

Modification of blood pressure in postmenopausal women: role of hormone replacement therapy

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Abstract: The rate of hypertension increases after menopause. Whether estrogen and progesterone deficiency associated with menopause play a role in determining a worst blood pressure (BP) control is still controversial. Also, studies dealing with the administration of estrogens or hormone therapy (HT) have reported conflicting evidence. In general it seems that, despite some negative data on subgroups of later postmenopausal women obtained with oral estrogens, in particular conjugated equine estrogens (CEE), most of the data indicate neutral or beneficial effects of estrogen or HT administration on BP control of both normotensive and hypertensive women. Data obtained with ambulatory BP monitoring and with transdermal estrogens are more convincing and concordant in defining positive effect on BP control of both normotensive and hypertensive postmenopausal women. Overall progestin adjunct does not hamper the effect of estrogens. Among progestins, drospirenone, a spironolactone-derived molecule, appears to be the molecule with the best antihypertensive properties.

Keywords: hormone replacement therapy, estrogen, progestin, blood pressure, menopause, hypertension

Introduction

Hypertension is a continuous, non-occasional state of elevated blood pressure (BP). BP increases with age. As a consequence of longer life expectancy and modern lifestyle, the prevalence of hypertension is expected to increase.¹ While diastolic BP starts to increase earlier, systolic BP starts to increase after 50 years of age. The increase of systolic BP is a higher health risk. A higher incidence of cardiovascular and cerebrovascular diseases is observed respectively 10 and 20 years after BP increase.² A 2012 World Health Organization report shows that the rise of BP causes 51% of deaths from stroke, and 45% of deaths from coronary artery diseases.³

There are sex differences in the development of hypertension. The National Health and Nutrition Examination Survey (NHANES) shows that, prior to 45 years of age, prevalence of hypertension is higher in men than in women. From 45 to 54 years and from 55 to 64 years of age, the percentage of hypertensive men is similar to that of hypertensive women. After 65 years of age, BP levels increase faster in women than in men.⁴

It has been suggested that sex steroids protect fertile women from hypertension, and that gonadal steroid withdrawal may play a role in the modifications of BP control.⁵ In fact, the role played by steroid withdrawal at menopause is still controversial.

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Menopause and BP

Cross-sectional studies show that hypertension is two times more prevalent in post- than in pre-menopausal women, regardless of age and body mass index (BMI),⁶ and that this prevalence is reduced by the use of hormone therapy (HT).⁷ In a cross-sectional Italian investigation performed on 22,250 women around the menopause, the postmenopausal status doubled the risk of developing hypertension.⁸ Similar results were observed in a study on hypertension prevalence in menopause in the Italian population, a cross-sectional investigation on 18,326 women from 46 to 59 years of age.⁹ Regardless of confoundings in the study, systolic and diastolic BP were slightly but significantly higher (+3.4 and +3.1 mmHg, respectively) in post- than in pre- and perimenopausal women. A recent article evaluating 908 female residents aged 45–54 years in a Prague district linked the postmenopausal BP rise to the increase of BMI,¹⁰ which is commonly observed in the menopausal transition.^{11–13}

In spite of these evidences, other studies could not find a direct correlation between the menopause event and the development of hypertension. In a 16-year study performed on 525 Italian pre- and post-menopausal women, systolic BP was found to be related to age, but not to hormonal status.¹⁴ Similarly, no correlation between menopausal status and hypertension emerged in a cross-sectional study on more than 22,000 Japanese post-menopausal women, once the data were adjusted for age and time since menopause.¹⁵ Similarly, a 16-year longitudinal study on more than 9,000 women aged 18–70 years showed that the worst BP profile observed in postmenopausal women was not the consequence of the menopausal status.¹⁶

Sex steroid effects on blood vessels

Experimental data indicate that gonadal steroids may regulate blood vessel functions. Estrogens influence the activity of endothelial cells, via genomic and non-genomic signaling. By binding to ER α , estrogens increase the production of vasodilating agents such as nitric-oxide, prostacyclin and prostaglandin E2 and reduce oxidative stress and proinflammatory cytokines.^{17–20} The binding of estrogens to ER β modulates the expression of ER α and antagonizes some of the beneficial effects of estrogens.²¹ Interestingly, ER β are overexpressed in women with a higher incidence of coronary artery disease.²² In addition to effects mediated by endothelial cells, estrogens may vasodilate vessels via an influence on calcium-dependent potassium channels, and a block of calcium channels.^{23,24} Progesterone itself, when binding to its receptor, may exert vasodilating effects,²⁵ depending on

the vessel and on the levels of the hormone,^{26,27} sometimes antagonizing the effect of estrogens.²⁷

Studies *in vivo* have shown that estrogens administered acutely and in high doses exert vasodilating effects,^{28–34} which are also observed,^{35–38} although inconsistently,^{39–40} with the prolonged administration of lower estrogen doses. This endothelium-mediated dilating effect of estrogens disappears in women with endothelium alterations⁴¹ and appears to decrease with time since menopause, being lost several years after the menopause.^{41,42} In this situation, the administration of estrogens appears to be deleterious by favoring a shift towards the production of proinflammatory cytokines.⁴²

