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Citation: EMJ Repro Health. 2026;12[Suppl 1]:95-98. https://doi.org/10.33590/emjreprohealth/X844TE7Y

Q1 To begin with, could you tell us about your professional journey and what initially drew you to the field of gynaecological endocrinology and menopause research?

My career in gynaecology began around 30 years ago with a 3-year residency in gynaecology and obstetrics in Ecuador, after which I qualified as a specialist.

Although I did not complete a formal fellowship, I undertook several courses in maternal–fetal medicine at New York University Langone Health, USA, and also trained for a period in a maternal–fetal unit in the KU Leven Faculty of Medicine, Belgium. My early career was strongly oriented towards obstetrics. I became director of a high-risk pregnancy, labour, and delivery unit, a role I held for almost 18 years.

At the same time, while working at the Hospital Gineco-Obstétrico Enrique C. Sotomayor, Guayaquil, Ecuador, I collaborated with the Hospital Director, and we published mainly in obstetrics and perinatal medicine. We collaborated with colleagues from Yale School of Medicine, New Haven, Connecticut, USA, and I still maintain those contacts today, as we continue developing research related to menopause and gynaecological endocrinology.

During that period, we began conducting menopause research, which is when I connected with Andrea R. Genazzani from the University of Pisa, Italy. I first engaged with him in 1999, so that collaboration now spans around 27 years. Over time, we carried out research together and published with Tommaso Simoncini, University of Pisa, and his group, collaborations that still continue today.

Later, when we moved to a new hospital with updated infrastructure, I transitioned to outpatient practice, seeing women who were pregnant and addressing general gynaecological issues, while continuing research and data collection. At the same time, I directed a molecular laboratory within my prior university that later developed into an institute.

After retiring from the hospital and my prior university, I was invited to join the university where I currently work. Their focus was clear: research visibility. Publications indexed in databases, such as Scopus, generate citations, and those citations contribute to university rankings and accreditation. In that sense, producing research output benefits the institution directly.

Around 6 years ago, Genazzani stepped down from his position as Editor-in-Chief of the official journal of the International Society of Gynecological Endocrinology (ISGE) and asked me to take on a greater role. I had been a very active editorial board member, regularly reviewing manuscripts, contributing papers, and supporting colleagues in publishing. That level of participation matters, because sometimes editorial board members are not active.

Over time, I also gained recognition across Latin America and internationally through work with the International Menopause Society (IMS) and participation on

> **High FSH levels may contribute to inflammatory pathways and cardiometabolic risk**

several boards. That exposure came gradually through years of clinical work, research, and collaboration.

Q2 Your research has extensively explored the cardiometabolic and quality-of-life consequences of menopause. In your view, what aspects of menopausal health remain most under-recognised in routine clinical practice today?

One area I often highlight is the link between obesity, hot flashes, inflammation, and cardiovascular risk.

Back in 2006, when I began presenting lectures on cardiometabolic risk during the menopausal transition and postmenopause, our group had already started studying this relationship. We screened postmenopausal women for metabolic syndrome using validated instruments and noticed that women with metabolic syndrome, particularly those with obesity, experienced more hot flashes and menopausal symptoms.

At the time, the connection was not widely recognised. We began publishing on the association between obesity, hot flashes, and cardiovascular risk. Our findings suggested that women with obesity or metabolic syndrome have a pro-inflammatory state, with higher levels of inflammatory markers, such as IL-6, TNF-α, and C-reactive protein (CRP), as well as lower nitric oxide levels.

This led us to propose that hot flashes might act as a surrogate marker of inflammation and cardiovascular risk.

More recently, attention has turned to follicle-stimulating hormone

(FSH). The 'hot topic', so to speak, is that hot flashes may not be driven solely by low oestrogen, but also by elevated FSH. High FSH levels may contribute to inflammatory pathways and cardiometabolic risk.

Another important issue is that some women who are still classified as premenopausal, because they have regular cycles, may already experience vasomotor symptoms. If a woman reports regular menses but also hot flashes, she likely has hormonal fluctuations causing elevated FSH. In those cases, she may effectively be entering the perimenopausal phase and should be evaluated and treated accordingly.

We currently have a paper under preparation examining this phenomenon using data from our Latin American research network. Another emerging area we are studying is menopause and the workplace, which is also becoming a major topic of interest.

Q3 You have contributed to numerous studies evaluating symptom burden and health risks in midlife women. Which tools or clinical approaches do you find most useful for assessing menopausal patients?

Two instruments are particularly useful.

The first is the Menopause Rating Scale (MRS). It provides a total symptom score, indicating overall symptom intensity, but it also divides symptoms into domains or subscales. This is extremely helpful in clinical practice.

For example, a 59-year-old woman might have a high total MRS score. However, when examining the domains, you may find that her symptoms are mainly urogenital rather than vasomotor.

This helps guide treatment decisions more precisely.

