Low testosterone levels are associated with endothelial dysfunction in oophorectomized early postmenopausal women

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Abstract

Background: The actual consequences of low testosterone levels in women remain uncertain.

Objective: To assess endogenous testosterone influence on body composition, vascular and metabolic function in recent postmenopausal women.

Design: We studied 81 postmenopausal women under transdermal estradiol (E 2) replacement therapy, 36 with bilateral oophorectomy (group O), and 45 controls (group C) through venous occlusion plethysmography, bioimpedance, DEXA, biochemical, hormonal, and inflammatory profile.

Results: Total testosterone level (TT) in group O was 11.0 (4.0–17.75) vs 23.0 (10.0–42.5) ng/dl in group C (P < 0.001). Forearm blood flow, in ml/min/100 ml tissue, was lower in group O compared to group C at baseline (1.57 (1.05–2.47) vs 2.19 (1.59–2.66) P < 0.036), following reactive hyperemia response (endothelium-dependent flow mediated dilatation, 3.44 (2.38–4.35) vs 4.3 (3.09–5.52), P = 0.031) and following nitroglycerin (endothelium-independent dilation, 1.39 (0.99–1.7) vs 1.76 (1.15–2.0), P < 0.025), with a positive correlation between TT and all parameters except for the reactive hyperemia response (r = 0.233–0.312, P = 0.036–0.004). The sVCAM1 levels were negatively correlated with TT (r = −0.320, P = 0.005). E2 and other hormone levels, biochemical parameters and body composition did not differ between groups. Multiple linear regressions showed that the levels of TT, compared with other confounding variables, may explain the variation observed on endothelial parameters, with low explanatory power.

Conclusion: The absence of ovarian testosterone production in recent postmenopausal oophorectomized women was associated with deleterious effects on endothelial function.

Introduction

A pronounced decline in estradiol (E2) levels follows menopause, a known risk factor for cardiovascular diseases (1). Data from experimental and clinical studies have shown a relationship between estrogen decay and endothelial dysfunction (2), the first and most precocious marker of atherosclerotic process, (3). Testosterone levels show less pronounced descent (2–4 times), compared with estrogens (16 times) (4) because postmenopausal ovaries continue to produce testosterone. This phenomenon elicits a relative hyperandrogenism in women who experience natural menopause. Oophorectomized women (O), on the other hand, go through a different scenario, in which both E2 and testosterone decline occurs abruptly.

The actual ovarian role after natural menopause and the consequences of low testosterone levels in oophorectomized women, especially regarding vascular health and body composition, have not been thoroughly studied.
This subject might influence the decision to perform ‘prophylactic’ bilateral oophorectomy during hysterectomy, a practice that has increased in the last decades (5), based on concepts that postmenopausal ovaries are not major hormone producing glands and on concerns about risk of ovarian cancer, a type of malignancy usually diagnosed in advanced stages, famed by difficult screening (6) and low survival rates (7).

Besides, the interest on testosterone therapy in women with low libido complaints has grown in the last few years, while cardiovascular consequences remain unclear. Our hypothesis is that low levels of testosterone in oophorectomized women, compared with women in natural menopause, could be associated with poor endothelial function. So, in this investigation we aimed to compare oophorectomized to naturally postmenopausal women, all under estrogen therapy, to determine if testosterone produced by early postmenopausal ovaries influence vascular function assessed by venous occlusion plethysmography, a well-validated method that measures blood flow at baseline and after endothelial nitric oxide production during the reactive hyperemia response. We believe that understanding the mechanisms and possible risks and benefits of endogenous testosterone is essential to decide for developing or disregarding testosterone therapies, and to know to which postmenopausal women they should be considered.

Subjects and methods

Study population

Eighty-one postmenopausal patients were studied, 36 with bilateral oophorectomy from etiology other than hormone-dependent cancer (group O) and 45 with both ovaries (group C), all with no more than 10 years of hypoestrogenism, and adequately compensated from climacteric symptoms by estrogen therapy.

Exclusion criteria were unilateral oophorectomy, contraindications to hormone therapy (previous or current history of breast or endometrial cancer; vaginal bleeding of unknown cause; serious or recent hepatobiliary disease; and thromboembolic, cerebral, or heart ischemic disease), history of polycystic ovary syndrome, or severe acne or hirsutism in reproductive years; users of glucocorticoids, antiandrogenic agents, phytoestrogens, smokers; diabetes using oral hypoglycemic agents or insulin, hypertension not adequately controlled with medication or use of calcium channel blockers or decompensated hyper or hypothyroidism.