The concomitant administration of progestins may antagonize the vasodilating effect of estrogens. Conflicting data have been reported for medroxyprogesterone acetate (MPA)^{43,44} and norethisterone acetate (NETA),^{45,46} and more neutral effect for desogestrel (DSG)⁴⁷ and physiological doses of progesterone.⁴⁸

Beside the direct effect on endothelial cells, complex modulation of the renin–angiotensin–aldosterone axis,^{49–53} as well as of the adrenergic stimulus^{41,54,55} should be taken into consideration when evaluating the possible influence of sex steroids or of their administration on the control of BP.

HT and BP

On the basis of actual knowledge it can be hypothesized that in postmenopausal women the administration of HT influences BP control. This effect may vary depending on the type of estrogen used, its dosage, its route of administration, and the progestin molecule eventually associated. Recent versus late postmenopausal women may also differ in their response. Indeed, there are a relevant number of studies dealing with the interaction between HT and BP regulation, and the results are often conflicting.⁵⁶

The present review summarizes actual knowledge of the effect of postmenopausal HT in modifying BP control. The effect of HT is presented separately for normotensive and hypertensive women. For each condition, data obtained with estrogen alone, estrogen plus progestin and the effect of different progestins are summarized. Data obtained with office and ambulatory blood pressure measurement are presented in sequence, grouped according to their concordance. Concordant data are presented in chronological order with cross-sectional studies preceding randomized clinical trials. Studies were retrieved by PubMed search and limited to the years 1980 to 2013. The research was implemented using references cited in selected articles. Search terms were menopause, blood pressure, hypertension, hormone therapy,

estrogen, and progestin. Only articles in the English language were retrieved.

HT in normotensive women

HT with estrogens alone in normotensive women

In the Rancho Bernardo study, a cross-sectional investigation of 1,044 postmenopausal women, the use of conjugated equine estrogens (CEE) for ten years seemed to induce a better BP control than in non-users.⁵⁷

These data were not confirmed by some clinical trials (Table 1). In the Women's Health Initiative (WHI), a placebo-controlled trial performed on more than 10,000 hysterectomized women 50–79 years of age with a mean age of 63.6 years at enrollment, 0.625 mg/d of CEE induced a small but significant increase of systolic BP.⁵⁸

Similar data were obtained in a 9-month prospective comparative study on 160 normotensive postmenopausal women, aged 52 years, where administration of CEE was associated with a marked elevation of BP.⁵⁹ During CEE administration, systolic BP increased more than 15 mmHg in about 20% of women treated, and diastolic BP increased more than 15 mmHg in 10% of the women.⁵⁹ Negative effects of CEE on BP were further published by the same authors in another study.⁶⁰ Interestingly, the administration of only estrone sulfate decreased BP. Because 50% of CEE is made by estrone sulfate, the negative effect of CEE on

BP may be due to equine derivatives (30%–40%) or other components that do not naturally occur in the human. In the Estrogen in the Prevention of Atherosclerosis Trial (EPAT), a placebo-controlled trial on 222 normotensive or hypertensive postmenopausal women, micronized estradiol (1 mg) instead of CEE was orally administered. Different effects were observed between younger and older women. In the former, systolic BP slightly increased; in the latter, diastolic BP slightly decreased.⁶¹

Several studies have placed their primary objective on the effect that estrogens exert on the control of BP throughout the 24-hour period (Table 1). These studies, although smaller in sample size, are stronger in terms of measurement, and more reliable than studies in which BP evaluation was performed by single office measurement and as a secondary objective of the study. In these studies, oral estrogens either increased (E2)⁶² or did not modify (CEE) 24-hour BP values.^{63,64} Transdermal estradiol instead was reported to decrease ambulatory BP in almost all studies reviewed (Table 1).

In 90 normotensive women 30 to 59 years of age in surgical menopause, randomized to a 6-month treatment with oral (combination of E2, estrone [E1], and estriol [E3]) or transdermal estrogens, nighttime systolic and both nighttime and daytime diastolic BPs decreased by about 4 mmHg in the transdermal but not in the oral estrogen group.⁶³ In a placebo-controlled study performed in 18 normotensive healthy postmenopausal women, transdermal E2 (50 µg/day per 8 weeks)

Table 1 Clinical trials investigating the effect of estrogens on blood pressure of normotensive postmenopausal women

