Premature ovarian failure

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Premature ovarian failure (POF) causing hypergonadotrophic hypogonadism occurs in 1% of women. In majority of cases the underlying cause is not identified. The known causes include: (a) Genetic aberrations, which could involve the X chromosome or autosomes. A large number of genes have been screened as candidates for causing POF; however, few clear causal mutations have been identified. (b) Autoimmune ovarian damage, as suggested by the observed association of POF with other autoimmune disorders. Anti-ovarian antibodies are reported in POF by several studies, but their specificity and pathogenic role are questionable. (c) Iatrogenic following surgical, radiotherapeutic or chemotherapeutic interventions as in malignancies. (d) Environmental factors like viral infections and toxins for whom no clear mechanism is known. The diagnosis is based on finding of amenorrhoea before age 40 associated with FSH levels in the menopausal range. Screening for associated autoimmune disorders and karyotyping, particularly in early onset disease, constitute part of the diagnostic work-up. There is no role of ovarian biopsy or ultrasound in making the diagnosis. Management essentially involves hormone replacement and infertility treatment, the only proven means for the latter being assisted conception with donated oocytes. Embryo cryopreservation, ovarian tissue cryopreservation and oocyte cryopreservation hold promise in cases where ovarian failure is foreseeable as in women undergoing cancer treatments.

Key words: autoimmune ovarian damage/environmental factors/genetic aberrations/hormone replacement/premature ovarian failure

Introduction

The average age for menopause in Western populations of women is approximately 51 years. Premature ovarian failure (POF) or premature menopause refers to development of amenorrhoea due to cessation of ovarian function before the age of 40 years. The diagnosis is based on elevated FSH levels in menopausal range (usually above 40 IU/l) detected on at least two occasions a few weeks apart (Conway, 2000).

Women with POF suffer from anovulation and hypoestrogenism and present with primary or secondary amenorrhoea, infertility, sex steroid deficiency and elevated gonadotrophins (Kalantaridou et al., 1998). The condition affects approximately 1% of women, occurring in 10–28% of women with primary amenorrhoea and 4–18% in those with secondary amenorrhoea (Coulam et al., 1986; Anasti, 1998). Early loss of ovarian function has significant psychosocial sequelae and major health implications (Taylor, 2001); nearly 2-fold age-specific increase in mortality rate has been reported (Snowdon et al., 1989).

A wide spectrum of pathogenic mechanisms may lead to the development of POF including chromosomal, genetic, autoimmune, metabolic (galactosaemia), infectious (mumps) and iatrogenic (anticancer treatments) causes. In a large proportion of cases no cause is found and they are classified as idiopathic or karyotypically normal spontaneous ovarian failure (Laml et al., 2000; Pal and Santoro, 2002); whereas up to 30% of cases may have an autoimmune cause (Conway et al., 1996).

In the embryo, germ cells migrate from the urogenital ridge to the primitive ovary where they proliferate to form $3.5 \times 10^8$ oocytes in each ovary by about 20 weeks of intrauterine life. Most of these germ cells are destroyed through apoptosis (Hsueh et al., 1994, 1996). The ovary is endowed with a fixed number of primordial follicles at the time of birth, about $1 \times 10^6$ in each ovary. This number steadily dwindles throughout life as a result of atresia and recruitment towards ovulation (Gosden and Faddy, 1998). Fewer than 500 of the original $7 \times 10^6$ (0.007%) oocytes are released in the entire reproductive life span of a woman.

In idiopathic POF, there may be involvement of as yet unknown mechanisms affecting the rate of oocyte apoptosis (Morita and Tilley, 1999). This may lead to a reduced complement of oocytes in the ovaries at birth or accelerated atresia. Using ultrasound, follicles have been reported in up to 40% of POF patients (Mehta et al., 1992). However, ultrasonography or ovarian biopsies are not helpful in prognostication of future ovulation and fertility.
In a recent thought provoking article, Johnson et al. (2004) have challenged the concept that each woman is endowed with an irreplenishable number of gametes in the ovary. Through three different sets of experiments they came to a conclusion that ovarian germ cells are a dynamic population and undergo constant renewal. Such a novel concept that challenges the central dogma in reproductive sciences is likely to stir a flurry of debate and to be followed by further studies exploring the issue.

Genetic causes of POF

Most cases of POF are idiopathic, and the underlying mechanisms are largely unknown; however, observation of familial cases with POF indicates the role of genetic aberrations in its pathogenesis (Conway, 1997). Though genetic defects mostly involve the X chromosome, an increasing number of studies have documented autosomal involvement (Table I).

Several methods have been used to elucidate the cause of POF—transgenic ‘knockout’ animals, mutation screening of candidate genes in affected women, analysing pedigree data in linkage analysis and lately, population genetics. Various genetic mechanisms implicated in pathogenesis of POF include reduced gene dosage and non-specific chromosome effects that impair meiosis. These can lead to ovarian failure by causing decrease in the pool of primordial follicles, increased atresia of the ovarian follicles due to apoptosis or failure of follicle maturation.

Familial POF

The overall incidence of familial cases among women with POF seems to be low, around 4%, though there are conflicting data from various studies (Starup and Sele, 1973; Conway et al., 1996). Epidemiological studies suggested a higher incidence of approximately 30% (Cramer et al., 1995; Torgerson et al., 1997). In a large Italian study, Vegetti et al. (1998) showed that in one-third of the idiopathic POF patients this condition was inherited. A subsequent study reported the incidence of familial cases to be 12.7% (van Kasteren et al., 1999). The variation between reported incidences might be explained by differences in the definition of POF and the idiopathic form, by differences in population recruitment and by selection and recall bias.

Pedigree studies on affected families show a mode of inheritance suggestive of autosomal dominant sex-limited transmission or X-linked inheritance with incomplete penetrance (Coulam et al., 1983; Mattison et al., 1984; Bondy et al., 1998; Christina-Maitre et al., 1998; Vegetti et al., 1998). Female sex preponderance was found in siblings of 30 families of idiopathic POF suggesting that an X chromosome defect is inherited as a major cause of ovarian failure (Davis et al., 2000).

An adequate family history can distinguish between familial or sporadic POF. The risk of female relatives developing POF may be high in familial POF as compared to sporadic cases. Early diagnosis of familial predisposition permits prediction of impending menopause and susceptible women can be guided to achieve their reproductive goals by timely planning of pregnancy (Davison et al., 1998).

When considering the following list of genetic associations of POF, it is obvious that the strength of evidence linking each anomaly with POF is variable. In some instances there is a statistical association with the anomaly also occurring in normal women [Fragile site mental retardation 1 gene (FMR1)] (Cronister et al., 1991); in others only a single case represents the link (Noggin) (Kosaki et al., 2004). Included here are conditions where the genetic link is indirect such as galactose-1-phosphate uridylyltransferase (GALT), where biochemical damage of the ovary occurs and autoimmune regulator (AIRE) which triggers autoimmune damage.

X chromosome defects

Familial as well as non-familial X chromosome abnormalities have been described in women with POF. These abnormalities range from a numerical defect like complete deletion of one X (Turner’s syndrome) and trisomy X to partial defects in form of deletions, isochromosomes and balanced X autosome translocations (Zinn, 2001).

X monosomy

Complete or near complete absence of one X chromosome, as seen in Turner’s syndrome leads to ovarian dysgenesis characterized by primary amenorrhea, short stature and characteristic phenotypic features.

One X chromosome is inactivated in each cell of female mammals for dosage compensation of X-linked genes between

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males and females (Lyon, 1994). However, several X-linked genes escape inactivation and are vital for normal function of X chromosome (Zinn et al., 1993; Zinn and Ross, 1998). Two functioning X chromosomes are therefore necessary for normal ovarian function.

In the presence of only one X chromosome in Turner’s syndrome, ovarian follicles degenerate by birth. This may be the result of a lack of diploid dosage of one or more vital genes, both alleles of which are active in oogenesis. Histological data indicate that oogenesis proceeds normally in these individuals until diplotene oocytes begin to be incorporated into nascent follicles. There is a subsequent block to production of complete follicles manifesting as fetal follicular atresia. In 80% of cases, the paternally derived X is lost (Loughlin et al., 1991).