This domain-based approach is also valuable in research. For example, we are currently analysing a large cohort studying statin use in postmenopausal women. Initially, we observed that women taking statins reported more symptoms. A reviewer asked us to analyse the MRS not only by total score, but also by domain. When we did that, we found that the difference was driven mainly by psychological symptoms rather than vasomotor symptoms. This kind of analysis helps clinicians interpret symptoms more accurately.

The second instrument I use frequently is the six-item version of the Female Sexual Function Index (FSFI). The original 19-item questionnaire is too long and can be burdensome for patients. The shorter version allows rapid assessment of sexual function domains, such as desire, orgasm, and pain.

It does not provide a definitive diagnosis, but it helps identify which domain may require attention. In some cases, patients may need referral for counselling, psychology, or sexology.

At our university, we are trying to establish a service that integrates clinical care with research. Ideally, clinicians in this service would both treat patients and collect research data.

Other tools, such as cognitive assessments or sarcopenia measures, are used in research, but in routine practice the MRS and the short FSFI are very practical.

Q4 As you have conducted research across different populations and regions, how important is it to consider cultural and geographic differences when studying menopausal health?

It is extremely important. Much of our research has focused on Latin America through the Red Latinoamericana de Investigación del Climaterio (REDLINC), a network studying menopause across the region.

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Our work increasingly considers menopause from a holistic perspective, including symptoms, sexuality, mental health, nutrition, and psychosocial factors.

One of my long-term goals is to create a specialised menopause care model within my university that could serve as a reference for Latin America. In many developed countries, hospitals have dedicated menopause or gynaecological endocrinology units. In Latin America, such structures are rarely part of standard hospital systems or training programmes.

Another challenge is cultural perception. In Europe, women may have no hesitation about visiting a 'menopause unit'. In Latin America, the term itself can carry stigma, with women associating it with ageing. Therefore, services may need to be framed differently, perhaps around metabolic health, endocrinology, or comprehensive women's health.

The model I envision would involve multidisciplinary assessment, directing women to appropriate specialists

depending on their primary concern, whether urogenital symptoms, psychological issues, sexual dysfunction, or cardiometabolic risk.

We have also observed geographic differences. For example, women living at high altitude appear to report more severe symptoms than those living at lower altitude or on the coast. This may relate to oxygen levels and their influence on ovarian function or FSH secretion, although more research is needed.

These regional and cultural factors are central to understanding menopausal health.

Q5 Let's discuss menopausal hormone therapy. What do you think clinicians should take away from the current evidence base?

In Latin America, fewer than 10% of women use menopausal hormone therapy.

Although recent regulatory changes may influence perceptions elsewhere, I do not believe these changes will significantly increase hormone therapy use in Latin America. Many women have longstanding concerns about hormone therapy, and those fears are difficult to change.

Even if doctors accept new evidence, patients may remain hesitant. Many women simply say they are afraid and prefer not to take hormones. That perception is deeply rooted.

For that reason, we are currently collecting data to understand how both doctors and patients perceive hormone therapy following the recent regulatory developments. Once we have the results, we will have a clearer understanding of whether attitudes are changing and can therefore propose regional strategies to improve the use of this important therapeutic option.

Q6 Reflecting on the recent ISGE 2026 Congress, which emerging topics in gynaecological endocrinology will have the greatest impact in the coming years?

Scientifically, menopause was an important theme, including treatment, cardiovascular risk, and symptom management. Other important topics included polycystic ovary syndrome, endometriosis, and broader areas of gynaecological endocrinology, such as amenorrhoea.

It was encouraging to see the Congress becoming more focused on endocrine aspects of women's health rather than surgical topics that are sometimes less directly related to the field.

The 40th ISGE Congress in Rome, Italy, was very successful, with approximately 3,000 participants. Because of this success, the society has decided to organise regional congresses between the main meetings. In 2027, we will hold a regional congress in Guayaquil, Ecuador for Latin America, and another regional meeting will take place in India, under the leadership of Shantha Kumari, Yashoda Hospital, Hyderabad, India.

These meetings aim to bring key topics from the main Congress to regional audiences, particularly those who were unable to attend the European meeting.

Q7 Looking ahead, what research priorities should the field focus on over the next decade?

Several priorities stand out. First, we need better identification of women who are still classified as premenopausal but already experience menopausal symptoms. These women may require earlier evaluation and treatment.

Second, we should improve early screening for cardiometabolic risk, hypertension, dementia risk, and cancer risk during midlife.

Lifestyle interventions will also remain critical. Research into cost-effective strategies such as diet, exercise, and other behavioural interventions can have a major impact on long-term health (for women and men).

Another key question is how menopausal hormone therapy will evolve globally. Uptake may differ between developed and developing countries depending on cultural attitudes, healthcare infrastructure, and education.

Finally, we must focus on building healthcare systems capable of screening women earlier for chronic disease risk and implementing preventive strategies. Early intervention and lifestyle modification are cost-effective approaches that can significantly improve long-term health outcomes for women.