Source of trial	Year of trial	Age of subjects	Number of subjects	Route of administration of estrogens	Estrogens administered	BP measurement mode	Effects of estrogens
WHI ⁵⁸	2004	63.6	~10,000	Oral	CEE 0.625 mg	Office	↑ systolic BP
Wren ⁵⁹	1981	52	160	Oral	E1 sulphate + CEE 0.625 mg	24-h	↓ BP ↑ BP
EPAT ⁶¹	2008	61	222	Oral	E2 1 mg	Office	↑ systolic BP in younger ↓ diastolic BP in older
Akkad ⁶³	1997	30–59	90	Transdermal Oral	E2 0.05 mg E2 + E3 + E1	24-h	↓ nocturnal systolic BP ↓ diastolic BP =24-h BP
Cardoso ⁶²	2011	45–60	47	Oral	E2V 1 mg	24-h	↑ systolic BP ↑ diastolic BP
Vongpatanasin ⁶⁴	2001	53	12	Transdermal Oral	E2 0.2 mg CEE 0.625 mg	24-h	↓ 24-h BP =24-h BP
Cagnacci ⁶⁵	1999	53.5	18	Transdermal	E2 0.05 mg	24-h	↓ nocturnal systolic BP ↓ nocturnal diastolic BP ↓ nocturnal mean BP
Driul ⁶⁶	2005	51.3	46	Transdermal	E2 0.05 mg	24-h	↓ diurnal diastolic BP ↓ nocturnal diastolic BP

Abbreviations: 24-h, 24-hour; BP, blood pressure; CEE, conjugated equine estrogen; EPAT, Estrogen in the Prevention of Atherosclerosis Trial; E1, estrone; E2, estradiol; E2V, oral estradiol valerate; E3, estriol; WHI, Women's Health Initiative; ↓, decrease; ↑, increase; =, no change.

magnified the nocturnal decrement of systolic (14.3 ± 7.2 versus 9.8 ± 6.7 mmHg, $P=0.0033$), diastolic (11.6 ± 5.0 versus 7.5 ± 7.3 mmHg, $P=0.028$), and mean (10.8 ± 5.6 versus 7.2 ± 4.5 mmHg, $P=0.011$) BP.⁶⁵ In a randomized crossover placebo-controlled study on 12 normotensive women, taking transdermal E2 (200 µg/day), oral CEE (0.625 mg/d), or placebo for 8 weeks, a small but significant decline of ambulatory BP was observed only with transdermal E2.⁶⁴ Finally, in a group of 46 women in surgical menopause (mean age of 51 years), transdermal E2 (50 µg/day) significantly decreased diurnal and nocturnal diastolic BP in the subgroup of smokers ($n=30$, 65.2%).⁶⁶

HT with estrogens plus progestins in normotensive women

Data on the effect of HT on office BP are rather conflicting; positive, neutral or negative effects have been reported. A positive effect was observed in the Coronary Risk Factors for Atherosclerosis in women (CORA) study. In this case control study, 200 consecutive pre- and post-menopausal women with incident coronary heart disease were matched with 255 controls. The study showed beneficial effects of HT on BP control of postmenopausal women with a previous cardiovascular disease.⁶⁷ Similar data were obtained in the Baltimore longitudinal study on aging, an observational study on 226 healthy, normotensive postmenopausal women aged 64 ± 10 years, who were followed for a mean period of 5.7 years. Seventy-seven women used either oral or transdermal estrogen plus progestin, and 149 used no hormone. After 10 years of follow-up, postmenopausal women taking HT showed a smaller increase in systolic BP versus non-users (7.6 mmHg versus 18.7 mmHg after 10 years), which was more evident in older women.⁶⁸

Hassager and Christiansen⁶⁹ published a summary of five trials performed with oral and transdermal estrogen associated with NETA, CPA, or micronized progesterone in about 270 women enrolled either earlier after or later after the menopause. The results of those trials indicate that any HT regimen decreases BP, particularly diastolic BP, of women earlier after the menopause. However, HT does not exert any effect in women later after the menopause (Table 2).⁶⁹

No effect of HT on office BP was observed in two major trials, the Postmenopausal Estrogen/Progestin Interventions (PEPI) trial,⁷⁰ and the Danish Osteoporosis Prevention Study (DOPS)⁷¹ (Table 2).

The PEPI trial evaluated the effects on the cardiovascular systems of 875 healthy postmenopausal women (45 to 64 years of age) of four estrogen-progestin regimens

(CEE, 0.625 mg/d; CEE, 0.625 mg/d plus cyclic MPA 10 mg/d for 12 d/month; CEE, 0.625 mg/d plus consecutive MPA, 2.5 mg/d; or CEE, 0.625 mg/d plus cyclic micronized progesterone [MP], 200 mg/d for 12 d/month; or placebo alone). No significant difference in BP was observed among treatments and placebo. Similarly, there was no difference associated with the different types and doses of progestin used.⁷⁰ In the DOPS study, women taking for five years oral E2, alone or in association with NETA, did not experience a reduction of BP in comparison to users of placebo.⁷¹ A negative effect of HT on BP was observed in one observational and two major clinical trials (Table 2).⁷²⁻⁷⁴

In a recent Australian study performed on 43,405 normotensive postmenopausal women, HT use was associated with significantly higher odds of having high BP, the risk becoming higher with longer HT use.⁷² An increase of BP induced by HT was also observed in two major placebo-controlled trials, such as the WHI and the Heart and Estrogen/Progestin Replacement Study (HERS).