Cytogenetic data indicate that most Turner’s syndrome physical features map to the short arm of the X (Xp) and Y (Yp) chromosomes (Kalousek et al., 1979; Fryns et al., 1981; Goldman et al., 1982; Jacobs et al., 1990; Temtamy et al., 1992; Ogata and Matsuo, 1995) and result from reduced dosage of genes on the short arm of the X chromosome. Further investigations narrowed down the search for the affected chromosomal segment to the 2.6 Mb Xp–Yp pseudoautosomal region. Zinn et al. (1998) using a statistical method to examine genotype/phenotype relations mapped Turner’s syndrome traits, including POF, to a critical region in Xp11.2–p22.1. X and Y copies of the region are identical, and all genes within this region appear to escape X inactivation (Rappold, 1993). Eighteen such candidate genes have been reported (Lahn and Page, 1997) and more are likely to exist.

Trisomy X

It is commonly believed that X trisomy, which affects 1 in 900 women in general population, has no significant effect on fertility; however, association with hypergonadotrophic POF has been reported. Jacobs et al. (1959) first described triple X syndrome with POF in 1959. Further documentation of associated ovarian failure in this rare sex chromosome aneuploidy is in form of occasional case reports (Menon et al., 1984; Itu et al., 1990; Holland, 2001). Its relative prevalence among women with POF is not known (Lucas et al., 1971). In one reported series, 2 of 52 (3.8%) patients with POF had the triple X syndrome (Goswami et al., 2003). POF has also been reported in a girl with 48XXXX (Rooman et al., 2002). The underlying mechanism could be analogous to that observed among patients with Klinefelter’s syndrome.

Mosaicism

45X/46XX and 45X/47XXX: These individuals carry mixed germ lines and manifest phenotypic abnormalities and POF similar to monosomy X but 12% are reported to menstruate (Simpson, 1975).

Deletions

X chromosome deletions associated with POF are more common than translocations. Deleted X chromosomes necessarily leave a portion of the normal X unpaired and isodicentric probably interfere with pairing, resulting in atresia of oocytes.

While deletions commonly involve the short arm of the X chromosome (Xp), the fraction of deletions that show POF is far higher in the Xq13–25 region (Simpson and Rajkovic, 1999).

Prevention of premature ovarian failure

Deletions at Xp11 result in 50% primary amenorrhoea and 50% secondary amenorrhoea. Deletions at Xq13 usually produce primary amenorrhoea. A phenotypic difference has also been noted between distal deletions, associated with preserved ovarian function, and proximal deletions, associated with ovarian failure. However, the relation is imperfect, since large deletions that remove the whole critical region for POF, in Xq21, were found not to be associated with ovarian failure (Merry et al., 1989).

Translocations

In contrast to generally neutral effects of balanced autosomal translocations, balanced X/autosomal translocations very often lead to POF with more than 100 cases of post-pubertal women with X/autosomal balanced translocations reported (Therman et al., 1990).

The deleterious effect on ovarian function results from X breakpoints that fall on the long arm between Xq13 and Xq26. A ‘critical region’ for normal ovarian function has therefore been proposed for Xq13–q26 (Sarto et al., 1973; Phelan et al., 1977; Therman et al., 1990). Within this region the most frequent breakpoints involve two specific regions defined as POF loci. POF1 Xq26–qter (Tharapel et al., 1993) and POF2 Xq13.3–Xq21.1 (Powell et al., 1994). These are separated by a short region in Xq22. It has been suggested that chromosome dynamics in the region could be sensitive to structural changes and the resulting unpaired chromosome provokes a pachytene checkpoint during meiosis leading to oocyte apoptosis (Burgoyne and Baker, 1984).

Distal deletions involving the POF1 locus are associated with POF at ages 24–39 years (Krauss et al., 1987; Tharapel et al., 1993). Various molecular techniques and bioinformatics have been used to map the POF1 locus and identify the putative genes for POF (Davison et al., 2000).

The translocations involving the POF2 locus cause POF at an earlier age of 16–21 years (Powell et al., 1994). Sala et al. mapped the X autosomal translocations in 11 women with POF to POF2 locus involving a 15 Mb YAC contig, with the majority of the breakpoints localized along the whole Xq21 region between loci DXS233 and DXS1171 (Sala et al., 1997). They suggested that a single gene is unlikely to be responsible for ovary development and/or oogenesis rather several genes may be present along the critical region and they may be interrupted by the balanced translocations. However, it must be noted that many breakpoints on the X chromosome are not associated with POF (Therman et al., 1990).

POF genes on the X chromosomes

Molecular investigations in women with POF and experiments on transgenic animal models have led to the identification of a number of candidate genes for POF. It is assumed that POF may result from mutations involving these genes. Such mutations have been identified in < 10% of POF cases (Harris et al., 2002) and functions of many of these genes are not known. Therefore, none is accepted as a genetic marker for POF.

FMR1

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a trinucleotide repeat located at its 5′ UTR region. Four types of alleles are identified based on the number of repeats: normal (6–40), grey-zone (41–60), premutated (61–200) and fully mutated (>200). The full mutation is associated with fragile X mental retardation syndrome, the most common form of inherited mental retardation.

The FMR1 gene is expressed in oocytes and encodes an RNA-binding protein involved in translation. Rife et al. conducted immunohistochemical fragile X mental retardation protein (FMRP) studies in a full mutated female fetus. In the ovary samples, FMRP expression was seen in all germ cells surrounded by FMRP-negative paragranulosa and interstitial cells. The Mullerian epithelium of the fetal Fallopian tube was continuously positive in the control case, whereas the full mutation carrier showed a discontinuous patchy pattern (Rife et al., 2004). In a study of murine FMR1 expression pattern, enhanced levels were seen in the fetal ovary while in the mature ovary no specific FMR1 expression signal was found. As proliferation of oogonia takes place in fetal ovary, it was suggested that FMR1 serves a special function during germ cell proliferation (Bachner et al., 1993).

POF was first noted as an unexpected phenotype among heterozygous carriers of the fragile X premutation in the early 1990s. Subsequent studies showed that FMR1 trinucleotide expansions in the premutation range of 50–200 repeat units, but not full mutations, are associated with POF (Cronister et al., 1991; Schwartz et al., 1994; Partington et al., 1996). The underlying mechanism for this association is not clear.

Presently, there exists firm evidence for a significant association between fragile X premutation carrier status and premature menopause as shown both by the analysis of women carrying the premutated allele (Cronister et al., 1991) and by the screening of women affected by POF (Conway et al., 1995, 1998; Vianna-Morgante et al., 1996; Murray et al., 1998). The results of an international collaborative study examining premature menopause in 760 women from fragile X families showed that 16% of the 395 premutation carriers had experienced menopause prior to the age of 40 compared with none of the 238 full mutation carriers and one (0.4%) of the 237 controls (Allingham-Hawkins et al., 1999).

The incidence of FRAXA premutations has been shown to vary among women with POF depending on the proportion of sporadic and familial cases. Thirteen per cent of pedigrees with the familial POF and 3% of women with the sporadic form of POF have been found to carry FRAXA premutations compared with an expected prevalence of 1:590 (Conway et al., 1998). Hundschied et al. (2000) reported that carriers who received the premutation from their fathers were at a higher risk of POF (28%) than those who received the premutation from their mothers (4%) suggesting that POF may be limited to premutations that are paternally inherited. However, this finding was not substantiated in subsequent studies (Murray et al., 2000; Vianna-Morgante and Costa, 2000). From the practical point of view, FRAXA premutations are certainly worth seeking in those with familial POF in order to enable genetic counselling and hopefully, limiting the transmission of Fragile X syndrome to future generations. Some units might also consider screening for FRAXA premutations in sporadic cases.

Fragile site, folic acid type, rare (FRAXE)/fragile site mental retardation 2 gene (FMR2)

In patients who have the cytogenetic changes of fragile X syndrome but who are FMR1-mutation negative, Sutherland and Baker (1992) identified a second site of fragility, symbolized FRAE. It was found to lie approximately 150–600 kb distal to the FRAXA site at Xq28 and to be folate sensitive.

An excess of small alleles with fewer than 11 repeats at the FRAXE locus were found in women with POF (Murray et al., 1998). In their subsequent study involving a cohort of 209 women with POF, these were traced to three females with cryptic deletions in FMR2, the gene associated with FRAE. They proposed that microdeletions within FMR2 may be a significant cause of POF, being found in 1.5% of women with the condition, and in only 0.04% of the general female population (Murray et al., 1999).