Patients were recruited through sample convenience from menopause clinics at Hospital Federal da Lagoa (HFL) and Instituto Estadual de Diabetes e Endocrinologia (IEDE) during their routine appointment with a doctor. The objectives, exams, risks, and benefits of the investigation were explained and those who agreed to participate signed the Term of Consent Agreement for the research project approved by IEDE Ethics Committee (01/2013).

Women taking oral estrogen had their treatment modified to percutaneous E2 gel (Estreva gel) for at least 1 month, in a dose equivalent to prior therapy, while those already in use of E2 gel maintained the same medication and dose. When symptoms of hypoestrogenism were properly compensated (based on clinical evaluation, by patient-oriented subjective score of hot flashes equal or <3 in a scale from 0 to 10) (8), they initiated the study procedures. The ones not compensated had their E2 gel dose adjusted and were monthly evaluated until they could start. If the patient had uterus and was using a progestin, it was temporarily interrupted, no longer than 3 months, to standardize the hormone therapy (HT) during the study. These women received 200 mg daily of micronized progesterone for 14 days after the conclusion of the study, when all returned to previous HT prescribed at their original clinics.

Data collection

Clinically compensated patients were instructed to perform a blood test at IEDE laboratory dosing serum levels of E2, estrone, androstenedione, FSH, TT, SHBG and albumin, DHEAS, complete lipid profile, fasting glucose, and insulin.

Fasting glucose, total cholesterol, triglycerides (TG), and HDL-c levels were analyzed by enzyme-colorimetric assay using Hitachi cobas c 701/702 systems, Roche Diagnostics GmbH). Glucose’s detection range was 2–750 mg/dl; intra and inter-assay coefficient of variation (CV) were <0.9 and <1.4% respectively. Total cholesterol’s detection range was 2.86–800 mg/dl; intra and inter-assay CV were <0.9 and <1.7% respectively. HDL-c’s detection range was 3–120 mg/dl; intra and inter-assay were CV <0.9 and <1.6% respectively. Triglycerides’ detection range was 8.85–885 mg/dl; intra and inter-assay CV were <1 and <2.1% respectively. Androstenedione was performed by competitive chemiluminescent enzyme immunoassay (IMMULITE 2000 analyzer, Siemens Medical Solutions Diagnostics, Los Angeles, CA, USA). The detection range was 300–1000 pg/ml; intra and interassay CV were <11.4 and <13.3% respectively.
DHEAS was performed by electrochemiluminescence (Elecys 2010 and cobas e 411, 601 and 602 analyzers, Roche Diagnostics GmbH). Detection range was 0.100–1000 pg/dl; intra and inter CV were <2.9 and <4.8%, respectively. Estrone was analyzed by competitive immunoassay (Diagnostics Biochem Canada, Inc., Ontario, Canada) and the limit detection value was 10 pg/ml; intra and inter CV were <9.2 and <11.8% respectively. E2, testosterone, FSH, and insulin were performed by electrochemiluminescence immunoassay (MODULAR ANALYTICS E 170, Elecsys 2010 and cobas e 411, 601 and 602 analyzers, Roche Diagnostics GmbH). E2’s detection range was 5–3000 pg/ml; intra and inter CV were <8.6 and <12% respectively. Testosterone’s detection range was 0.72–432.2 ng/dl; intra and inter CV were <4.6 and <4.2% respectively. Validation tests are routinely performed in our laboratory upon kits opening. For testosterone, 20 samples were compared with determination of Pearson’s CV of 0.998, and in all tests the total error was lower than total allowable error for the method. FSH’s detection range was 0.1–200 mIU/ml; intra and inter CV were <5.4 and <2.9% respectively. Insulin’s detection range was 0.2–1000 μU/ml; intra and inter CV were <5 and 3.8% respectively. LDL-C, HOMA IR, free and bioavailable testosterone were calculated (9, 10, 11) according to well-established methods.