The WHI investigation evaluated 16,608 women, aged 50–79 years, taking CEE plus MPA or placebo. After two years of treatment with HT, there was an increase of 1.5 mmHg of systolic but not of diastolic BP. Furthermore, women taking HT showed a 25% increased risk of developing hypertension.⁷³ In the HERS study, performed on women with cardiovascular disease, an increase of systolic BP was described in women receiving CEE plus MPA versus placebo.⁷⁴

More reassuring are the data of studies performed with 24-hour ambulatory BP monitoring (Table 2). Oral E2 (1 mg) combined with 5 or 10 mg dihydrogesterone (DYD) to 29 healthy normotensive postmenopausal women (mean age 52.3 years) induced a decrease of 24-hour systolic and diastolic BP in comparison to control women.⁷⁵

Harvey et al⁷⁶ monitored 24-hour BP of 24 normotensive postmenopausal women (median age 54 years). For each subject there were four randomized treatment phases, each lasting 4 weeks. The treatments were 0.625 mg estrone sulphate, 2.5 mg estrone sulphate, 0.02 mg ethinylestradiol, all of them associated to 10 mg of oral MPA for 14 days, and matching placebo. Combinations containing either natural or semisynthetic estrogen reduced nighttime ambulatory BP.⁷⁶

In a placebo-controlled, randomized crossover study, sixteen healthy normotensive post-menopausal women (age 55 ± 3 years) were randomized to E2 plus cyclic NETA or placebo in two 12-week periods of treatment. Ambulatory systolic and diastolic BP were reduced after 10 days of

Table 2 Clinical trials investigating the effects of hormone therapy on blood pressure of normotensive postmenopausal women

Source of trial	Year of trial	Number of subjects	Age of subjects	Route of administration of HT	Estrogens administered	Progestins administered	Mode of BP measurement	Effects of hormone therapy
Hassager ⁶⁹	1988	875	Earlier in PMW Later in PMW	Oral Transdermal Oral	E2 E2 E2 0.05 mg E2	NETA CPA MP 200 mg NETA	Office	↓ diastolic BP = BP
PEP ⁷⁰	1995	875	45–64	Oral	CEE 0.625 mg CEE 0.625 mg CEE 0.625 mg	– MPA 10 mg MPA 200 mg	Office	↑ systolic BP = diastolic BP
DOPS ⁷¹	2002	1,006	45–58	Oral	E2 2 mg E2 2 mg CEE 0.625 mg	– NETA 1 mg MPA 2.5 mg	Office	= diastolic BP = systolic BP ↑ systolic BP = diastolic BP
WHI ⁷³	2000	90,755	50–79	Oral	CEE 0.625 mg	MPA 2.5 mg	Office	↑ systolic BP = diastolic BP
HERS ⁷⁴	2002	2,763	67	Oral	CEE 0.625 mg	MPA 2.5 mg	Office	↑ systolic BP
van Ittersum ⁷⁵	1998	29	52	Oral	E2 1 mg	DYD 5–10 mg	24-h	↓ systolic BP ↓ diastolic BP
Harvey ⁷⁶	1999	24	47–60	Oral	E1 sulphate 0.625 mg E1 sulphate 2.5 mg EE 0.02 mg E2 4 mg	MPA 10 mg	24-h	↓ nocturnal BP
Sorensen ⁷⁷	2000	16	55	Oral	E2 4 mg	NETA 1 mg	24-h	↓ systolic BP ↓ diastolic BP ↓ systolic BP
Manwaring ⁷⁸	2000	17	N/A	Oral	CEE 0.625 mg CEE 0.625 mg	MPA 5 mg	24-h	↓ systolic BP
Cacciatore ⁷⁹	2001	73	45–57	Oral Transdermal	E2 2 mg E2 0.05 mg E2	NETA 1 mg NETA 50 µg NETA	24-h 24-h 24-h	↓ diastolic 24-h ↓ systolic 24-h ↓ systolic BP
Paakari ⁸⁰	1996	63	N/A	Oral Transdermal	E2 0.05 mg E2	NETA 50 µg NETA	24-h 24-h	↓ diastolic 24-h ↓ systolic 24-h ↓ systolic BP
Pripp ⁸¹	1999	59	59	Oral Transdermal	CEE 0.625 mg E2 0.05 mg E2V 2 mg E2 0.05 mg	MPA 5 mg CPA 2 mg	24-h 24-h 24-h 24-h	↓ systolic BP ↓ diastolic BP ↓ systolic BP ↓ diastolic BP
Zacharieva ⁸²	2002	28	45–55	Oral Transdermal	E2 0.1 mg E2 0.1 mg	P 300 mg	24-h	↓ nocturnal systolic BP ↓ nocturnal diastolic BP ↓ nocturnal mean BP
Seely ⁸³	1999	15	56	Transdermal	E2 0.1 mg E2 0.1 mg		24-h	↓ nocturnal systolic BP ↓ nocturnal diastolic BP ↓ nocturnal mean BP
Deuringer ⁸⁷	2000	416	N/A	Transdermal	E2 0.05 mg	NETA 1 mg CMA 2 mg	Office	= diastolic BP = systolic BP
Mueck ⁸⁸	1997	159	N/A	Oral	E2	CMA 0.5, 1, 2, 3 mg	Office	= diastolic BP = systolic BP
Mueck ⁸⁹	1998	N/A	N/A	Oral	E2	DNG 0.5, 1, 2, 3, 4 mg	Office	= diastolic BP = systolic BP

