

Evans ML, Pritts E, Vittinghoff E, McClish K, Morgan KS, Jaffe RB.

Management of postmenopausal hot flashes with venlafaxine hydrochloride: a randomized controlled trial. *Obstet Gynecol.* 2005;105:161-166.

### FAST TRACK

**Patient-perceived mean hot flash scores dropped 51% from baseline with venlafaxine, versus 15% with placebo**

## Q Does venlafaxine reduce hot flashes?

**A** Yes. In this well-designed, randomized, placebo-controlled study, extended-release venlafaxine reduced the frequency (but not severity) of patient-perceived hot flashes in healthy postmenopausal women over the 3-month study period. Physicians may consider this therapy when treating women with vasomotor symptoms—especially those who cannot or wish not to take estrogen.

### EXPERT COMMENTARY

For 12 weeks, Evans et al examined the effect of venlafaxine, a serotonin noradrenergic reuptake inhibitor, on patient-perceived hot flash scores. The authors randomized 80 healthy postmenopausal women with at least 14 hot flashes per week to receive placebo or extended-release venlafaxine 37.5 mg daily for 1 week followed by 75 mg daily for 11 weeks. Sixty-one women completed the study.

**Drug effect sustained, placebo effect fades.** Both venlafaxine and placebo decreased the hot flash score at 1 month. However, unlike placebo, venlafaxine produced a further drop in hot flashes at 2 months, which was sustained at 3 months. All told, patient-perceived mean hot flash scores dropped 51% from baseline with venlafaxine compared with a 15% drop with placebo. Most women (93%) on venlafaxine planned to continue the treatment after the study concluded.

### Confirms previous trials

These findings reinforce data from previous venlafaxine studies, in which an approximately 60% drop in hot flash score was seen with venlafaxine compared with an approximately 30% drop with

placebo,<sup>1</sup> and add to our knowledge by offering a longer study period. Prior venlafaxine studies included women with a history of breast cancer, as well as those who simply had a fear of the disease.

### How does venlafaxine compare with other options?

**Fewer side effects than clonidine,** whose side-effect profile limits use in many women, according to a 2004 position statement on vasomotor symptoms from the North American Menopause Society.<sup>2</sup> Thus far, research has found venlafaxine to have fewer adverse effects, which include decreased appetite, dry mouth, and initially nausea.

**On par with paroxetine.** The reduction in hot flashes with venlafaxine 75 mg in this and previous studies is comparable with findings from a study of controlled-release paroxetine, a selective serotonin reuptake inhibitor, at doses of 12.5 mg or 25 mg.<sup>3</sup>

**Probably less effective than estrogen.** Evans et al did not directly compare venlafaxine with estrogen, but their findings suggest that venlafaxine is probably not as effective as estrogen for vasomotor symptoms.

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### REFERENCES

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2. North American Menopause Society. Treatment of menopause-associated vasomotor symptoms: position statement of The North American Menopause Society. *Menopause.* 2004;11:11-33.
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CONTINUED

Kiss H, Petricevic L, Husslein P. Prospective randomized controlled trial of an infection screening programme to reduce the rate of preterm delivery. *BMJ*. 2004;329:371-375.

## Q Can screening for vaginitis reduce preterm birth?

**A** Perhaps. Women treated for subclinical infection had significantly fewer preterm births than controls, Kiss et al found. However, I am not yet ready to embrace routine screening of all gravidas for asymptomatic candidiasis, trichomoniasis, and bacterial vaginosis (BV), though I strongly recommend treating *symptomatic* infections.

### EXPERT COMMENTARY

Before you embrace the screening program recommended by Kiss et al, be aware that their observations are inconsistent with other published reports and with our understanding of the pathophysiology of preterm delivery related to genital tract infection.



*Trichomonas vaginalis*

In this prospective, randomized trial, more than 4,000 *asymptomatic* gravidas

were screened for vaginal candidiasis, trichomoniasis, and BV. When infection was detected, the intervention group was treated and the control group was not. The frequency of preterm birth was 3.0% in the intervention group ( $P=.0001$ ) and 5.3% in the control group. The intervention group also had significantly fewer infants weighing less than 2,500 g.



*Candida albicans*

### How the findings contradict other data

I question these findings due to the following:

- To my knowledge, the study is unique in suggesting an association between vaginal candidiasis and preterm delivery.
- In a large multicenter US study,<sup>1</sup> treating gravidas with asymptomatic trichomoniasis did not prevent preterm delivery. In fact, treated women had a higher frequency of preterm delivery (19.0% versus 10.7%,  $P=.004$ ).
- In another large multicenter US study,<sup>2</sup>



Bacterial vaginosis

treating asymptomatic BV did not reduce the frequency of preterm delivery or other adverse outcomes.

The regimens Kiss et al used for trichomoniasis and BV are not standard in the United States. They administered topical metronidazole to treat trichomoniasis and topical clindamycin for BV. The current recommendation for treating trichomoniasis in pregnancy is a single 2-g oral dose of metronidazole.<sup>3</sup> For BV, recommended treatment is oral metronidazole, 250 mg three times daily for 7 days.<sup>3</sup>

Systemic regimens are based on the hypothesis that organisms ascend from the lower genital tract through the endocervical canal and colonize the membranes, causing inflammation and activating the prostaglandin cascade. Presumably, topical vaginal therapy will not eradicate organisms colonizing the upper genital tract.

These results may not be widely applicable, since the women treated by

Kiss et al were extremely low-risk. Ninety-eight percent of the women were white, and the total prevalence of the 3 vaginal infections was only 20%. In many US sectors, the prevalence of BV alone exceeds

30%. Unfortunately, based on results of the studies cited above, I do not believe US obstetricians should anticipate the favorable results noted by Kiss et al. ■

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### REFERENCES

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3. Sexually transmitted diseases treatment guidelines—2002. Centers for Disease Control and Prevention. *MMWR Recomm Rep*. 2002;51:1-78.

### FAST TRACK

**“I strongly recommend treating symptomatic infections”**