During the same week, in previously scheduled day, patients attended the Laboratory for Clinical and Experimental Research in Vascular Biology (BioVasc) after 12 h fast, waited for at least 20 min in an acclimatized room and then proceeded to the examination room, where anthropometric evaluation was performed, comprising height, weight, waist (WC), and hip (HC) circumferences. Blood pressure assessment was carried out by two measurements with 10-min interval, with the mean of both being considered. WC was defined as the average of two measurements made after expiration horizontally at the midpoint between the last rib and iliac crest while HC was measured at the greatest width of the femoral trochanter (12). Waist hip ratio (WHR) was estimated, dividing WC by HC. Weight was measured with patients in light clothes, without shoes, in a high-precision digital scale (Filizola, São Paulo, SP, Brazil) and height was obtained from a wall stadiometer to calculate BMI, dividing body weight in kg by the square of height in meters.

Blood samples were collected and plasma stored at −80°C for later analyses of inflammatory biomarkers (adiponectin, lipocalin-2/NGAL (neutrophil gelatinase-associated lipocalin), adipsin and Plasminogen Activator Inhibitor 1 (PAI1) that were dosed by Milliplex, using MAP-Human Panel Adipokine Magnetic Bead 1 kit, reference HADK1MAG-61K (EMD Millipore Corporation, Billerica, MA, USA). The sample dilution factor was 1:400; with CV for intra and inter-assay of <3.75 and 3.49% respectively. GDF15 levels (Growth Differentiation Factor 15), MPO (Myeloperoxidase), Myoglobin, P-selectin (Platelet selectin) and Soluble Vascular Cell Adhesion Molecule-1 (sVCAM1) were evaluated by MAP kit Milliplex-Human cardiovascular disease (CVD) Panel 2 Magnetic Bead Kit, reference HCVD2MAG-67K, with dilution factor of 1:100, intra and inter-assay CV% <5.33 and <7.79% respectively. All tests were conducted using simultaneous analysis of multiple analytes in magnetic format; concentration of biomarkers was determined by correlation between fluorescence value of samples to ones used for standard curves generated by logistic fit, by data analysis program (Milliplex Analyst Software Vigene Tech EMD Millipore, Billerica, MA, USA).

After collecting blood, patient’s regional body composition and differentiated lean, fat and bone tissue components were evaluated at the Nutrition Evaluation Laboratory, UERJ, by (13) dual energy X-ray absorptiometry densitometry (DEXA, GE Healthcare, Lunar iDXA, precision of 0.9% for fat percentage, 0.8% for fat mass and 0.5% for lean mass) (14). The percentage of body fat was evaluated in total, as well as in android (A) and gynoid (G) distribution. Other evaluated parameters were fat mass, total lean mass and A/G rate. Adequate position of the patient at the scanner table, proper hydration status, fasting for solids and light clothing were observed (15).

Back to BioVasc, body composition was also analyzed by tetrapolar bioelectrical impedance to discriminate total content of lean and fat mass, by different impedances that water-rich (muscles, organs) or poor tissues (fat) have to electrical flow. Distal and proximal electrodes were fixed on the dorsal surface of the hands and feet with the individual in supine position (16). A low intensity alternating current (between 500 and 800 mA) originates from emitting electrodes and the current difference, caused by resistance and reactance, outline tissue impedance values.

Finally, patients underwent venous occlusion plethysmography of the brachial artery, a non-invasive method to study vascular function through baseline flows, response to reactive hyperemia (endothelium-dependent vasodilation) and nitroglycerin (endothelium-independent vasodilation). Briefly, patients were accommodated in the supine position at the examination room, with temperature between 22 and 25°C. Two pneumatic cuffs,
connected to Hokanson plethysmograph system (Bellevue, DC, USA), were placed, one around the left arm and another around the left wrist to isolate forearm circulation, as well as an elastic stretch mercury sensor, positioned at the largest circumference of the left forearm. Blood pressure was measured in the contralateral arm and heart rate continuously monitored by electrodes placed on the chest connected to the plethysmograph. The examination began with the reading of baseline flow rate (BF1). For ischemia, the arm cuff was inflated to 200 mmHg for 5 min and then deflated (17). Within 10 s, the cuff was inflated again, now to 50 mmHg. This pressure, higher than venous pressure and lower than diastolic blood pressure, causes selective interruption of venous flow and allows increased forearm blood volume in response to release from ischemia, similar to what occurs with physical exercise, since flow increases after ischemia (shear stress) stimulates endothelial release of nitric oxide. Flow measurements during the reactive hyperemia (RHF) response were recorded 10 s after ischemia release and during 2 min. The procedure was followed by 15-min interval and new baseline measurement (BF2). Subsequently, the patient received sublingual nitroglycerin (Nitrolingual BurnsAdler Pharmaceuticals, Inc., Charlotte, NC, USA), at a dose of 400 µg and after 5 min reactive nitroglycerine flow (RNF) measurement was performed to evaluate vascular response to a nitric oxide donor and, thus, the integrity of the vascular wall, which, together with endothelial function estimated by RHF, provide consistent data of global vascular function.