(Continued)

Table 2 (Continued)

Source of trial	Year of trial	Number of subjects	Age of subjects	Route of administration of HT	Estrogens administered	Progestins administered	Mode of BP measurement	Effects of hormone therapy
Mueck ⁹⁰	2001	52	55	Oral	E2V E2V	– DNG	Office	= diastolic BP = systolic BP
van der Moeren ⁹¹	1996	563	N/A	Oral	E2 2 mg	DYD 5, 10, 15, 20 mg	Office	↓ diastolic BP ↓ systolic BP
Kessel ⁹²	2001	52	52	Oral	E2 1–2 mg	DYD 5–20 mg	Office	= diastolic BP = systolic BP
Harvey ⁹³	2001	20	53	Oral	CEE 0.625 mg	MPA 2.5, 5, 10 mg	24-h	↓ diurnal diastolic BP ↓ diurnal mean BP
White ⁹⁵	2005	213	45–58	Oral	E2 1 mg	DRSP 3 mg	24-h	↓ systolic BP
White ⁹⁶	2006	750	45–75	Oral	E2 1 mg	DRSP 2 mg	24-h	↓ systolic BP
White ⁹⁷	2006	748	56	Oral	E2 1 mg	DRSP 3 mg	24-h	↓ systolic BP
Gambacciani ⁹⁸	2011	52	53	Oral	E2 1 mg	DRSP 1, 2, 3 mg DRSP 2 mg	Office	↓ early morning systolic BP = diastolic BP
Battaglia ⁹⁹	2009	30	48–56	Oral	E2 1 mg E2 1 mg	DRSP 2 mg NETA 0.5 mg	Office	= systolic BP in normotensive ↓ systolic BP in hypertensive = 24-h BP = daytime BP = nocturnal BP

Abbreviations: 24-h, 24-hour; BP, blood pressure; CEE, conjugated equine estrogen; CMA, chlormadinone acetate; DNG, dienogest; DOPS, Danish Osteoporosis Prevention Study; DRSP, drospirenone; DYD, dihydrogesterone; EE, ethinylestradiol; E1, estrone; E2, estradiol; E2V, oral estradiol valerate; HERS, Heart and Estrogen/Progestin Replacement Study; HT, hormone therapy; MP, micronized progesterone; MPA, medroxyprogesterone acetate; NETA, norethisterone acetate; P, progesterone; PEPI, Postmenopausal Estrogen/Progestin Intervention; PMW, postmenopausal women; WHI, Women's Health Initiative; ↓, decrease; ↑, increase; =, no change; CPA, cyproterone acetate; N/A, not available.

E2 (−5.1 and −3.2 mmHg, respectively). During the addition of NETA, diastolic BP was further reduced (−3.6 mmHg), suggesting additive BP-lowering effects of this molecule.⁷⁷ In a 3-month randomized double-blind placebo-controlled crossover trial performed in 17 normotensive postmenopausal women, CEE (0.625 mg/day) alone or associated with continuous MPA (5 mg/day) reduced 24-hour diastolic BP by 4 and 5 mmHg, and systolic BP by 6 and 9 mmHg, respectively.⁷⁸ In a randomized study of 73 normotensive women, a significant decrease of daytime systolic BP was observed after 2 months of treatment with 2 mg of oral (3.8 ± 0.2 mmHg) or 50 µg of transdermal E2 (4.0 ± 0.3 mmHg), both sequentially associated with NETA. Mean daytime BP also decreased, both in the oral (-1.8 ± 0.8 mmHg) and transdermal (-3.5 ± 0.7 mmHg) groups. Nighttime BP remained unaffected by either treatment.⁷⁹ In another study, 8 weeks of treatment with E2, oral or transdermal plus NETA, significantly reduced 24-hour systolic BP of about 4–5 mmHg.⁸⁰ Sixty patients (aged 59 years) were randomized to receive 0.625 mg/day CEE, or 50 µg/day transdermal E2 or placebo for 18 days, then treatments were combined with 5 mg MPA for an additional 10 days. After one year of therapy, night-time systolic BP decreased significantly in the CEE group, and both systolic and diastolic BP decreased significantly in the transdermal group.⁸¹ In 28 postmenopausal women 45 to 55 years of age, oral estradiol valerate (E2V) (2 mg) or transdermal estradiol (0.05 mg) decreased 24-hour systolic BP.⁸² Similarly, in a placebo-controlled study the association of transdermal E2 (0.2 mg/day) plus intravaginal progesterone (300 mg/day) significantly decreased nighttime systolic, diastolic, and mean BP in 15 healthy postmenopausal women. Daytime BP followed the same trend, but was significantly lower only for mean BP. The addition of progesterone resulted in no further fall.⁸³

