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Testimony Title: Working with Researchers and Non-Profit Organizations to Identify and Treat Cognitive and Mood Symptoms During the Menopausal Transition

Testimony Description:

My name is Dr. Pauline Maki. I am an Associate Professor of Psychiatry and Psychology at the University of Illinois at Chicago. I am a member of the Board of Trustees of the North American Menopause Society (NAMS) and a Chair-Elect of the NAMS Research Affairs Committee. I present my public testimony today as a member of NAMS and as a clinical researcher with longstanding interest in menopause, cognition and mood.

The North American Menopause Society is a 20-year-old nonprofit organization dedicated to promoting the health and quality of life of women through an understanding of menopause. Its membership of about 2,000 interacts with women via many disciplines, including medicine, nursing, and research. The professional diversity of the NAMS membership provides a unique opportunity to highlight gaps in knowledge,

identify research opportunities, translate and disseminate the best quality research on menopause, and ultimately improve the care of peri- and postmenopausal women.

The diverse membership of NAMS has consistently identified the subject of mood and cognition as an important research topic and a subject for continuing education for menopause practitioners. Evidence that NAMS values the dissemination of research on cognition and mood comes from a review of publications in the official NAMS journal, *Menopause*. From the year 2000 to 2007, 18 percent of articles published in NAMS were on the topic of cognition and mood.

The 2005 NIH State-of-the-Science Conference Statement on Management of Menopause-Related Symptoms concluded that the evidence that the menopausal transition leads to mood changes was mixed, and evidence that the menopausal transition leads to cognitive changes was considered insufficient. Although evidence of cognitive changes remains inconclusive, research over the past seven years has contributed to a profound shift in our understanding of the effects of menopause on depression.

Now, at least four prospective studies have documented that there is an increased risk of clinically significant depressive symptoms in women as they transition from the premenopausal stage to the perimenopausal stage. The magnitude of this risk is substantial. Compared to when she was premenopausal, a woman is two to four times as likely to have symptoms of depression during the perimenopausal stage. Importantly, this risk is observed in women who have no history of clinical depression. It is important to stress that the majority of women do not experience clinically significant depressive symptoms. However, as with premenstrual dysphoric disorder (PMDD), commonly known as PMS, there appears to be a significant subgroup of women for whom the menopausal transition represents a period of increased vulnerability to clinically significant depressive symptoms.

Clinical depression predisposes a woman not only to psychiatric complications, but also to the development of cardiovascular disease and dementia. In 2002, the U.S. Preventive Services Task Force (USPSTF) concluded that one-time screening for depressive disorders in adults, when combined with effective follow-up, reduces the risk for persistent depression. In addition, the task force concluded that such screening programs are as cost-effective as mammography screening of women over age 50 or treatment of mild-to-moderate hypertension. Therefore, it is critically important that menopausal practitioners are able to identify and treat depression in their patients.

To that end, I would like to express my gratitude to the ORWH, the NIA, and the NIH for supporting the sold-out NAMS Symposium entitled "Depressive Symptoms and Cognitive Complaints in the Menopause Transition." That Symposium translated the recent scientific literature on depression to an audience comprised primarily of menopause practitioners. The ORWH and the NIH also support the Study of Women's Health Across the Nation, which has yielded more than 200 publications on the natural and treated history of the menopause, and several impactful publications on menopause and depressive symptoms. The NIH also supports the ongoing MS-FLASH project which seeks alternative treatments for menopausal symptoms.

Despite these notable successes, much more research needs to be done to further our understanding of the psychological symptoms of the menopausal transition. For today, I

will conclude my testimony by noting just three of the many topics in need of further research. The first topic is depressive disorders. We are beginning to appreciate that a subset of women are at risk for depression as they transition through the menopause, but we do not yet know how to best identify them in order to prevent or treat their perimenopausal depression. The second topic is anxiety disorders. Our understanding of anxiety disorders in the menopausal transition is especially poor, though a recent study from the Mayo Clinic demonstrated a 50 percent increased risk for anxiety disorders in women who had their ovaries removed before the menopause. The third topic is cognitive function. Clinical trials have demonstrated that certain forms of combination (estrogen plus progesterone) hormone therapy effectively treat hot flashes but lower memory performance, even when administered to younger postmenopausal women with moderate to severe hot flashes. To date, there have been no head-to-head clinical trials to guide treatment decisions about which forms of combination hormone therapy have neutral, or possibly beneficial, effects on cognitive function. Such trials are needed, because the majority of women who receive hormone therapy receive combination hormone therapy.

In summary, I would like to thank the ORWH, the NIA and the NIH for their strong support of research on psychological risk factors of menopause. I would also like to encourage them to continue to work with the North American Menopause Society and other non-profit organizations to improve the lives of women by translating new research findings to clinical practice.

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Testimony Title: Infectious determinants of chronic disease

Testimony Description:

The lives of women are multi-dimensional and so should the research that affects them be. While there are other agencies which cover psychosocial research, the NIH focus on biomedical research can and should be unparalleled.

Although the "germ theory" may be widely disparaged in some circles, conflicting ideology should never be an excuse for the scientific failure to rigorously examine infectious determinants of complex and chronic diseases, immune-mediated diseases and autoimmune diseases, many of which disproportionately affect women.

Not all chronic conditions will have infectious agent roots, but the failure to fund such research based on past failures due to undeveloped technology or differing ideology runs the risk of slamming the door in the face of biomedical progress. Many a woman