After plethysmography, patients received a snack and were released with recommendation to return to HT previously prescribed at their original clinic.

Statistical analysis

The descriptive analysis was expressed as median and interquartile range (25–75%), according to: i) comparison of clinical and laboratory variables between groups O and C by Student t-test for independent samples or Mann-Whitney test for numerical data and chi-square ($\chi^2$) or Fisher exact tests for categorical data and ii) association between numeric variables by Spearman correlation coefficient. Nonparametric methods were applied, due to dispersion of data and rejection of normality hypothesis of Shapiro-Wilks test. Multiple linear regression analysis was performed to assess simultaneous influence of testosterone in presence of confounding variables on endothelial function measurements. Variable selection process was ‘stepwise forward’ at the level of 5%. Logarithmic transformation was applied on endothelial function measurements (dependent variables) to homogenize variance. Explanatory variables considered were: testosterone levels, hormone replacement time, hypoenstrogenism time, BMI, waist circumference, DEXA, and E2 values. Statistical analyses were done with the Software SAS System, version 6.11 (SAS Institute, Inc., Cary, North Carolina, USA) and 5% was the level of significance.

Results

The whole sample comprised 81 postmenopausal women, median age 53.0 (50.0–56.5) years, who started HT at 51.0 (47.0–53.0) years, had maximum of 10 years of hypoenstrogenism and BMI of 28.0 (25.9–32.7) kg/m². When compensated, after at least a month of using percutaneous estrogen, their serum E2 levels were 52.7 pg/ml (from median applied E2 dose of 1 mg), FSH 47.86 mIU/ml, SHBG 54.0 nmol/l, and DHEAS 65.5 µg/dl.

Thirty-six patients had undergone bilateral oophorectomy for benign diseases, at 47.0 (41.3–50.0) years (group O), while 45 kept their two ovaries (group C).

The groups did not differ in age, BMI, WC, WHR, blood pressure, and heart rate (Table 1). However, group O had less time of hypoenstrogenism than group C (12.0 (6.0–48.0) vs 36.0 (12.0–60.0) months, $P=0.046$), reflecting earlier HT use in women that removed both ovaries. Although both groups had similar serum E2 levels, the dose of E2 gel needed to control climacteric symptoms was higher in group O compared with group C (1.5 vs 1 mg, $P=0.023$). Group O had fewer years of education than group C (8.0 (6.0–11.0) vs 11.0 (8.0–11.0), $P=0.028$).

Testosterone levels differed between groups: TT was 11.0 (4.0–17.75) in group O and 23.0 (10.0–42.5) ng/dl in group C ($P=0.001$). The same occurred with calculated free (0.136 (0.046–0.236) vs 0.350 (0.121–0.603) ng/dl, $P=0.001$), and bioavailable testosterone levels (3.21 (1.06–5.84) vs 8.2 (2.97–14.6) ng/dl, $P=0.001$). No statistically significant differences were found for other hormonal and metabolic variables (Table 1).

All parameters evaluated by venous occlusion plethysmography (BF1, RHF, BF2, and RNF) were significantly lower for group O compared with group C (Fig. 1).

The groups did not differ in body composition, either by densitometry through DEXA or bioimpedance (Table 2) nor in inflammatory biomarkers (Table 3).

Testosterone levels showed positive correlations with vascular flow at all stages of plethysmography except for the reactive hyperemia response ($r=0.233–0.312$, $P=0.001$).
Table 1  Clinical, hormonal and biochemical features of the groups. Data are presented as median and interquartile range (25–75%).