HT with progestins in normotensive women

There are few studies reporting the effects of progestins on the vascular system. Progestins are a multitude of compounds, and their effect may vary depending on different pharmacokinetic properties, type of molecule, and route of administration, some negative effects being evident with the oral but not the transdermal route of administration.⁸⁴ In addition, the major negative effects of progestins are related to vascular damages and injuries that are already established. For this reason, conflicting evidence may be present in the literature.⁸⁵

An antihypertensive effect of oral progesterone was described in four hypertensive women and six hypertensive

men.⁸⁶ Several studies have investigated whether the administration of different progestins can influence BP regulation (Table 2).

HT with chlormadinone acetate and NETA in normotensive women

A study on 416 women tested the effect of chlormadinone acetate (CMA) (2 mg/day), a C21 gestagen with antiandrogenic properties, and NETA (1 mg/day), a C19 gestagen with androgenic properties, given in sequential combination (12 days/cycle) with transdermal E2 (0.05 mg/day). No significant effects were observed over the 4-month period of treatment.⁸⁷

In a prospective randomized comparison, different doses of CMA (0.5, 1.0, 2.0, and 3.0 mg per day) in association with transdermal or oral E2 were tested on 159 postmenopausal women. CMA in any dose did not modify BP.⁸⁸

HT with dienogest in normotensive women

Mueck et al also tested the effects of dienogest (DNG), another C19 gestagen with antiandrogenic properties, on BP. In a randomized comparison of 0.5, 1, 2, 3, and 4 mg of DNG continuously combined with E2 for 6 months, no effect of increasing DNG dose was observed on BP.⁸⁹ In addition, DNG adjunct did not modify the effect exerted by E2 alone.⁹⁰

HT with dihydrogesterone in normotensive women

In another study, 563 postmenopausal women were treated with micronized E2 (2 mg), sequentially combined with various doses of DYD. After 6 months of treatment, a slight but significant fall of systolic and diastolic BP was registered for the entire pooled group. After 1 year, however, the group receiving 10 mg of DYD showed a significant rise (about 2–3 mmHg) of both systolic and diastolic BP.⁹¹ In another study, DYD in doses ranging between 5 and 20 mg per day, combined with 1 or 2 mg of E2, appeared to be particularly neutral in terms of both metabolic and vascular effects.⁹²

HT with MPA in normotensive women

In a double-blind crossover study, 20 normotensive postmenopausal women (median age 53 years) were randomized to four MPA treatment phases of 4 weeks each. CEE 0.625 mg was associated with MPA 2.5 mg, MPA 5 mg, MPA 10 mg, or placebo, in the last 14 days of each 28-day treatment cycle. In comparison to placebo, during progestin administration

there was a dose-dependent decrease of ambulatory daytime diastolic and mean BP.⁹³

HT with drospirenone in normotensive women

Drospirenone (DRSP) is derived from spironolactone, and possesses antialdosteronic properties. This molecule can control water retention, weight increase, and BP levels. Several papers deal with the capability of DRSP to reduce BP in hypertensive women.^{94–97} On the other hand, clinical studies performed in normotensive women did not report any effect of DRSP on BP. In a group of 30 women randomly treated with either DRSP 2 mg/E2 1 mg or with NETA 0.5 mg/E2 1 mg, no significant difference was observed in 24-hour, daytime, and nighttime BP values.⁹⁸ In another Italian study, postmenopausal women were treated with E2 (1 mg/day) plus DRSP (2 mg/day). Both systolic and diastolic BP did not vary. In subjects with systolic BP lower than 130 mmHg at baseline, no changes in systolic BP values were registered, while women with baseline

high-normal systolic BP (130–139 mmHg) experienced a significant BP decline.⁹⁹

Hypertensive women HT with estrogens alone in hypertensive women

There are few studies dealing with the effect of estrogens alone in hypertensive postmenopausal women (Table 3). In a randomized placebo-controlled study, 2 mg or 4 mg of micronized E2 were given to 20 normotensive and 20 hypertensive postmenopausal women.¹⁰⁰ E2 decreased systolic and diastolic BP in both normotensive and hypertensive women. The decrease of BP was more clear in hypertensive than normotensive subjects. In a randomized double-blind placebo-controlled study performed in 30 hypertensive women (mean age 55 years), transdermal E2 (0.05 mg/day) significantly decreased 24-hour systolic and diastolic BP. Furthermore, in the non-dipper subgroup, E2 restored the expected reduction of BP at night.¹⁰¹