Bone morphogenetic protein 15 gene, BMP15 (GDF-9B)

Bone morphogenetic proteins (BMPs) are extracellular signalling proteins belonging to transforming growth-factor-β superfamily, which also includes growth/differentiation factors (GDFs). BMP15 is an oocyte-specific GDF that stimulates folliculogenesis and granulosa cell growth and is expressed in oocytes during early folliculogenesis. It shares a coincident expression pattern with the closely related mouse GDF-9 gene, which is essential for normal folliculogenesis in mice (Dong et al., 1996). BMP15 gene maps to Xp11.2 within the Xp POF critical region (Dube et al., 1998; Aaltonen et al., 1999). It is presumably expressed from both X chromosomes in oocytes, and could potentially show a gene dosage effect.

Di Pasquale et al. (2004) reported heterozygous mutation in BMP15 in two sisters with POF presenting with primary amenorrhoea. The mutation involved A to G transition at base pair 704 of the BMP15 gene that resulted in a tyr235-to-cys (Y235C) amino acid substitution. The father was a hemizygous carrier, whereas the mother had a wild type BMP15 coding sequence. The mutation was found in a highly conserved part of the BMP15 gene encoding the propeptide region and was not found in 210 alleles from 120 ethnically matched controls. This condition represents an unusual example of X-linked human disease exclusively affecting heterozygous females who inherited the genetic alteration from the unaffected father.

Autosomal involvement in POF

Autosomal translocations

Autosomal translocations are uncommon in women with POF; most reports of translocations document X/autosome balanced translocations, with no common autosomal breakpoint. Burton et al. (2000) reported translocation between two autosomes, chromosomes 2 and 15–46; XX,t(2;15) (q32.3;q13.3) in a woman with POF. They also reviewed three other cases of autosomal translocations in women with POF (Hens et al., 1989; Kawano et al., 1998).

Autosomal genes

POF is seen in several disorders involving autosomal genes.
Blepharophimosis-ptosis-epicanthus inversus syndrome (BPES)

This autosomal dominant genetic condition, first described by Vignes in 1889, is characterized by complex eyelid malformation. Two forms are described—type I with POF in affected females and type II not associated with POF (Zlotogora et al., 1983). POF related infertility is inherited as an autosomal dominant sex-limited trait in these families.

Amati et al. (1996) showed that the BPES-1 associated with POF maps to 3q22–q23, as does type II. Crisponi et al. (2001) cloned putative winged helix/forkhead transcription factor gene, FOXL2 that is mutated in both BPES types I and II. FOXL2 appears predominantly in the ovary in adult humans and its corresponding gene is the first human autosomal gene in which dominant mutations have been implicated in ovarian maintenance and differentiation. Recently, a human FOXL2 intragenic mutation database was published that included 135 intragenic mutations and variants of FOXL2 (Beyen et al., 2004). Harris et al. (2002) found two FOXL2 variants with a presumed pathogenic effect in 2 of 70 patients with non-syndromic POF. However, other studies involving phenotypically normal women affected by POF did not reveal any mutations indicating that mutations in the FOXL2 coding region are rarely associated with non-syndromic POF (De Baere et al., 2001, 2002; Bodega et al., 2004).

FSH receptor (FSHR)

FSH has an important role in the recruitment and development of ovarian follicles during the folliculogenesis. FSHR gene maps to 2p21–p16. Aittomaki et al. (1995) reported a missense mutation of the FSHR in six multiplex families in Finnish population. The mutation at position 566 of exon 7 of the FSHR gene resulted in a substitution of a valine for alanine at residue 189 and was manifest as hypergonadotrophic ovarian dysgenesis. Transfection experiments showed that the mutation leads to a dramatically reduced binding capacity and cyclic AMP production after FSH stimulation in spite of apparently normal binding affinity in cells expressing the mutated receptor protein. Other novel mutations involving FSHR have also been reported (Tournai et al., 1999; Doherty et al., 2002; Meduri et al., 2003).

In the UK and in other populations, mutations of the FSHR gene were found to be rare in women with POF or resistant ovary syndrome (Layman et al., 1998; Conway et al. 1999; Takakashi et al., 2001; Sundblad et al., 2004).

An earlier study of FSHR genes in patients with POF revealed the existence of polymorphisms (Whitney et al., 1995), which do not appear to have pathophysiological significance with regard to ovarian function (Liu et al., 1998; Conway et al., 1999).

LH receptor

LH receptor maps to 2p21. Latronico et al. (1996) reported a woman with amenorrhoea and ovarian resistance to LH who had a homozygous substitution of thymidine for cytosine at position 1660 of the LH receptor gene that resulted in abnormal truncation of the receptor. The affected male siblings had Leydig cell hypoplasia.

FSH beta-subunit variant

Gonadotrophins (FSH and LH) and intact hypothalamo–pituitary–ovarian axis are vital for normal ovarian functions. Severe gonadotrophin receptor defects or defects in post-receptor mechanisms may contribute to hyposensitivity or early atresia of follicles leading to POF (Conway, 1996). Matthews et al. reported a case with primary amenorrhoea and infertility due to a mutation in the gene (map locus 11p13) encoding β-subunit of FSH (Matthews et al., 1993). However, in another study no mutations were found in the gene for FSH-β in 18 women with POF that would diminish binding of FSH to target cells (Layman et al., 1993).

LH beta-subunit variant

Takahashi et al. (1999) have reported an increased prevalence of a variant LH with a mutant beta subunit in women with POF (18.4%) as compared to controls (8.5%). In a subsequent study involving women with ovulatory disorders, they reported five novel silent polymorphisms of LH-β subunit using PCR-amplified gene sequencing (Takahashi et al., 2003).

Inhibins

Inhibin, a glycoprotein, is a gonadal hormone that inhibits synthesis and secretion of pituitary FSH. It has been considered as a strong candidate gene in the aetiology of POF.

An elevated serum FSH level and low inhibin B level in the early follicular phase has been reported to relate with reproductive ageing (Soules et al., 1998) and diminished ovarian reserve (MacNaughton et al., 1992). The presence of low serum inhibin levels in POF further supports its role in the pathophysiology of POF (Petraglia et al., 1998).

One variation of INH alpha gene, G769A, has been associated with POF (Shelling et al., 2000; Marozzi et al., 2002; Dixit et al., 2004), the prevalence of which may vary in different populations from 0–11% (Dixit et al., 2004; Jeong et al., 2004).

GALT gene

Impairment in GALT metabolism leads to galactosaemia, a rare autosomal recessive disorder. The GALT gene maps to chromosome 21q13. POF is reported in 60–70% of female patients with galactosaemia (Waggoner et al., 1990; Lam et al., 2002). Galactosaemia induced decrease in initial number of oogonia, ovarian follicular damage in fetal life induced by galactose or its metabolites and defective gonadotrophin function and could be involved in pathogenesis of POF.

AIRE gene

Mutations in the AIRE gene, responsible for autoimmune polyendocrinopathy-candidiasis-ectodermal dystrophy (APECED) syndrome, can lead to ovarian insufficiency. The gene maps to chromosome 21q22.3. More than 40 AIRE gene mutations are known (Wang et al., 1998; Lam et al., 2002). In a survey of 72 patients with APECED, hypogonadism was present in 60% of patients aged >12 years (Perheentupa, 1996).

Eukaryotic initiation factor 2B

A rare association of ovarian failure with white-matter abnormalities on cerebral magnetic resonance imaging has
been observed (Schiffmann et al., 1997). These cerebral abnormalities are similar to those in childhood ataxia with CNS hypomyelination (CACH)/vanishing white-matter leukodystrophy (Schiffmann et al., 1994; van der Knaap et al., 1997). Fogli et al. (2003) tested eight karyotypically normal patients from seven families with association of ovarian failure with white-matter abnormalities for mutations in the five sub-units (α–ε) of the eukaryotic translation initiation factor 2B (eIF2B). They found mutations in three of the five EIF2B genes (EIF2B2, -4 and -5, which map to 14q 24.3, 2p23.3 and 3q27, respectively) that were earlier shown to cause childhood ataxia with central nervous system hypomyelination/vanishing white-matter disease leukodystrophy (Leegwater et al., 2001; van der Knaap et al., 2002). However, in a subsequent study involving 93 patients with POF who did not have leukodystrophy or neurological symptoms none of these mutations were identified. The authors concluded that EIF2B mutations are an uncommon cause of pure spontaneous POF (Fogli et al., 2004).