<table>
<thead>
<tr>
<th></th>
<th>Group O</th>
<th>Group C</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>53.0 (49.0–57.0)</td>
<td>53.0 (50.0–56.0)</td>
<td>0.89*</td>
</tr>
<tr>
<td>Education (years)</td>
<td>8.0 (6.0–11.0)</td>
<td>11.0 (8.0–11.0)</td>
<td>0.028*</td>
</tr>
<tr>
<td>E₂ gel used dose (mg)</td>
<td>1.5 (1.0–1.5)</td>
<td>1.0 (1.0–1.0)</td>
<td>0.023*</td>
</tr>
<tr>
<td>Age of menopause (years)</td>
<td>47.0 (41.3–50.0)</td>
<td>48.0 (46.0–51.0)</td>
<td>0.097</td>
</tr>
<tr>
<td>Months of hypoestrogenism</td>
<td>12.0 (6.0–48.0)</td>
<td>36.0 (12.0–60.0)</td>
<td>0.046*</td>
</tr>
<tr>
<td>Age of HT start (years)</td>
<td>49.0 (45.3–52.8)</td>
<td>51.0 (48.5–53.0)</td>
<td>0.029*</td>
</tr>
<tr>
<td>Months of HT</td>
<td>24.0 (1.0–105.0)</td>
<td>1.0 (1.0–21.0)</td>
<td>0.015*</td>
</tr>
<tr>
<td>BMI (kg/m²)</td>
<td>27.6 (26.5–32.6)</td>
<td>28.01 (25.3–32.9)</td>
<td>0.90</td>
</tr>
<tr>
<td>Waist circumference (cm)</td>
<td>93.5 (84.5–98.9)</td>
<td>93.0 (86.5–101.75)</td>
<td>0.71</td>
</tr>
<tr>
<td>Waist–hip ratio</td>
<td>0.881 (0.828–0.920)</td>
<td>0.878 (0.826–0.911)</td>
<td>0.73*</td>
</tr>
<tr>
<td>sSBP (mmHg)</td>
<td>127.5 (118.3–134.0)</td>
<td>127.0 (111.5–137.5)</td>
<td>0.82</td>
</tr>
<tr>
<td>dPB (mmHg)</td>
<td>74.5 (71.3–78.8)</td>
<td>76.0 (79–82)</td>
<td>0.86</td>
</tr>
<tr>
<td>E₂ (pg/ml)</td>
<td>59.1 (20.0–103.5)</td>
<td>50.98 (20.90–85.16)</td>
<td>0.65</td>
</tr>
<tr>
<td>Estrone (pg/ml)</td>
<td>85.0 (64.0–145.0)</td>
<td>94.0 (53.0–137.4)</td>
<td>0.76</td>
</tr>
<tr>
<td>Androstenedione (pg/ml)</td>
<td>569.0 (392.5–1132.5)</td>
<td>800.0 (400.0–1315.0)</td>
<td>0.12</td>
</tr>
<tr>
<td>FSH (mIU/ml)</td>
<td>51.2 (26.6–63.8)</td>
<td>40.1 (21.59–60.65)</td>
<td>0.48</td>
</tr>
<tr>
<td>Total T (ng/dl)</td>
<td>11.0 (4.0–17.75)</td>
<td>23.0 (10.0–42.5)</td>
<td>0.001*</td>
</tr>
<tr>
<td>Free calculated T (ng/dl)</td>
<td>0.1355 (0.046–0.246)</td>
<td>0.35 (0.1215–0.6025)</td>
<td>0.001*</td>
</tr>
<tr>
<td>Bioavailable T (ng/dl)</td>
<td>3.205 (1.06–5.84)</td>
<td>8.2 (2.97–14.6)</td>
<td>0.001*</td>
</tr>
<tr>
<td>SHBG (nmol/l)</td>
<td>54.85 (33.1–68.9)</td>
<td>52.7 (35.8–67.45)</td>
<td>0.73</td>
</tr>
<tr>
<td>DHEAS (µg/dl)</td>
<td>56.5 (41.3–93.3)</td>
<td>92.0 (47.5–114.0)</td>
<td>0.15</td>
</tr>
<tr>
<td>Total cholesterol (mg/dl)</td>
<td>212.0 (186.5–241.3)</td>
<td>203.0 (179.5–224.0)</td>
<td>0.33*</td>
</tr>
<tr>
<td>HDL-cholesterol (mg/dl)</td>
<td>60.71 (54.7–76.6)</td>
<td>62.0 (52.0–77.5)</td>
<td>0.79</td>
</tr>
<tr>
<td>LDL-cholesterol (mg/dl)</td>
<td>115.0 (91.3–153.5)</td>
<td>115.71 (100.51–138.4)</td>
<td>0.87</td>
</tr>
<tr>
<td>Triglycerides (mg/dl)</td>
<td>114.0 (89.0–143.0)</td>
<td>103.0 (75.6–143.5)</td>
<td>0.32</td>
</tr>
<tr>
<td>Fasting glucose (mg/dl)</td>
<td>96.0 (89.3–102.0)</td>
<td>91.5 (83.5–100)</td>
<td>0.956*</td>
</tr>
<tr>
<td>Insulin (µU/ml)</td>
<td>7.035 (5.04–10.05)</td>
<td>7.2 (4.22–9.9)</td>
<td>0.75</td>
</tr>
<tr>
<td>HOMA IR</td>
<td>1.755 (1.16–2.46)</td>
<td>1.73 (0.99–2.22)</td>
<td>0.56</td>
</tr>
</tbody>
</table>

