in women in specific situation in our experience.

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**INV24****Statins for the treatment of hypercholesterolaemia in post menopausal women - solution or problem?**

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Studies have demonstrated that statins reduce cardiovascular risk in men and women, but the effectiveness of statins among low-risk women continues to be contentious. One reason is that the number of women enrolled in statin trials has been small relative to men, limiting statistical inferences. Also, for any given age women have a lower absolute risk of cardiovascular disease when compared to men. When absolute benefit is low, the risk of adverse effects becomes more important. Myopathy and rhabdomyolysis are rare but established side-effects of statin therapy, and concern

is growing that statins could increase the risk of development of diabetes mellitus.

Clinicians should be encouraged to assess baseline risk to help guide decisions about starting statins. This applies to primary prevention, as there is no contention in the secondary prevention setting where statins in women have established 1A clinical evidence for their effectiveness.

Simple tools to assess absolute risk in postmenopausal women should be encouraged and will be discussed in the session. If risk is accurately assessed, then sex-based disparities will be minimized and women are likely to benefit with a reduction in future cardiovascular events.

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**INV25****MHT in myocardial infarction and stroke survivors**

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30 years ago, it was believed that there is a clear cut protective effect of estrogen in women with coronary artery disease. This was based on studies that monitored the outcomes of postmenopausal hormone therapy (MHT) in women with various basal clinical scenarios, such as myocardial infarction, coronary angiography or coronary artery bypass. These studies were observational, and treatment usually comprised of conjugated equine estrogen alone or combined with medroxyprogesterone acetate. However, results of randomized, placebo-controlled trials (secondary prevention, but mainly primary prevention) pointed at neutrality or even harm in hormone users. Taking into account the known association of MHT with increased risk for stroke and thromboembolism, this became an important factor in the clinical considerations prior to prescribing MHT. Since the beginning of this millennium, guidelines for MHT turned against using it in the set-up of either secondary prevention of cardiovascular (CV) disease, or in women with a history of CV event, resulting in shutdown in initiation of new large-scale studies in such cohorts. Although we are aware today of the impact of age, dosage, type of hormone (for example different thrombogenicity of transdermal estrogen) on CV risk-benefit equation, there are no relevant data in recent years that could provide ammunition to challenge the current recommendation against MHT in women who suffered a CV event.

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Society Symposium: German-Chinese Society of Obstetrics and Gynecology e.V.: German-Chinese cooperation projects in research and clinic

**INV26****Osteoporosis and breast cancer: pathogenesis, diagnosis and treatment**

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Osteoporosis is one of the most frequent diseases in postmenopausal women leading to an increased fracture risk due to the physiologic loss of the bone protective effects of estrogen. Hereby, several risk factors for fracture such as prevalent frac-