Noggin mutation

Haplo-insufficiency of the NOG gene on 17q22 encoding Noggin leads to proximal symphalangism (SYM1), an autosomal-dominant disorder characterized by ankylosis of the proximal interphalangeal joints, fusion of carpal and tarsal bones, brachydactyly and conductive deafness (Gong et al., 1999). NOG is expressed in the ovary and acts as an antagonist for BMPs, including BMP4 and BMP7 (Zimmerman et al., 1999; Groppe et al., 2002) which play an important role in ovarian function (Shimasaki et al., 1999, 2003).

Kosaki et al. (2004) have recently reported a case of POF and SYM1 with mutation in NOG. They proposed that an NOG mutation raises the susceptibility to POF by perturbing the functions of BMPs in a certain fraction of patients who have a high predisposition to POF because of other genetic and/or environmental factors.

Mitochondrial DNA polymerase γ mutations

Luoma et al. have reported that women with progressive external ophthalmoplegia have early menopause—before the age 35 years. They analysed the gene sequence of mitochondrial DNA polymerase γ (POLG), the enzyme implicated in pathogenesis of this mitochondrial disease, and documented mutations in members of all the seven families studied. The corresponding gene maps to 15q25. Clinical assessment of these patients showed significant cosegregation of Parkinsonism with POLG mutations (Luoma et al., 2004).

Syndromal associations

Cheng and Stenson (2003) described two siblings with bilateral corneal anaesthesia associated with multiple systemic abnormalities including ovarian failure. The combination of these abnormalities with parental consanguinity was suggestive of an inherited syndrome. Women with POF are also more likely to exhibit ocular surface damage and symptoms of dry eyes than age-matched controls suggesting a role of sex hormones in the health and disease of the ocular surface (Smith et al., 2004).

Schupf et al. (1997) reported that age-adjusted likelihood of menopause was twice as high in women with Down’s syndrome as in women with other intellectual disabilities. Treated thyroid conditions did not influence menstrual status and did not modify the relationship between Down’s syndrome and menstrual status. The underlying cause could be related to accelerated ageing.

Candidates genes for POF

While any gene encoding a component of reproductive function can be considered a candidate, here we review a selection of ‘candidate’ POF genes that have been raised in the past.

Diaphanous 2 Drosophila homologue (DIAPH2)

Bione et al. (1998) characterized human homologue of the DIAPH2 and demonstrated that this gene is disrupted by a breakpoint in a family with POF associated with a balanced X; 12 translocation, t(X; 12) (q21; p1.3).

The protein (DIA) is a member of the formin homology FH1/FH2 family of proteins and affects cytokinesis and other actin-mediated morphogenetic processes that are required in early steps of development. Mutated alleles of the gene affect gonadogenesis and lead to sterility (Castrillon and Wasserman, 1994). DIA is proposed to be involved in oogenesis and affects the cell divisions that lead to ovarian follicle formation.

Drosophila fat facets related X-linked gene (DFRFX)

This gene, also known as USP9X, maps to Xp11.4 and encodes an enzyme that removes ubiquitin from protein conjugates, protecting them from proteosomal degradation (Jones et al., 1996). USP9X is ubiquitously expressed, has a Y homologue, and escapes X inactivation, consistent with possible gene dosage effects. No mutations have been reported in USP9X; however, azoospermic males have been reported to harbour deletions and point mutations of closely related USP9Y homologue (Brown et al., 1998; Sun et al., 1999).

X-prolyl aminopeptidase 2 (XPNPEP2) gene

This gene encodes an X-linked aminopeptidase P enzyme that hydrolyzes N-terminal Xaa–Pro bonds that are found in bradykinins, other cytokines and collagen. It maps to critical region Xq25. Although the physiologic substrates for the enzyme are not known, XPNPEP2 is believed to be a candidate gene for POF as it was found to be disrupted by a balanced X-autosome translocation associated with secondary amenorrhoea (Prueitt et al., 2000).

X-linked zinc finger gene (ZFX)

ZFX lies within the critical region for ovarian failure and maps to Xp22.2–p21.3. It encodes a ubiquitously expressed zinc finger transcription factor of unknown function (Page et al., 1987). ZFX was cloned as a homologue of ZFY, a former candidate for the testis determining factor on the Y chromosome. It escapes inactivation, and therefore deletions or mutations in one of its copies might cause haploinsufficiency (Schneider-Gadicke et al., 1989). Heterozygous and homozygous Zfx mutant female mice have been shown to have a diminished germ cell numbers suggesting a role for this gene in POF (Luoh et al., 1997).
It is the human homologue of rat gene Leucine-Rich Primary Response Gene-1 (LRP1), which is rapidly induced in Sertoli cells in response to FSH (Roberts et al., 1996). It maps to Xq22 and is expressed in the developing ovary, even before the FSHR. It is therefore proposed as a candidate gene for disorders of gonadal development and gametogenesis.

**X inactivation-specific transcript (XIST)**

An abnormality in the mechanism of X inactivation may lead to POF. XIST is a gene exclusively expressed from the inactive X. It is located within the X inactivation centre at band Xq13.2 and is thought to be intricately involved in X inactivation (Brown et al., 1991). Mutations in human XIST might cause skew inactivation patterns resulting in haploinsufficiency of vital ovarian developmental genes and POF.

**Wilms tumor 1 gene (WT1)**

The transcriptional factor WT1 is expressed in high levels in follicles at early stages of development and because WT1 overexpression represses the promoter activity of inhibin-alpha gene, this nuclear protein may be important in the maintenance of follicles at early stages of development. The gene is proposed as a candidate gene for POF and maps to 11p13 (Rose et al., 1999).

**Ataxia telangectasia**

Infertility is a common feature of the inherited human disease ataxia telangectasia (Boder, 1975). ATM, the mutated gene maps to chromosome 11q 22.3 and is a member of a family of kinases involved in DNA metabolism and cell-cycle checkpoint control. The ATM gene product plays an essential role in a diverse group of cellular processes, including meiosis, the normal growth of somatic tissues, immune development and tumor suppression. ATM-deficient mice are completely infertile due to complete absence of mature gametes in adult gonads (Barlow et al., 1996; Elson et al., 1996; Xu et al., 1996). Infertility in the mouse models is attributed to meiotic arrest at the zygote/pachytene stage of prophase I as a result of abnormal chromosomal synapsis and subsequent chromosome fragmentation.

**Negative studies**

Here we report those candidate genes that have been subject to mutation screening with a negative result. It is likely that many such studies may not have been published and therefore this cannot be considered a definitive list.

**Angiotensin II type 2 (AT2) receptor genes**

AT2 receptor is highly expressed in fetal tissues and rapidly decreases after birth. The receptor is activated in some pathophysiological states and is suggested to be involved in pathogenesis of diseased states like myocardial infarction and cardiac hypertrophy. Granulosa cells of rat atretic follicles express high level of AT2 receptor and therefore its role in POF has been investigated. However, examination of the entire coding sequence of this receptor (mapped to Xq22–q23) in two different families of sisters with POF failed to reveal any changes in nucleotide sequences (Katsuya et al., 1997).

**c-kit gene**

Studies in mice have demonstrated that c-kit, a transmembrane tyrosine kinase receptor, plays a critical role in gametogenesis. The human KIT gene is located on chromosome 4 at map locus 4q12. Mutations in the human KIT gene have been identified as a cause of Pielbaldism, a rare autosomal dominant disorder of melanogenesis characterized by patchy absence of pigmentation of the skin and overlying hair (Spritz and Beighton, 1998; Richards et al., 2001). Shibanuma et al. (2002) investigated 40 women with, 46; XX spontaneous POF using PCR based single-stranded conformational polymorphism analysis and DNA sequencing and found one silent mutation and two intronic polymorphisms. They concluded that mutations in the coding regions of the KIT gene appear not to be a common cause of 46XX spontaneous POF in the studied population of North American women.

