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This e-newsletter presents reviews of important, recently published scientific articles selected by The North American Menopause Society (NAMS), the leading nonprofit scientific organization dedicated to improving women's health and quality of life through an understanding of menopause and healthy aging. Each review has a commentary from a recognized expert that addresses the clinical relevance of the item. Oversight for this e-newsletter issue was by Chrisandra L. Shufelt, MD, MS, NCMP, Chair-elect of the 2012-2013 NAMS Professional Education Committee. Opinions expressed in the commentaries are those of the authors and are not necessarily endorsed by NAMS or Dr. Shufelt.

Cognitive behavioral therapy for menopause symptoms

Green SM, Haber E, McCabe RE, Soares CN. Cognitive-behavioral group treatment for menopausal symptoms: a pilot study. *Arch Womens Ment Health.* 2013 April 21 [Epub ahead of print]. **Level of evidence: II-2.**

Summary. In this pilot study, researchers developed a cognitive behavioral therapy (CBT) program for treating menopause symptoms in midlife. They ran two 10-week pilot groups of four participants each. Participants were referred through the Women's Health Concerns Clinic and community advertising.

A reduction in frequency and interference associated with hot flashes, depression, anxiety, and an overall improvement in quality of life were confirmed in the study. Over the course of the treatment, there was a trend in the reduction of sleep difficulties and sexual concerns. Researchers describe their pilot program as a promising alternative or complementary treatment for physical and emotional symptoms common during menopause.

Comment. CBT is a well-researched treatment for anxiety, depression, and sleep problems with strong evidence for its efficacy. Recently, three randomized controlled trials including over 600 women have also demonstrated that CBT is effective in reducing the impact of hot flashes and night sweats, ie, menopausal symptoms.[1-3]

In these trials, CBT was found to be effective for peri- and postmenopausal well women, as well as women with menopausal symptoms induced or exacerbated by breast cancer treatments. Moreover, a self-help form of the CBT (a booklet and CD) was as effective as 8 hours of group CBT.[1,4] While both forms of the intervention also improved mood, sleep, and aspects of quality of life, group CBT was more effective in these respects.

Green et al present a pilot study that draws on the above approaches and offers group CBT, combining sessions on hot flashes, mood, sexual problems, and sleep. The setting is a women's health clinic serving women with mental health difficulties such as anxiety and depression in perinatal and menopausal contexts. Although only eight women were included, six of whom had a psychiatric diagnosis, there were significant benefits in terms of hot flashes, mood, and quality of life. Given that emotional problems are common during this life stage and that women are more likely to seek help when they experience both menopause symptoms and low mood, this represents an innovative type of service. However, one cannot conclude that the psychiatric problems are due to menopause; there are likely to be complex interactions.

Given its effectiveness, CBT should arguably be offered within the context of multidisciplinary menopause clinics and within breast cancer services.

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2. Mann E, Smith MJ, Hellier J, et al. Cognitive behavioural treatment for women who have menopausal symptoms after breast cancer treatment (MENOS 1): a randomised controlled trial. *Lancet Oncol.* 2012;13(3): 309-318.
3. Duijts SF, van Beurden M, Oldenburg HS, et al. Efficacy of cognitive behavioral therapy and physical exercise in alleviating treatment-induced menopausal symptoms in patients with breast cancer: results of a randomized, controlled, multicenter trial. *J Clin Oncol.* 2012:30(33):4124-4133.
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Effect of Mediterranean diet on cognitive impairment

Tsivgoulis G, Judd S, Letter AJ, et al. Adherence to a Mediterranean diet and risk of incident cognitive impairment. *Neurology.* 2013;80(18):1684-1692.
Level of evidence:II-3.

Summary. Researchers examined a prospective, population-based cohort enrolled in the Reasons for Geographic and Racial Differences in Stroke (REGARDS) Study to determine the relationship between adherence to a Mediterranean diet and incident cognitive impairment. A food frequency questionnaire was used to evaluate adherence to a Mediterranean diet and cognitive status was determined at baseline and annually using the Six-item-Screener cognitive assessment tool.