Table 3 Clinical trials investigating the effect of estrogens alone or with hormone therapy on blood pressure of hypertensive postmenopausal women

Source of trial	Year of trial	Number of subjects	Routes of administration	Estrogens	Progestins	Mode of measurement	Effects
Luotola ¹⁰⁰	1983	40	Oral	E2 2 mg E2 4 mg	–	Office	↓ diastolic BP ↓ systolic BP
Mercuro ¹⁰¹	1998	30	Transdermal	E2 50 µg	–	24-h	↓ diastolic BP ↓ systolic BP
Kornhauser ¹⁰⁴	1997	55	Oral Oral + im	Estradiol valerate 10 mg Estradiol valerate 4 mg	– Prasterone enanthate 200 mg	Office	↑ systolic BP ↑ diastolic BP
Jespersen ¹⁰⁵	1993	24	Oral	E2 E2 + E1	– NETA	Office	↓ systolic BP = diastolic BP
van der Mooren ⁹¹	1996	99	Oral	E2	DYD	Office	↑ systolic BP ↑ diastolic BP
Harvey ¹⁰⁶	2000	14	Oral	CEE 0.3, 0.625, 1.25 mg	MPA 10 mg	Office	↓ BP
Mueck ¹⁰²	2000	13,190	Oral	CEE 0.3, 0.625, 1.25 mg	MPA 10 mg	Office	↓ systolic BP ↓ diastolic BP
Foidart ¹⁰⁸	1991	92	Transdermal + Oral	E2 50 µg	MPA 10 mg	Office	= diastolic BP = systolic BP
Sumino ¹⁰⁷	2003	31	Oral	CEE 0.625 mg	MPA 2.5 mg	Office	= BP
Kaya ¹¹⁰	2006	66	Oral	E2 1 mg	DYD 10 mg	24-h	↓ systolic BP ↓ diastolic BP ↓ mean BP
Wong ¹¹¹	2005	34	Oral	E2	Norgestrel	24-h	↓ daily mean BP
Affinito ¹¹²	2001	60	Transdermal	E2 50 µg	MPA 10 mg	24-h	↓ diastolic BP ↓ systolic BP
Szekacs ¹¹⁴	2000	30	Transdermal	E2 50 µg	Norgestrel	24-h	↓ diastolic BP ↓ systolic BP

Abbreviations: 24-h, 24-hour; BP, blood pressure; CEE, conjugated equine estrogen; DYD, dihydrogesterone; E1, estrone; E2, estradiol; im, intramuscular; MPA, medroxyprogesterone acetate; NETA, norethisterone acetate; ↓, decrease; ↑, increase; =, no change, –, none.

HT with estrogens plus progestins in hypertensive women

A revision of case-control and cross-sectional studies published between 1960 and 2004 reported that HT, performed with either oral or transdermal estrogen, does not consistently increase BP.¹⁰² In the Italian Climacteric Research Group Study (ICARUS), an observational investigation on 9,309 women, HT use was associated with significantly lower BP values in both normotensive and hypertensive women.¹⁰³ In a randomized double-blind placebo-controlled trial performed in 55 postmenopausal women with mild to moderate hypertension, 4 mg and 10 mg of E2 valerate plus 200 mg prasterone enanthate, administered for 3 months, did not induce any change of BP (Table 3).¹⁰⁴ Jespersen et al investigated the effects of a 6-month treatment with E2 either alone or in sequential association with NETA on 24 postmenopausal women (12 normotensive and 12 hypertensive). In normotensive women, HT did not significantly modify systolic or diastolic BP. However, in hypertensive women systolic BP fell significantly during the treatment with either E2 or E2 plus NETA.¹⁰⁵

On the other hand, the administration of oral E2 plus DYD caused an increase of 6.8 and 8.6 mmHg of systolic and diastolic BP, respectively, in a group of 99 hypertensive women.⁹¹ Fourteen postmenopausal women with grade 1–2 hypertension were enrolled in a double blind crossover study. There were four randomized treatment phases, each lasting 4 weeks: CEE 0.3 mg, CEE 0.625 mg, CEE 1.25 mg and placebo. Each subject also received MPA (10 mg for 14 days). In hypertensive postmenopausal women, HT exerted a variable effect on BP that was dependent on CEE dose. The “lower” and “middle” doses of CEE produced a small reduction of BP, which tended to reverse with the “higher” CEE dose.¹⁰⁶

Studies with transdermal estradiol and office BP measurement do show either a neutral or BP lowering effect (Table 3). A study was performed on 13,910 post-menopausal women, some of whom (n=1,516) were taking transdermal E2 (0.025, 0.05, and 0.01 mg daily) with or without progestin (NETA 47.2%, MPA 23.8%, medrogestone 10.8%, CMA 2.0%, or DYD 1.5%). After 2 months of treatment there was no effect of treatments on BP of normotensive women, while a decrease of office systolic and diastolic BP was observed in hypertensive women (2–3 mmHg). In women with baseline diastolic BP higher than 100 mmHg, systolic BP decreased 7 mmHg and diastolic BP decreased 9 mmHg.¹⁰⁷ In another study performed on 92 hypertensive postmenopausal women, the 6-month administration of transdermal E2 plus 10 mg