**SRY related HMG-box (SOX) 3 gene**

The genes encoding DNA-binding motif of the HMG-box class and showing homology to SRY (sex determining region Y), the putative testis determining gene have been named SOX, for SRY related HMG-box. The close homology between SRY and SOX3 might suggest that each is responsible for its respective gonadal development: SRY for the testis and SOX3 for the ovary.

The SOX3 gene has been mapped to Xq26–q27 (Stevanovic et al., 1993). A deletion of this gene was detected in a male patient with a contiguous gene syndrome of severe mental retardation, small testes, lower limb skeletal defects and contractures (Wolff et al., 1997). However, screening of 164 women with POF did not reveal any mutations in this gene (Conway, unpublished observations).

**Müllerian-inhibiting substance (MIS) gene**

MIS is a testicular hormone responsible for Müllerian duct regression in male sexual development and acts as an oocyte meiosis inhibitor in the rat ovary (Takahashi et al., 1986; Ueno et al., 1989). In mice, MIS null females though fertile have been shown to undergo earlier reproductive senescence possibly because of a early depletion of their stock of primordial follicles (Durlinger et al., 1999). The MIS gene (map locus 19p13.3–p13.2) and the MIS receptor type II gene (map locus 12q13) were evaluated as candidate genes for POF and polycystic ovary syndrome; however, direct sequencing revealed no causative mutations in the coding regions of these genes (Wang et al., 2002).

**Autoimmune causes of POF**

Some cases of POF may be due to an abnormal self-recognition by the immune system. Irvine et al. reported on autoimmunity in patients with POF using indirect immunofluorescence (IFL) in 1968. Subsequently, in the past three decades much evidence has accumulated to suggest that autoimmune mechanisms are involved in pathogenesis of up to 30% of cases of POF (Conway et al., 1996). This evidence takes the form of clinical association of POF with other autoimmune diseases, demonstration of ovarian autoantibodies, studies involving mouse models or histological studies on ovarian tissue from affected patients.
Clinical associations

The most convincing evidence comes from the commonly observed association of POF with other autoimmune disorders. In general, it is considered that about 20% may have a history of other autoimmune disorders, most commonly autoimmune thyroid disease. Occasional studies have reported this association in as many as 39% of women with chromosomally competent POF (Alper and Garner, 1985; LaBarbera et al., 1988). Both endocrine (thyroid, hypoparathyroid, diabetes mellitus, hypophysitis) and non-endocrine (chronic candidiasis, idiopathic thrombocytopenic purpura, vitiligo, alopecia, autoimmune haemolytic anaemia, pernicious anaemia, systemic lupus erythematosus (SLE), rheumatoid arthritis, Crohn’s disease, Sjogren syndrome, primary biliary cirrhosis and chronic active hepatitis) autoimmune associations are described (Rebar and Cedars, 1997; Betterle et al., 2002). The authors suggested that measuring adrenal antibodies would be an effective screening method to detect autoimmune adrenal insufficiency in young women with spontaneous POF and that a standard adrenocorticotropic hormone stimulation test should be performed when positive.

POF may be part of the autoimmune polyglandular syndromes (APS) when accompanied by other autoimmune endocrinopathies (Table II). POF is more common with APS types I and III than with APS type II (Kauffman and Castracane, 2003). Sharing of autoantigens between ovary and adrenal glands, particularly the side-chain cleavage enzyme may explain the association of ovarian failure and Addison’s disease. An autoimmune response to these steroidogenic enzymes and ovarian steroid cells appears to mediate destruction of ovarian function in these cases.

**POF in absence of Addison’s disease**

Thyroid autoimmunity is the most common association followed by parietal cell antibodies (Hock et al., 1997). More than normal association with insulin-dependent diabetes mellitus (IDDM) and myasthenia gravis has also been reported (Ryan and Jones, 2004). In one study of women with SLE, anti-ovarian antibodies were detected in 84% (Moncayo-Naveda et al., 1989). In many cases non-ovarian autoimmune involvement may exist only at subclinical level.

Non-ovarian autoantibodies

Several studies have reported increased prevalence of positive thyroid peroxidase and parietal cell autoantibodies in POF (de Moraes et al., 1972; Mignot et al. 1989a). Belvisi et al. (1993) reported that 40% of 45 women with POF were positive for at least one organ-specific autoantibody most common being antithyroid antibodies (20%). In the control group, only one woman (3.6%) showed autoimmunity. A more recent study by Novosad et al. (2003) reported similar findings; they did not find higher prevalence of antinuclear antibodies as reported earlier (Ishizuka et al., 1999).

**Ovarian autoantibodies**

The presence of organ specific autoantibodies supports the role of autoimmune mechanism in several endocrine diseases. Anti-ovarian antibodies are reported in POF by several studies but their specificity and pathogenic role are questionable.

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**Table II. Autoimmune polyglandular syndromes and POF**

<table>
<thead>
<tr>
<th>APS type</th>
<th>Inheritance</th>
<th>Autoimmune involvement</th>
<th>Age group</th>
<th>Incidence of POF</th>
</tr>
</thead>
<tbody>
<tr>
<td>APS I Autosomal recessive caused by a mutation in the autoimmune regulator (ARE) gene on chromosome 21</td>
<td>Chronic mucocutaneous candidiasis, adrenal and parathyroid failure</td>
<td>Children age 3–5 years or in early adolescence</td>
<td>17–50% (Ahonen et al., 1990)</td>
<td></td>
</tr>
<tr>
<td>APS II Polygenic, characterized by dominant inheritance and association with HLA DR3</td>
<td>Primary adrenal failure (Addison’s disease with autoimmune thyroid disease (Schmidt’s syndrome) and/or type 1 diabetes (Carpenter’s syndrome)</td>
<td>Adults in the third or fourth decade</td>
<td>3.6–10% (Beterle et al., 2004)</td>
<td></td>
</tr>
<tr>
<td>APS III Apart from the absence of adrenal failure, no clinical differences between types II and III have been described</td>
<td>Thyroid failure and other immunological syndromes with exclusion of Addison’s disease</td>
<td>Adults</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Histological evidence for autoimmune damage in POF**

Histological examination of ovarian biopsies in POF with associated adrenal autoimmunity reveals lymphocytic and plasma cell infiltration of the ovary particularly around steroid-producing cells of the developing follicles, and sparing of primordial follicles. Perivascular and perineurial infiltrates are also seen (Sedmak et al., 1987; Bannatyne et al., 1990). Histological evidence of oophoritis is reported to be rare (<3%) in POF in absence of adrenal involvement (Hoek et al., 1997).
In an initial study, Coulam and Ryan (1979) demonstrated presence of ovarian antibodies in serum of patients with POF by immunoprecipitation of radiolabelled human ovarian protein. Different methods have since been tried to identify anti-ovarian antibodies the most common being enzyme-linked immunosorbent assay (ELISA) and IFL. However, search for organ specific ovarian antibodies in POF has yielded conflicting results so far.

Luborsky et al. (1990) used ELISA to study sera from 45 patients POF. A combined total of 69% of the sera were positive for either ovary or oocytes. In a subsequent study, ovarian antibodies were found in 53% of women with premature menopause (Luborsky et al., 1999). Using whole tissue homogenate from human ovaries at different ages as antigen, Fenichel et al. (1997) found positive circulating ovarian antibodies with ELISA in 59% of patients with idiopathic POF. Wheatcroft et al. (1997) found that ovarian antibodies were detected in 27% of idiopathic POF patients by ELISA but only 7% were positive by IFL. Such variable results were attributed to the different stages of the disease when tested, methodological differences and by the multiplicity of potential immune targets that comprise various steroidogenic enzymes, gonadotrophins and their receptors, the corpus luteum, zona pellucida and oocyte.

Presently none of these tests is well standardized, nor do they relate with ovarian histology. Use of commercial ovarian antibody tests therefore needs caution as immunomodulatory treatment based on these results may cause more harm than good; osteonecrosis secondary to glucocorticoid therapy in POF has been reported (Kalantaridou et al., 1999).

Possible antigenic targets for antibody mediated autoimmune damage in POF

Study of anti-ovarian autoantibodies has led to the identification of putative ovarian epitopes, which may enable better understanding of the pathologic mechanisms involved in POF.