Higher adherence to a Mediterranean diet was associated with lower likelihood of incident cognitive impairment before and after adjusting for confounders (demographic characteristics, environmental factors, vascular risk factors, depressive symptoms, and self-reported health status). Researchers noted that in persons with diabetes, higher adherence to a Mediterranean diet was not associated with less likelihood of incident cognitive impairment (OR, 1.27; 95% CI, 0.95-1.71; $P = 0.1063$).

Comment. The Mediterranean diet includes a reduced intake of saturated fat, meat, and dairy products with increased intake of fruits, vegetables, cereals, legumes, and olive oil. The present study revealed an association between adherence to this diet and reduced risk of incident dementia in a cohort study from the Stroke Belt, a southeastern region of the United States with a disproportionately high incidence of not only stroke and cardiovascular disease but also dementia.[1] The findings from this study, which oversampled blacks, are consistent with the broader scientific literature. Findings from an earlier meta-analysis indicated that adherence to a Mediterranean diet was associated with a 13% reduction in the incidence of neurodegenerative disorders,[2] the same magnitude of reduction observed in the present study. A systematic review of 11 observational studies (not including the present study) and one randomized trial also concluded that the diet is associated with reduced risk of cognitive decline and dementia.[3]

Although the consistency of findings is encouraging, results from the Women's Health Initiative Dietary Modification Trial suggested that findings from observational studies and randomized controlled trials do not reach consistent conclusions regarding dietary interventions. The Women's Health Initiative Trial found that a low-fat diet did not lower the incidence of coronary heart disease, stroke, or cardiovascular disease,[4] despite evidence from the Nurses' Health Study and others that diets low in polyunsaturated fat intake are associated with a reduced cardiovascular disease risk.[5] Impressively, however, a recent randomized

trial on the effects of the Mediterranean diet on cardiovascular outcomes was stopped early after an interim analysis found that those randomly assigned to the diet showed a 30% reduced risk of cardiovascular events.[6] Those findings raise the likelihood that the diet might also confer cognitive benefits because cardiovascular risk factors also extend to dementia.[7] Indeed, discussing the link between cardiovascular disease and dementia may increase patient's motivation to engage in dietary and other lifestyle changes to improve their health as they age. This approach may be especially effective for female patients given new evidence that women report greater worry and fear of dementia than men[8] and may have a greater risk of dementia than men.[9]

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Urinary incontinence severity and QOL

Barentsen JA, Visser E, Hofstetter H, Maris AM, Dekker JH, de Bock GH. Severity, not type, is the main predictor of decreased quality of life in elderly women with urinary incontinence: a population-based study as part of a randomized controlled trial in primary care. *Health Qual Life Outcomes.* 2012;10:153. **Level of evidence:III.**

Summary. Do different types of urinary incontinence (UI; stress, urgency, or mixed) cause varying severity of symptoms? This cross-sectional study followed 225 Dutch participants (aged ≥55 years) with UI in a randomized, controlled trial in primary care. Women completed a questionnaire on the physical and emotional impact of incontinence and limitations resulting thereof. They were also interviewed regarding demographic characteristics and comorbidity. Least squares regression analyses estimated the differences between incontinence type and severity.

Stress UI had a lower impact on the emotional domain of quality of life compared with mixed UI. Most patients had mixed UI and symptoms of moderate severity. The level of severity affected both overall and condition-specific quality of life, suggesting that severity is the main predictor of decreased quality of life.

Comment. These findings support previously published work on severity and type of UI and the relationship to quality of life. Additionally, these findings correspond to clinical practice. Urge incontinence tends to be more bothersome because it is unpredictable, uncontrollable, and is associated with larger volume leakage. Alternatively, stress UI is typically associated with increases in intra-abdominal pressure (which can be predicted or avoided) and smaller volume leakage (which can be controlled with

smaller incontinence products and is less likely to wet clothing).

Strengths of the study include the use of validated questionnaires, the use of general and condition-specific questionnaires, and a respectable response rate. Weaknesses include potential reporting and participant bias and the lack of comparison of this cohort with a cohort of women without UI, especially in terms of quality-of-life results).

Because quality of life is very specific to culture, the findings may not be generalizable to women of other nationalities. Additionally, the findings cannot be generalized to younger women who likely have different quality-of-life expectations and may be more bothered by stress UI.