HT, hormone therapy; sSBP, systolic blood pressure; dPB, diastolic blood pressure; T, testosterone. Reference values: E₂ <55 pg/ml (post menopause) and >45 pg/ml (under HT); Estrone 10–60 pg/ml; androstenedione 300–3700 pg/ml; FSH > 25.8 mIU/ml (post menopause) and 3.5–12.5 mIU/ml (under HT); total T 3–63 ng/dl; free calculated T 0.01–1.07 ng/dl; bioavailable T 4.4–39 ng/dl; SHBG 16–76 nmol/l; DHEAS 35–331 µg/dl (45–54 years old women), 19–295 µg/dl (55–64 years old women).

*P<0.05 by Student’s t-test or Mann-Whitney test.

**P<0.05 as well as negative correlations with sVCAM1 levels (Table 4).

In a multiple linear regression model, despite an overall low explanatory power, TT levels, compared to other confounding variables, independently explained the variation in RHF (r² = 0.054, P = 0.004) and RNF (r² = 0.14, P = 0.025). Other variables that showed an independent contribution at the level of 5% were WC in relation to BF2 (r² = 0.075, P = 0.016) and to RNF (r² = 0.14, P = 0.019) and time of HT in relation to BF1 (r² = 0.073, P = 0.018).

Discussion

Endothelial dysfunction is an early marker of cardiovascular diseases (18), the leading cause of death in women after 50 years of age (19). The association between hypoestrogenism and endothelial dysfunction is well established (1) as well the beneficial effects of estrogen administration on endothelium (20) in early post menopause.

In this study we have demonstrated, to our knowledge for the first time, that even in recent menopause and under appropriate estrogen replacement, oophorectomized women presented consistent signs of endothelial dysfunction associated with lower levels of endogenous testosterone, compared to women with both ovaries. Endothelial dysfunction was observed at baseline and under endothelium-dependent (reactive hyperemia response) or independent vasodilatation (sublingual nitroglycerin), reflecting respectively decreased bioavailability of nitric oxide (21) associated with increased vascular wall stiffness in group O (22). Oophorectomized women have higher risk of cardiovascular events according to Women’s Health Initiative study (23). Populational studies including menopausal women up to 69 years reported higher cardiovascular risk in those who underwent bilateral oophorectomy before 50 years.
of age (24), which occurred in 26/35 (almost 75%) of women in our group O. Montalcini et al. (25) described a positive correlation between serum testosterone levels and flow-mediated brachial artery vasodilatation assessed by Doppler in 60 postmenopausal women. Likewise, Worboys et al. (26), found increased endothelium-dependent and independent vasodilatation after using, associated with estrogen-progestin therapy, 50 mg subcutaneous testosterone implants for 6 weeks.

The mechanisms by which testosterone regulates vascular tone may result from direct androgen receptor mediation or testosterone aromatization into E₂, being E₂ the activator, via paracrine, of endothelial nitric oxide synthase by non-genomic pathway (27). The aromatase enzyme, responsible for testosterone transformation into E₂, was identified in the smooth muscle layer of arteries but not in human endothelial cells (28). However, serum E₂ levels were similar between groups, even group O women requiring larger doses of topical E₂ gel preparation to compensate from climacteric symptoms (29), as observed for classical cardiovascular risk factors (age, BMI, WC, glucose, blood pressure, and lipids). Yet, despite the shorter time of hypoestrogenism in group O, given by earlier onset of HT, their vascular response was poor. Endothelial dysfunction in group O seems to reflect the low endogenous testosterone levels, the only evident potential deleterious difference between the groups, reinforcing the importance of testosterone for proper vascular function in early menopause.