Steroid producing cells

Autoantibodies to steroid-producing cells—steroid cell autoantibodies (SCA)—have been detected in POF by IFL (Elder et al., 1981; Sotsiou et al., 1980; Betterle et al., 1993). SCA react with cells active in steroid synthesis, such as adrenal cortex, ovarian theca interna and corpus luteum, testicular Leydig cells, and placental trophoblasts (Elder et al., 1981). These antibodies are widely present in POF associated with Addison’s disease (87%) but are rare in POF with non-adrenal associations or in isolated POF (Falorni et al., 2002). These findings support the idea of a shared autoimmune response in ovarian and adrenal autoimmunity. The molecular nature of autoantigen(s) in POF unassociated with Addison’s disease (idiopathic POF) remains unclear.

3β-hydroxysteroid dehydrogenase (3β-HSD) autoantibodies

The steroid cell enzyme, 3β-HSD has been identified as a target of SCA in POF. It is involved in the steroid metabolic pathway and is expressed in tissues recognized by SCA. 3β-HSD autoantibodies were found in 21% women with isolated idiopathic POF using immunoblotting techniques and adrenal cDNA library screening (Arif et al., 1996). However, a later study reported 3β-HSD antibodies to be rare (2%) in women with POF (Reimand et al., 2000).

Gonadotrophin receptors blocking antibodies

Antibodies against FSH and LH receptors have been postulated as having a role in the mechanism of ovarian failure (Anonymous, Case records of the Massachusetts General Hospital, 1986) akin to the antireceptor antibodies in other autoimmune disorders, such as myasthenia gravis (Lindstrom et al., 1976) (blocking antibodies to the acetylcholine receptor), some forms of insulin-resistant diabetes (blocking antibodies to the insulin receptor), and primary hypothyroidism (blocking antibodies to the TSH receptor) (Drexhage et al., 1981). Studies by Austin et al. (1979), Tang and Faiman (1983) and Anasti et al. (1995) were unable to demonstrate blocking antibodies to LH or FSHRs in patients with POF. However, Tang and Faiman did observe greatest interference with FSHR interaction in a patient who had POF with other autoimmune associations. In a recent study using cell lines expressing human gonadotrophin receptors, gonadotrophin receptor blocking antibodies were not detectable in 69 patients with POF (Tonacchera et al., 2004).

Other ovarian antigens

Several other targets within the ovary for autoantibody induced damage have been identified (Forges et al., 2004). McNatty et al. (1975) detected cytotoxic effect of serum from patients with Addison’s disease and autoimmune ovarian failure on human granulosa cells in culture. In another study, sera from 21 of 26 patients with POF were able to block the growth of rat granulosa cells in vitro (van Weissenbruch et al., 1991). The oocyte and zona pellucida are other possible antigenic sites (Shivers and Dunbar, 1977; Rhim et al., 1992; Smith and Hosid, 1994). Autoantibody to a zona pellucida 3 epitope has been shown to induce autoimmune ovarian disease and POF in neonatal mice (Setiady et al., 2003). The underlying mechanism was suggested to be stimulation of de novo autoimmune pathogenic CD4 (+) T cell response by epitope-specific autoantibody.

Cellular immune abnormalities

Alteration of T cell subsets and T cell mediated injury is likely to play an important role in pathogenesis of autoimmune POF as evidenced by human studies and animal models of autoimmune oophoritis (Mignot et al. 1989b, Melner and Feltus, 1999; Nelson, 2001). This is similar to the pathology in other endocrine autoimmune diseases, such as IDDM, Graves’ disease, and Addison’s disease. Chernyshov et al. (2001) have reported an increase of autoantibody producing B cells and a low number of effector suppressor/cytotoxic lymphocytes in their study comprising 68 patients with POF. Reduced NK cell number and impaired NK cell activity have been documented in women with POF and in murine post-thyromectomy autoimmune oophoritis (Pekonen et al., 1986; Hoek et al., 1995; Maity et al., 1997). The role of cytokines has also been described in causing follicular atresia in POF (Coulam and Stern, 1991; Naz et al., 1995).

Animal models

Autoimmune oophoritis and POF can be induced in mice by neonatal thymectomy done 3 days after birth (Taguchi et al., 1980; Koijima and Prehn, 1981; Kalantaridou and Nelson, 1998). The autoimmune damage is primarily mediated by T cells (Sakaguchi et al., 1982; Smith et al., 1991). Humoral
autoimmunity may also play a role as these mice generate a spectrum of antibodies most of which react with antigens in the oocyte cytoplasm. The inciting antigen in autoimmune disease could be a common target of both autoreactive B and T cells. Using immune serum from these mice, Tong and Nelson (1999) isolated and characterized a novel oocyte-specific protein that may play a role in autoimmune POF. Nelson (2001) cloned the gene for the oocyte specific antigen designated ‘Maternal Antigen That Embryos Require’. Such studies may lead to recognition of a similar antibody marker for the human disease.

**Immunogenetics in POF**

The studies investigating genetic susceptibility for autoimmune POF may help understand its pathogenesis.

Animal studies suggest involvement of immune-regulatory regions outside the H-2 locus in determining susceptibility to murine post-thyectomy autoimmune oophoritis (Kojima and Prehn, 1981; Nair et al., 1996). Teuscher et al. (1996) identified the locus determining genetic susceptibility to autoimmune POF on mouse chromosome 3. There may be a role of similar predisposing genes for POF in women.

Among human studies, HLA-DQB1*0301 and HLA-DQB1*0603 were shown to be associated with 3β-HSD autoimmunity in POF (Arif et al., 1999). In a study comprising 37 patients with POF and 100 organ donors from the same population, no statistically significant difference was found in the distribution of A, B, Cw, DR and DQ antigens (Jaroudi et al., 1998). Studies on APS show association of HLA-DR3 with APS type 2 (Farid et al., 1980; MacLaren and Riley, 1986; Weetman, 1995). The most likely genetic candidate in this condition is proposed to be at a locus controlling T cell development. Associations with HLA class II alleles have been reported in PAS type I as well (Betterle et al., 1998). In APS I, mutations of the AIRE gene play an important role. The AIRE gene is assigned to chromosome 21q22.3 (Aaltonen et al., 1997) and its more than 40 mutations are reported (Wang et al., 1998).

In view of inconsistent findings on clinical and laboratory studies, the mechanism for ovarian autoimmunity remains obscure. Genetic or environmental factors might initiate the immune response. The role of major histocompatibility complex antigen and cytokines has been explored in human autoimmune POF. The relative contribution of cell-mediated immunity and antibody-mediated immunity is controversial. There exists a possibility for disease-specific therapy to prevent further autoimmune ovarian damage in selected POF patients with proven autoimmune aetiology.

**Diagnosis of autoimmune ovarian failure**

The gold standard for detecting autoimmune causes of immune ovarian destruction has been ovarian biopsy. However, because there is no treatment proven safe and effective to restore fertility this procedure cannot be advised in routine clinical practice (Khastgir et al., 1994).

Specific defects of expression of cell surface markers on peripheral blood lymphocytes have been shown to identify individuals destined to develop autoimmune pancreatic destruction and type I diabetes mellitus, even before any other evidence of autoimmunity. A similar study exploring cell surface expression in women with POF showed a statistically significant increase in CD8 density on T cells (Yan et al., 2000). Further development of cell surface markers in combination with other diagnostic tests could result in diagnosis of autoimmune POF before the development of complete ovarian failure.

**Miscellaneous causes of POF**

**Galactosaemia**

Classic galactosaemia is a rare cause of POF. It is caused by GALT deficiency and leads to a severe disease in the newborn. According to one study, 81% of 47 affected women developed ovarian failure, with primary amenorrhoea noted in eight, and the majority experienced POF shortly after puberty (Waggoner et al., 1990). Intracellular accumulation of galactose metabolites or deficient glycosylation reactions could lead to decrease in the initial number of oogonia through apoptosis. The clinical management essentially includes hormonal replacement therapy (Forges and Monnier-Barbarino, 2003).

**Iatrogenic**

In patients developing malignant diseases, radiotherapy and chemotherapy can lead to POF (Koyama et al., 1977; Howell and Shalet, 1998). However, there is little risk of premature menopause in women treated with radiation fields that exclude the pelvis (Madsen et al., 1995). Ovarian radiation of 9 Grays render humans infertile, though pregnancies have been reported after significantly higher irradiation exposure (Spinelli et al., 1994). The effect of radiotherapy is also dependent on dose and age and on the radiation therapy field. The prepubertal ovary is relatively resistant to this form of gonadotoxicity (Beerendonk and Braat, 2005). Transposition of the ovaries in young women requiring pelvic irradiation helps in preserving their ovarian function.

