

# Restless Sleep? Hot Flashes Could Be to Blame

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ATLANTA — Sleep problems in perimenopausal women can diminish quality of life significantly and should not be minimized or overlooked, according to Hadine Joffe, M.D.

In general, hormonal fluctuations may be to blame, but hot flashes and night sweats in particular are often linked to insomnia, disturbed sleep, and sleep loss during the menopausal period, Dr. Joffe said in a satellite presentation at the annual meeting of the American Psychiatric Association.

"Considering the median duration of perimenopause is 4 years, many women may suffer from issues related to insomnia for a long time if they don't get treatment," said Dr. Joffe, director of endocrine studies in the perinatal and reproductive psychiatry clinical research program at Massachusetts General Hospital, Boston.

The data on the association between hot flashes and sleep quality and duration during perimenopause are contradictory, Dr. Joffe said. "A number of studies have shown that total sleep time in perimenopausal women who experience frequent hot flashes does not suffer, compared with women who don't have hot flashes, while other studies have shown that what does suffer is sleep quality," she said. "Hot flashes and night sweats interrupt sleep, causing lower sleep efficiency and longer REM latency, and the frequent awakenings cause next-day fatigue."

Still other studies have shown that mood symptoms, which are common in perimenopausal women, may influence the perceived intensity of hot flashes as well as self-reported sleep quality, Dr. Joffe said.

Whether driven by mood or the nature and frequency of hot flashes, menopause-related sleep disturbances can improve with treatment. "The most effective treatment continues to be hormonal therapy. Estrogen therapy in particular has been shown to improve subjective sleep quality and continuity and to increase REM and reduce REM latency," she said. "And the impact of estrogen on sleep is greatest in women with hot flashes."

However, concerns about using hormonal therapy for long periods as well as its contraindication in some patients have led to the consideration of other treatment strategies for improving sleep, including the use of serotonergic antidepressants and hypnotic agents, she said.

In a recent Finish study, investigators looked at the impact of the selective serotonin reuptake inhibitors fluoxetine and citalopram on menopausal symptoms. While neither appeared to have a significant effect on hot flashes, insomnia improved significantly in the citalopram group versus placebo (Menopause 2005;12:18-26).

Several studies also have shown that paroxetine and venlafaxine can significantly decrease hot flashes, and as such may improve sleep. Similarly, there is some evidence that the anticonvulsant gabapentin and the antihypertensive clonidine can effectively treat the vasomotor symptoms of menopause, Dr. Joffe said.

Hypnotic agents also may improve sleep

quality compromised by multiple factors, including hot flashes, she explained.

In one 4-week randomized, multicenter, double-blind, placebo-controlled study, women taking the benzodiazepine receptor agonist zolpidem reported an increase in total sleep time, a decrease in the number of awakenings, improved sleep quality, and improvements in sleep-related difficulty with daytime functioning (Clin. Ther. 2004;26:1578-86).

Preliminary data from an ongoing trial

of eszopiclone at Massachusetts General Hospital also has been linked to significantly improved sleep onset, sleep maintenance, total sleep time, and sleep quality, compared with placebo.

When treating menopause-related insomnia, first rule out underlying conditions, then consider patient factors and the severity of the problem, Dr. Joffe advised. Some antidepressants may take 3-4 weeks before noticeable improvement, so patients with severe symptoms might be re-

luctant to wait that long, she noted. Hypnotics may work faster, but they do have the potential for morning "hangover," and they are not appropriate in the presence of any coexisting chemical dependency.

Dr. Joffe receives research support from Abbott Laboratories. She also is on the speakers' bureau for Eli Lilly & Co. The APA-sponsored satellite symposium was supported by an unrestricted educational grant from Neurocrine Biosciences Inc. and Pfizer Inc. ■

## ADVERTISEMENT

# PERTUSSIS transmission

How do infants get  
**PERTUSSIS?**

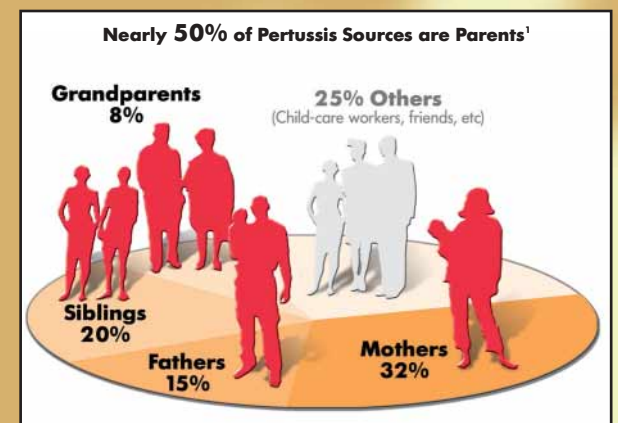
They get it from their family.

That's right — their  
**MOMS** and

dads, brothers and sisters,

even grandma and grandpa!

Nearly 75% of the time, a family member is the source of pertussis disease in infants<sup>1</sup>



References: 1. Bisgard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J.* 2004;23:985-989. 2. National Center for Health Statistics. *Health, United States, 2004 with Chartbook on Trends in the Health of Americans.* Hyattsville, MD: 2004. 3. Centers for Disease Control and Prevention. Pertussis Surveillance Report, Feb. 23, 2005. 4. Centers for Disease Control and Prevention. Pertussis Surveillance Report, Aug. 6, 2004. 5. Vitek CR, Pascual FB, Baughman AL, Murphy TV. Increase in deaths from pertussis among young infants in the United States in the 1990s. *Pediatr Infect Dis J.* 2003;22:628-634. 6. Centers for Disease Control and Prevention. Summary of notifiable diseases—United States, 2000. *MMWR.* 2000;49(53):12. 7. Centers for Disease Control and Prevention. Summary of notifiable diseases—United States, 2001. *MMWR.* 2001;50(53):15. 8. Centers for Disease Control and Prevention. Summary of notifiable diseases—United States, 2002. *MMWR.* 2002;51(53):28. 9. Scott PT, Clark JB, Miser WF. Pertussis: an update on primary prevention and outbreak control. *Am Fam Physician.* 1997;56:1121-1128. 10. Centers for Disease Control and Prevention. *Epidemiology and Prevention of Vaccine-Preventable Diseases: The Pink Book.* 8th Ed. Atlanta, Ga: Department of Health and Human Services, Public Health Foundation; 2004:75-88. 11. De Serres G, Shadmani R, Duval B, et al. Morbidity of pertussis in adolescents and adults. *J Infect Dis.* 2000;182:174-179.

According to a recent study of pertussis in 264 infants, a family member was identified as the source of the disease in three quarters of the cases. In fact, the infant's mother was positively identified as the source in 32% of the cases. In addition to Mom, other confirmed sources included Dad 15% of the time, Grandma/Grandpa 8% of the time, and a sibling 20% of the time. This study provides clear documentation of the threat of pertussis within the family setting and serves as a window to the growing problem of pertussis in the general population.<sup>1</sup>