DHEAS and androstenedione, androgens from adrenal and mixed origin (ovarian and adrenal) respectively showed no changes in group O compared with group C, as described by Davison et al. (30) while TT was 10.95 ± 7.49 vs 19.02 ± 11.53 ng/dl respectively (30). More recently, Fogle et al. (31) collected samples from ovarian and peripheral veins of women undergoing hysterectomy and demonstrated significant production of ovarian testosterone even 10 years after natural menopause, possibly mediated by high levels of LH in ovarian theca cells.

**Figure 1**
Venous occlusion plethysmography results between groups.
*P < 0.05 by Mann-Whitney test. FBF, forearm blood flow; BH, baseline flow; RHF, reactive hyperemia.

**Table 2** Comparisons of body fat distribution and composition between groups, by anthropometric measurements, bioimpedance and DEXA. Data are presented as median and interquartile range (25–75%).

<table>
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</tr>
<tr>
<td>Bioimpedance</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>LM (kg)</td>
<td>46.4 (41.1–50.1)</td>
<td>44.6 (41.1–52.55)</td>
<td>0.95</td>
</tr>
<tr>
<td>FM (kg)</td>
<td>25.5 (20.2–32.2)</td>
<td>26.1 (20.75–32.0)</td>
<td>0.90</td>
</tr>
<tr>
<td>LM (%)</td>
<td>63.5 (59.5–68.0)</td>
<td>62.8 (60.05–67.3)</td>
<td>0.62</td>
</tr>
<tr>
<td>FM (%)</td>
<td>36.5 (32.1–40.5)</td>
<td>37.2 (32.7–39.9)</td>
<td>0.71</td>
</tr>
<tr>
<td>DEXA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Android fat tissue (kg)</td>
<td>48.15 (43.9–53.4)</td>
<td>49.8 (46.7–55.3)</td>
<td>0.22</td>
</tr>
<tr>
<td>Gynoid fat tissue (kg)</td>
<td>46.85 (42.6–51.0)</td>
<td>48.55 (42.7–51.4)</td>
<td>0.35</td>
</tr>
<tr>
<td>Total fat tissue (kg)</td>
<td>43.15 (39.9–48.4)</td>
<td>44.95 (41.4–48.1)</td>
<td>0.51</td>
</tr>
<tr>
<td>Total fat tissue (kg)</td>
<td>30 569 (24 520–37 332)</td>
<td>30 022 (24 942–38 729)</td>
<td>0.81</td>
</tr>
<tr>
<td>Total lean tissue (kg)</td>
<td>39 942 (34 818–43 246)</td>
<td>37 667 (35 408–43 159)</td>
<td>0.78</td>
</tr>
<tr>
<td>A/G</td>
<td>1.05 (0.925–1.1)</td>
<td>1.05 (0.97–1.13)</td>
<td>0.90*</td>
</tr>
</tbody>
</table>

LM, lean mass; FM, fat mass; A/G, android/gynoid fat tissue.

*P < 0.05 by Student’s t-test or Mann-Whitney test.
BMI of our sample was 28.0 (25.9–32.7) kg/m², reflecting the current prevalence of overweight worldwide not different between groups O and C suggesting that observed endothelial dysfunction could be mediated by androgen levels. McCarty et al. (32), examining oophorectomized women from the National Health and Nutrition Examination Survey (NHANES III) found that fat mass measured by bioimpedance, skinfold thickness, WC and BMI were significantly higher only in women who underwent oophorectomy before 40 years, characterizing premature menopause with stronger associations in those who did not take HT. These results are not comparable to ours: our entire sample was in estrogen replacement and androgen levels. McCarty et al. (32), examining oophorectomized women from the National Health and Nutrition Examination Survey (NHANES III) found that fat mass measured by bioimpedance, skinfold thickness, WC and BMI were significantly higher only in women who underwent oophorectomy before 40 years, characterizing premature menopause with stronger associations in those who did not take HT. These results are not comparable to ours: our entire sample was in estrogen replacement and all women were operated after 40 years. Taken together, these studies suggest that low estrogen levels, particularly before age 40, may be higher determinants of body composition than low testosterone levels, being postmenopausal fat more related to low E₂ than to testosterone.