POF is important sequelae of cytotoxic chemotherapy given for various malignant diseases in young women. The structure and function of granulosa cells and oocytes are affected by chemotherapeutic agents. The gonadotoxic effect of chemotherapy is largely drug- and dose-dependent and is related to age.

Almost any pelvic surgery has the potential to damage the ovary by affecting its blood supply or causing inflammation in the area. The exact risk is unknown and is thought to be very small for routine operations. Uterine artery embolization, an interventional technique used to manage various gynaecological disorders, also has a potential to result in POF by compromising the vascular supply to the ovary (Amato and Roberts, 2001).

**Toxins and viruses**

It is popular belief that sperm counts have fallen over recent years because of exposure of the testicle to environmental toxins or drugs. It is possible that the ovary is affected by the viruses or toxins in a similar way. There also exist anecdotal reports of virus infections being followed by ovarian failure (Wood, 1975; Fox, 1992). Mumps oophoritis has been considered to be a cause of POF (Morrison et al., 1975). Cigarette smoking is also
implicated. Female smokers have been shown to experience menopause earlier than non-smokers suggesting a possible detrimental effect of cigarette smoking on ovarian function though further investigations are needed in this field (Di Prospero et al., 2004). Women with epilepsy have also been reported to have an increased risk for developing POF (Klein et al., 2001).

The effects of endocrine disruptors, heavy metals, solvents, pesticides, plastics, industrial chemicals and cigarette smoke on female reproduction has been reviewed (Sharara et al., 1998). The mechanism by which chemicals affect ovarian function may involve hormonal or immune disruption, DNA adduct formation, altered cellular proliferation, or inappropriate cellular death. Data on the association of chemical exposures and adverse reproductive outcomes in humans are, however, equivocal and further studies are needed to clarify which toxicants affect human reproduction and how.

Management of POF

Management of POF needs to address the two major medical issues—hormone replacement therapy (HRT) and infertility. Women also require personal and emotional support to deal with impact of diagnosis on their health and relationships. In addition, associated pathology needs to be assessed and managed so that long-term follow-up is essential to monitor HRT and for health surveillance. Various issues of importance in the management of women with POF are summarized in Table III.

HRT

Long-term HRT is needed for relief of menopausal symptoms (including vasomotor instability, sexual dysfunction, mood, fatigue and skin issues) and to prevent long-term health sequel of estrogen deficiency, such as osteoporosis (Davis, 1996). Estrogen replacement is usually continued up to the age of 50 years, when the risk and benefit of continued treatment are reviewed (Armitage et al., 2003). No data are available to evaluate the impact of treatment on risk factors, such as the development of breast cancer or of cardiovascular events in young women with POF and extrapolation from studies in older women may not always be appropriate.

A wide range of HRT preparations are available for estrogen replacement including oral, transdermal, subcutaneous and vaginal routes of administration. An HRT regimen should be based on the individual preferences of each patient. The dose of estrogen required by young women is titrated to prevent vasomotor symptoms and vaginal dryness and may be higher than that used in an older age group. Serum estradiol (E2) may be helpful in those women using implants so as to avoid tachyphylaxis, but in the majority symptoms alone are sufficient guide.

Once the choice of estrogen has been made, separate consideration can be given to the progestin in women with an intact uterus. First, the route may be oral, transdermal or uterine. With the oral and transdermal routes there is a choice between continuous or sequential (for 10–14 days each month) delivery. Continuous regimen avoids menstrual flow but break through bleeding may be more common in young women compared to an older age group in whom there is greater uterine atrophy. Sequential regimen ensures monthly menstrual bleed, which may be a psychological benefit to some young women (and absurd to others!). Progestins vary from the more potent such as norethisterone to the weaker such as dydrogesterone. Trial and error will allow the user to find the most suitable progesterone preparation. Uterine delivery with the levonorgestrel intrauterine device (Mirena) has a great theoretical advantage allowing ‘estrogen only’ systemic preparations to be used avoiding the adverse effects of oral progestins highlighted in the WHI and Million women studies of older women (Beral, 2003; Chlebowski et al. 2003). Androgen replacement is useful in some instances when persistent fatigue and loss of libido persist despite optimised estrogen replacement (Mazer, 2002; Arlt, 2003; Davis and Burger, 2003; Chu and Lobo, 2004; Shifren, 2004).

To return to oral estrogen choices, conjugated equine estrogen and 17β-E2 have consistent and comparable effects on hot flashes and may have similar short-term adverse effects (Nelson, 2004). Transdermal estrogen is very attractive because the avoidance of first-pass liver metabolism, rapid onset and termination of action, non-invasive self-administration, attainment of therapeutic hormone levels with low daily doses and potential for improved patient compliance. (Henzl and Loomba, 2003). Of particular note is the recent data that transdermal estrogen may be free of an excess risk of thrombosis (Scarabin et al., 2003).

Lastly, some young women find the combined oral contraceptive (COC) pill to be a ‘peer friendly’, discrete form of estrogen replacement as opposed to HRT preparations. The COC, however, provides a fixed combination of estrogen and progesterone with a ‘pill free week’ which contrasts from the greater flexibility and uninterrupted estrogen possible with the HRT alternatives.

Subcutaneous estrogen replacement involves placement of 25–50 mg E2 pellets usually in the lower abdomen or buttocks. Insertion is a minor office procedure and can also include testosterone implants if indicated. Return of symptoms, combined with serum levels of E2, can be used to determine the timing of redosing, which is about every 6 months for most women (Jones, 2004).

Topical vaginal estrogen is often neglected and may be used as an adjunct to systemic estrogen. Creams, pessaries, tablets
and vaginal ring appear to be equally effective for control of symptoms (Suckling et al., 2003).

Natural estrogens do not prevent any spontaneous ovulatory activity. Moreover, ovulation and pregnancy may occur in women with POF who use the COC. Barrier contraceptives are therefore recommended for women with POF who wish to avoid pregnancy.

The general measures advised for prevention of bone loss include improved physical activity, adequate diet, calcium and vitamin D, and avoidance of behaviours that promote bone loss, such as smoking and alcohol abuse. Monitoring bone mineral density with dual energy X-ray absorptiometry scan helps identify the women with osteoporosis who require specific additional intervention such as with bisphosphonates.

The efficacy of non-estrogen treatment modalities including other hormonal preparations, non-hormonal drugs, homeopathic preparations and non-drug treatments is not well documented (Bachmann, 1994), but may find favour in women who are intolerant to exogenous estrogen.

Infertility

Women with POF have a 5–10% chance of conceiving at some time after diagnosis. Pregnancy loss in these circumstances is reported at 20%, which is similar to that of normal population (van Kasteren and Schoemaker, 1999). There are many case reports and small series reporting use of various medical therapies in an attempt to induce fertility in women with POF; however, the few randomized therapeutic trials that are available fail to demonstrate any significant improvement in ovulation and pregnancy rates. In a systematic review of the various therapeutic interventions thought to restore ovarian function in POF, the authors concluded that interventions were equally ineffective and unlikely to be an improvement on expectant management (van Kasteren and Schoemaker, 1999). Only IVF and embryo transfer using donor oocytes has demonstrated high success rates and is considered to be the fertility treatment of choice in patients with POF (van Kasteren, 2001).

The likelihood of recovery of ovulation is not possible to predict. However, it cannot be assumed that infertility in women with POF is permanent or irreversible as in some cases hormone levels and disease activity fluctuate and return to biochemical normality. In a study of the effectiveness of gonadotrophins suppression using gonadotropin-releasing hormone agonist (GnRHα) 4/26 (17%) women appeared to ovulate over 4 months and the intervention had no effect on this outcome (Nelson et al., 1992). In a similar study using E2 instead of GnRHα, 17/57 (46%) women were found to ovulate at least once during the 12 week study (Taylor et al., 1996).