MPA did not cause any significant variation of office systolic and diastolic BP.¹⁰⁸

Studies with 24-hour ambulatory BP monitoring report more consistent evidence of a BP lowering effect exerted by HT (Table 3). In one study performed on 31 hypertensive women, CEE in doses of 0.625 mg per day did not modify 24-hour ambulatory BP.¹⁰⁹ However, in two other studies performed with oral E2, a decrease of 24-hour BP was observed during treatment. In a 12-month prospective study, 66 postmenopausal women with mild to moderate hypertension were randomly assigned to receive 1 mg/day micronized E2 sequentially combined with MPA 10 mg/day, or no therapy. A significant fall in 24-hour systolic, diastolic, and mean BP was observed, with decreases in both daytime and nighttime ambulatory BP.¹¹⁰ A positive effect of oral HT on BP was also described in a Canadian study showing that, in non-dipper individuals, HT significantly lowers daytime BP and induces a smaller nocturnal BP reduction than in dipper. Daytime diastolic BP was significantly and inversely related to duration of HT use.¹¹¹

Studies with transdermal estradiol consistently show a reduction of BP during treatment (Table 3). In a study performed on 60 hypertensive women, transdermal E2 after 3 and 6 months significantly decreased systolic and diastolic daytime BP.¹¹²

By evaluating the different effect of estrogen on daytime and nighttime BP, it seems to emerge that, in normotensive women, the effect of estrogen is confined mainly to nighttime, with a magnification of the nocturnal BP pressure decline.¹¹¹ In hypertensive women, however, reduction of BP induced by estrogen is more evident during the day.^{112, 113} Indeed, a prospective study performed on 34 postmenopausal women 53 years of age with hypertension found that treatment with a cyclic combination of transdermal estradiol and norgestrel for 19 weeks significantly decreases daily systolic and diastolic BP.¹¹⁴

HT with progestins in hypertensive women

Studies dealing with the effect of progestins in hypertensive postmenopausal women were mainly limited to the investigation of DRSP (Table 3). In a randomized double-blind multicentric study performed in hypertensive postmenopausal women, the association of 3 mg DRSP with 1 mg of oral E2 significantly lowered both office and 24-hour systolic BP.⁹⁵ The same authors reported a decrease of 6.1 and 4.7 mmHg of daily systolic BP during the addition to E2 of 3 or 2 mg of DRSP, respectively.⁹⁶ Lately, the same

authors evaluated the effects of DRSP on early morning BP of mild and slight hypertensive women. The association of 3 mg, 2 mg, or 1 mg of DRSP with E2 significantly reduced early morning systolic BP. In this study, modifications induced by E2 alone were not significantly different from those observed with placebo. The reduction of early morning BP was related to the dose of DRSP, higher doses being associated with greater effects both in systolic and diastolic BP. The magnitude of these effects is similar to that reported for anti-hypertensive medicines. The fact that they are confined to the night is probably related to the major effect of the renin–angiotensin system at night.⁹⁷ DRSP (3 mg), associated with enalapril and administered for two weeks in 24 healthy, non-smoking postmenopausal women, decreased significantly systolic and diastolic BP in comparison to placebo.¹¹⁵ Similarly, a multicentric study on 230 hypertensive women showed that the association of DRSP with angiotensin-converting-enzyme (ACE) inhibitors or angiotensin II antagonists induces a significant decrease of BP in comparison to placebo.¹¹⁶

Conclusion

The relationship between menopause, hormonal status, age, and BP is not clearly defined. Both estrogens and progestins may directly influence vasodilation, but their effect may be additive or antagonist. In vivo studies also indicate that estrogens may activate other mechanisms that regulate BP, such as catecholamines or renin–angiotensin–aldosterone systems. Some clinical trials which mainly address blood pressure modification as a secondary endpoint of the trial have shown some negative effects of oral estrogens on office BP. This is particularly evident in trials enrolling women several years after menopause, and with the use of oral CEE. The data are more convincing and reassuring when results obtained with 24-hour BP monitoring are considered. These studies are much smaller in terms of sample size but more accurate and usually performed in recently postmenopausal women. These studies do not show major negative effects of oral estrogen in the control of BP. Furthermore, they consistently show a reduction of BP with the use of transdermal estradiol. The effect appears to be evident both in normotensive and hypertensive postmenopausal women. Most of the progestins tested either do not affect or favor the hypotensive effect of estrogens. Among the progestins, DRSP appears to provide the best anti-hypertensive effects.

Disclosure

The authors report no conflicts of interest in this work.

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