Though it is very important to identify UI severity and to understand the impact on quality of life, understanding the type of UI is critical in clinical practice, because treatment options vary widely. While urge UI is most often treated with behavioral therapy, bladder retraining, medications, and procedures such as intradetrusor botulinum toxin or neuromodulation, stress UI is most successfully treated surgically. Correctly diagnosing the type of UI is imperative to treating the patient appropriately.

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Estrogen and menopausal joint pain

Chlebowski RT et al. Estrogen alone and joint symptoms in the Women's Health Initiative randomized trial. *Menopause.* 2013 Mar 18 [Epub ahead of print].

Summary. Data from the Women's Health Initiative (WHI) continue to provide insight into the effects of estrogen therapy on menopausal symptoms. In a post hoc analysis of the placebo-controlled, estrogen-only component of the WHI trial, researchers evaluated the relationship between estrogen use and joint symptoms. Participants completed questionnaires at baseline and 1, 3, and 6 years later in which they reported any experience of mild, moderate, or severe joint pain or swelling.

Joint pain was reported by 77% of participants at baseline. At 1 year, pain was reported less commonly in the estrogen group than the placebo group (76.3% vs. 79.2%, $P = 0.0001$) and mean joint pain scores (range, 0–3) were modestly lower (1.16 vs 1.22, $P = 0.0001$). At 3 years, 72.5% of adherent women in the estrogen group reported joint pain, whereas 81.7% of those in the placebo group reported pain ($P = 0.006$).

Comment. Proposed mechanisms of estrogen's action include attenuation of inflammation and cartilage turnover. The authors note that adherence-adjusted analysis strengthened the association between exogenous estrogen and reduced joint pain; nonetheless, this improvement was still generally modest. For those recently menopausal women whose bothersome symptoms are relieved by estrogen therapy—and who also note improvement in joint pain—the benefits and risks of longer-term estrogen might be considered.

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Menopause Editor's picks from May 2013

NAMS spotlights selections from the most recent issue of the Society's official journal, *Menopause*, chosen by its Editor-in-Chief, Isaac Schiff, MD.

Does risk for anxiety increase during the menopausal transition? Study of Women's Health Across the Nation.
Bromberger, Joyce T.; Kravitz, Howard M.; Chang, Yuefang; Randolph, John F. Jr; Avis, Nancy E.; Gold, Ellen B.; Matthews, Karen A.

♦

Effects of short-term estradiol and norethindrone acetate treatment on the breasts of normal postmenopausal women.
Cheng, Guojun; Butler, Ryan; Warner, Margaret; Gustafsson, Jan-Ake; Wilczek, Brigitte; Landgren, Britt-Marie.

♦

Overexpression of progesterone receptor membrane component 1: possible mechanism for increased breast cancer risk with norethisterone in hormone therapy.
Neubauer, Hans; Ruan, Xiangyan; Schneck, Helen; Seeger, Harald; Cahill, Michael A.; Liang, Yayun; Mafuvadze, Benfor; Hyder, Salman M.; Fehm, Tanja; Mueck, Alfred O.

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The level of evidence indicated for each study is based on a grading system that evaluates the scientific rigor of the study design, as developed by the US Preventive Services Task Force. A synopsis of the levels is presented below.

Level I	Properly randomized, controlled trial.
Level II-1	Well-designed controlled trial but without randomization.
Level II-2	Well-designed cohort or case-control analytic study.
Level II-3	Multiple time series with or without the intervention (eg, cross-sectional and uncontrolled investigational studies).
Level III	Meta-analyses; reports from expert committees; descriptive studies and case reports.

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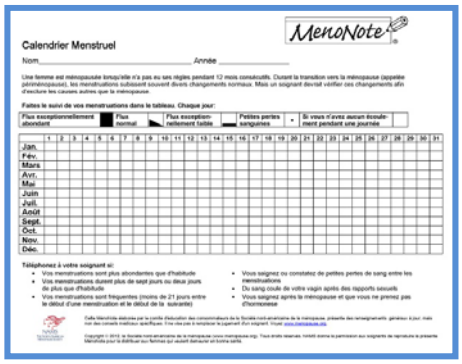
MenoNotes

Six free handouts summarize some of the most confusing menopause-related topics. Hot flashes, vaginal dryness, bioidentical hormone therapy, and a menstrual calendar (in English, French, and Spanish) are clearly explained with the most up-to-date information. More topics will be added regularly so check back often.



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