There are several isolated cases of spontaneous pregnancies in women with POF taking both estrogen and, interestingly, the COC (Polansky and De Papp, 1976; Szlachte et al., 1979; Ohsawa et al., 1985; Varma and Patel, 1988; Bouliue and Bully, 1993; Menashe et al., 1996). Alper et al. reported six women who conceived after a diagnosis of POF. Two pregnancies occurred while the women were receiving conjugated estrogen therapy, two while taking oral contraceptives and two women conceived spontaneously. There may be differences in fertility outcome in cases with ovarian failure depending on the age of onset. In a retrospective analysis of 86 ovarian failure patients, none of the 23 patients with primary amenorrhoea due to ovarian failure ovulated while seven of 63 (11.1%) with secondary amenorrhoea due to ovarian failure ovulated, and three of them conceived and delivered normal, healthy infants (Keiner et al., 1988). The authors recommended a trial of E2 replacement with close monitoring for ovulation in the women with secondary amenorrhoea due to POF before oocyte donation. In another series of 115 women with POF, those with secondary amenorrhoea continued to have intermittent ovarian function. Ovulation was detected in 24% and pregnancy occurred in 8% while ovulation was not detected in any of the women with primary amenorrhoea (Rebar and Connolly, 1990).

Exogenous estrogen could act by sensitizing the granulosa cells to the effect of FSH leading to ovulation and conception (Alper et al., 1986). Oral contraceptives may act similarly by down-regulating the LH and FSHRs (Check et al., 1989). However, interventional studies using oral contraceptives for gonadotrophin suppression in POF failed to show resumption of follicular activity (Buckler et al., 1993). Successful attempts at ovulation induction have been reported with clomiphene (Nakai et al., 1984) and gonadotrophins (Check et al., 1991; Blumenfeld et al., 1993; Chatterjee et al., 1993). Recently, pregnancy was reported after stimulation with recombinant FSH of a galactosaemia patient with ovarian failure (Menez et al., 2004). It was suggested that the impact of galactosaemia on the ovary could be due to the absence of recognition of circulating FSH by its receptor and not to a toxic alteration of the ovary by itself. Combination of different modalities of treatment has also been tried (Davis and Ravnikar, 1988).

Suppression of gonadotrophin secretion using GnRH analogues has been tried in an attempt to reverse POF but was not successful (Ledger et al., 1989; Surrey and Cedars, 1989). Similarly no benefit could be demonstrated from the immunomodulatory and gonadotrophin-suppressing effects of danazol in patients with karyotypically normal spontaneous POF (Anasti et al., 1994).

Recovery of ovarian function may occur after regression of the autoimmune status and control of coexistent endocrine disease. In women with myasthenia gravis and ovarian failure, thymectomy has resulted in resumption of menses, with or without recovery of fertility (Lundberg and Persson, 1969; Bateman et al., 1983; Chung et al., 1993). Finer et al. (1985) reported a 32-year-old woman with POF associated with ovarian autoantibodies, autoimmune Addison’s disease and primary hypothyroidism who became pregnant following the treatment of her thyroid and adrenal deficiencies.

There also exist a few reports on a successful ovulation-inducing treatment of selected women with POF (those with other autoimmune phenomena) with immunomodulating therapies, such as corticosteroids (Rabinowe et al., 1986; Taylor et al., 1989). Pregnancy after corticosteroid administration has been reported in POF occurring in a patient with polyglandular endocrinopathy syndrome (Cowchock et al., 1988). In another study, 11 consecutive women with POF were given prednisone 25 mg four times per day for 2 weeks. Two women demonstrated normalization of their serum gonadotrophins, an increase of serum E2, and ultrasonographic visualization of follicular growth, and both conceived (Corenblum et al., 1993). Despite these case
reports none of immunosuppressive therapies is proven to be safe and effective by prospective randomized placebo-controlled study and may be associated with complications such as osteonecrosis (Kalantaridou et al., 1999).

Several novel strategies have been tried including combined pentoxifylline–tocopherol treatment using 800 mg of pentoxifylline combined with 1000 IU of vitamin E given daily for 9 months (Letur-Konirsch and Delanian, 2003) and growth hormone-releasing hormone given in a dose of 1000 mg/day (Busacca et al., 1996).

Assisted conception with donated oocytes has been used to achieve pregnancy in women with POF since 1987 (Asch et al., 1987; Oksarsson et al., 1990; Rotsztejn et al., 1990). Presently it remains the only means for fertility treatment in POF that carries high success rate (Anonymous, Society for Assisted Reproductive Technology and the American Society for Reproductive Medicine. Assisted reproductive technology in the United States, 2002). Cryopreserved embryos have also been used for ovum donation in POF with a high pregnancy rate of 30% per transfer (Abdalla et al., 1989).

In some cases, it is possible to foresee premature menopause as in patients undergoing anticancer treatment with chemotherapy. Because dividing cells are more sensitive to the cytotoxic effects of these drugs, it has been hypothesized that inhibition of the pituitary–gonadal axis using GnRHa would render the germinal epithelium less susceptible to the cytotoxic effects of chemotherapy (Ataya and Moghissi, 1989). Subsequent studies confirmed that GnRHa cotreatment protects against POF during cytotoxic chemotherapy (Blumenfeld et al., 1996, 2002). This approach has also been advocated for young women requiring gonadotoxic treatments for SLE, organ transplantation and other autoimmune diseases (Blumenfeld and Haim, 1997; Blumenfeld et al., 2000). Use of oral contraceptives during chemotherapy has also been studied but the results failed to show protective effect on ovarian function (Longhi et al., 2003).

Use of apoptotic inhibitors, such as sphingosine-1-phosphate, is also been suggested as radioprotective and chemoprotective agent against germ cell death. This agent may act by inhibiting the signalling events involved in apoptotic process and protect the patient from POF (Morita et al., 2000; Spiegel and Kolesnick, 2002; Tilley and Kolesnick, 2002). The various attempts at preventing POF in young women exposed to gonadoxic chemotherapy have been reviewed (Blumenfeld, 2003).

Other fertility options for women diagnosed with cancer include IVF followed by cryopreservation of embryos, cryopreservation of mature oocytes and cryopreservation of ovarian tissue (Poirtet et al., 2002). The first option is not feasible in all cases. Pregnancies and life births have been reported after oocyte cryopreservation and subsequent intracytoplasmic sperm injection (Chen, 1986; Borini et al., 2004). Preservation of the structural complexity of the ovum is an important factor in determining the outcome (Falcone et al., 2004). The use of ovarian tissue cryopreservation for later use has been explored in women undergoing anticancer treatment. Similarly, adolescent girls with Turner’s syndrome still have follicles in their ovaries (Hreinson et al., 2002) and could be candidates for ovarian cryopreservation.

Cryopreserved ovarian tissue could be used in two ways—autograft and in vitro folliculo–oocyte maturation. Cryopreserved human ovarian tissue has been found to be functional after re-plantation (Oktay and Karliskaya, 2000; Radford et al., 2001; Gook et al., 2001). The first live birth after orthopic transplantation of cryopreserved ovarian tissue has been reported recently (Donnez et al., 2004). Successful pregnancy is possible following in vitro maturation of oocytes from antil follicles (Cha et al., 1991). Human preantral follicles have been isolated and cultured in humans and several animal species (Roy and Treacy, 1993; Gutierrez et al., 2000). However, the vast majority of follicles in human ovarian cortical tissue are primordial, which do not grow well in culture (Abir et al., 2001) and it is not practical to isolate primordial follicles from the cortical tissue before cryopreservation. Maturation of oocytes from primordial follicles after cryopreservation of ovarian tissue for use in IVF would be a further step in management of infertility due to cancer treatment or genetic causes (Hovatta, 2004).

A woman’s age would be a determining factor when considering ovarian cryopreservation. Children are most likely to benefit from it as their ovary contains more primordial follicles than adult women and other alternatives of oocyte or embryo cryopreservation are unavailable for them. It is also expected that by the time these children grow up and need their ovarian tissue, the modalities for its optimal use would become available (Aubard et al., 2001).

Ovarian tissue cryopreservation and oocyte cryopreservation thus hold promise for fertility preservation in the women likely to undergo ovarian failure following cancer treatments. This treatment may, however, be contraindicated in cases with possible metastasis to the ovaries where oocyte donation and IVF would be safer (Shaw et al., 1996).

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Premature ovarian failure


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