What's Up, Doc?

Hot flashes: What works?

Estrogen is the most effective treatment for hot flashes in menopause; however, some women fear its side effects and seek other treatment options. The results of a systematic review of placebo-controlled trials of non-estrogen therapies suggest that progesterone may have its own positive effect on relieving hot flashes, and selective serotonin reuptake inhibitor antidepressants and gabapentin also show promising results in small studies. Despite popular use, soy products had inconsistent results, and improvements in hot flash symptoms seen with vitamin E and black cohosh were small and delayed. Red clover, evening primrose oil, ginseng root, topical wild Mexican yam and dong quai did not improve symptoms. Researchers concluded that more data are needed on alternative therapies, including the long-term effects of herbal therapies. *Acta Obstet Gynecol Scand* 2005;84:972-9

Nasal sprays for rhinitis

Researchers in Germany compared the efficacy and cost-effectiveness of and patient tolerance for 3 nasal sprays used for seasonal allergic rhinitis. A total of 123 patients used a glucocorticoid (mometasone furoate 200 µg once a day), a topical antihistamine (levocabastine hydrochloride 200 µg twice a day) or the cromone disodium cromoglycate (5.6 mg 4 times a day). Users of glucocorticoids had greater reductions in nasal symptoms (sneezing, itching, runny nose) and in eosinophil protein counts in nasal secretions. Improvement in nasal inspiratory flow was greater in the glucocorticoid and antihistamine groups. The 3 drugs had a similar impact on eye complaints related to allergic rhinitis and to side effects. Although glucocorticoids are more expensive, improved treatment results meant that it remained cost-effective in this study. *Ann Allergy Asthma Immunol* 2005;95:272-82

COMSTOCK

Non-estrogen therapies for treating hot flashes.

Self-managing INR

UK researchers randomly assigned 617 patients to either manage their own warfarin dosing or have their physician do so. All of the patients had already been taking warfarin for at least 6 months. Patients in the self-care group used a home testing device to measure their international normalized ratio (INR) twice a week and a simple dosing chart to calculate their dose of warfarin. After 12 months researchers found no difference in the percentage of time patients spent within the therapeutic range of INR in the 2 groups (70% v. 68%). Importantly, there was no increase in serious adverse events (2.8 v. 2.7 events per 100 patient years) among patients using self-care. Researchers concluded that, with appropriate training, many patients can manage their own anticoagulation using these tools. Of note, only 25% of eligible patients participated in the trial, perhaps because of the demands of self-care or an unwillingness to participate in clinical trials. *BMJ* 2005; doi:10.1136/bmj.38618.580903.AE (published 2005 Oct 10)

Flu vaccine and the elderly

A systematic review of studies of the influenza vaccine reveals that the vaccine is more effective in elderly people living in homes than in those living in the community. For residents of homes, the vaccine reduced rates of influenza-like illness (vaccine efficacy [VE] 23%, 95% CI 6–36), hospital admissions (VE 45%, 95% CI 16–64), pneumonia (VE 46%, 95% CI 30–68) and all-cause deaths (VE 60%, 95% CI 23–79). Among elderly people in the community there was no improvement in influenza-like illness rates or in the number of influenza cases or pneumonia, although hospital admissions for influenza and pneumonia (VE 26%, 12–38) and deaths (VE 42%, 24–55) were reduced. Researchers concluded that the effectiveness of vaccination for elderly people in the community is modest, perhaps because of the difficulties in achieving good coverage in those who need it most. Baseline health differences between those living in homes and in the community may also explain the findings. *Lancet* 2005;366(9492):1165-74 — Compiled by Sally Murray, *CMAJ*

DOI:10.1503/cmaj.051515