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(AGEs), capable of generating reactive oxygen species and translocation of kappa B nuclear factor, which triggers inflammation, immune response and apoptosis (40). Diamanti-Kandarakis et al. (41), in a cross-sectional study with 106 healthy postmenopausal women, found that those with testosterone levels in the highest quartile (53–160 ng/dl) had significantly higher serum AGEs levels compared to the three quartiles comprising testosterone levels between 2 and 53 ng/dl, even after adjustments for insulin and HOMA-IR. In our study oophorectomized women and those with both ovaries had median testosterone levels comparable to Diamanti-Kandarakis’s first (2–23 ng/dl) and second (23–35 ng/dl) quartiles respectively where AGEs were reported to be lower. We excluded women with a history of polycystic ovary syndrome, severe acne or hirsutism in reproductive years; besides, all were on estrogen therapy, which reduces gonadotropins and, thus, ovarian stimulation, which may explain why testosterone levels in our study were all below 42.5 ng/dl; equally, insulin, glucose and HOMA-IR were not different between the groups we analyzed. Therefore, lower postmenopausal testosterone levels may directly depress endothelial nitric oxide (NO) production mediated through the androgen/estrogen receptor, while higher levels increase AGEs and impair NO bioavailability at a post-receptor level. Altogether, these studies suggest that, concerning endothelial function, an optimal range of circulating testosterone may exist, not as low as post oophorectomy neither as high as in PCOs.

Regarding androgen replacement, in a recent randomized study, Huang et al. (42) provided weekly placebo vs 3, 6.25, 12.5 or 25 mg testosterone enanathate i.m. injections to hysterectomized women with serum total testosterone concentrations less than 31 ng/dl during 24 weeks, achieving mean on-treatment nadir total concentrations of 14, 79, 105, 130, and 232 ng/dl respectively. No significant changes in cardiovascular risk markers such as fasting glucose, fasting insulin, HOMA IR, high sensitivity C-reactive protein, adiponectin, blood pressure, and heart rate were observed in any subgroup. However, the long-term consequences of androgen replacement are not known. Potential masculinizing effects like acne, hirsutism or alopecia are dose related, especially due to supraphysiological hormone levels. Besides, endometrial changes can vary from atrophy to hyperplasia, in a result from peripheral conversion to estrogens.

One of the strengths of our study was to focus on androgen influences in early postmenopausal women, an important phase recognized by the literature. Endothelial dysfunction and inflammatory biomarkers represent gold standard signals of the atherosclerotic process initiation and the great homogeneity between groups O and C, especially in relation to cardiovascular risk factors, constitutes a major advantage. Furthermore, all women were studied under adequate estrogen replacement, so we could analyze, in fact, the isolated effects of low endogenous testosterone levels in oophorectomized women.

As limitations, data at the time of hypoestrogenism and age of oophorectomy are subject to recall bias. An explorative study carries an innate risk of false positive findings and although we performed a multiple linear regression, other adjustments for multiple tests could not be applied because they are designed for comparisons of more than two groups. Direct measurement of immunoassays for testosterone are susceptible to cross-reaction due to structural similarity between them and methods such as chromatography/mass spectrometry are preferred in groups with low hormone levels, like children and postmenopausal women; however, electrochemiluminescence immunoassay was the only available method for measuring testosterone in our city until very recently (August 2015) and it is still the standard process. Besides, there is a biological plausibility for the lower testosterone levels found in oophorectomized women supported by the population study of Davison et al. (30) who provided normative data for physiological androgen levels in adult females according to age and found significantly lower testosterone levels in oophorectomized compared to age matched women in spontaneous early menopause. Nonetheless, the findings of this study cannot be extrapolated for other androgen imbalance conditions like primary adrenal insufficiency or male hypogonadism.

In conclusion, postmenopausal oophorectomized women, compared with controls, both in early post menopause and under proper estrogen replacement, showed low endogenous testosterone levels associated with poor endothelial function. More studies are needed regarding delaying progression of cardiovascular disease through ovary preservation during gynecological surgery or providing low doses of testosterone to early postmenopausal oophorectomized women.

Declaration of interest
The authors declare that there is no conflict of interest that could be perceived as prejudicing the impartiality of the research reported.

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