Effexor Eases Hot Flashes in Breast Ca Patients

Dr. Loprinzi, an oncologist who works better. I think it is a reasonable opinion, according to randomized, controlled trials presented in posters at the annual meeting of the American Society of Clinical Oncology.

In a trial organized by the German Breast Group, venlafaxine reduced frequency of hot flashes by 62% and severity by 67% in breast cancer patients. Clonidine reduced frequency by 22% and severity by 48%, reported Sibylle Loibl, M.D.

In a North Central Cancer Treatment Group trial, venlafaxine reduced hot flash frequency by 52% and median hot flash scores by 77% in the first 185 patients evaluated. A single 400-mg dose of medroxyprogesterone acetate (MPA, Depo-Provera) achieved an 85% drop in frequency and reduced risks and benefits with patients. Dr. Loprinzi.

Most patients also had a better side effect profile than venlafaxine, but the North American trial did not address safety in women at risk for breast cancer.

“The bottom line is, it [MPA] clearly works better. I think it is a reasonable option to give,” Dr. Loprinzi, an oncologist at the Mayo Clinic, Rochester, Minn., said in an interview. “Whether it is a small effect on breast cancer risk of recurrence or developing or decrease is unknown.”

For the most part, MPA was also better tolerated, with patients reporting significantly less constipation, hot flash distress, abdominal sweating, and sleeplessness, as well as significantly more satisfaction with hot flash control and trends toward less trouble with sleeping and orgasm.

Based on efficacy, MPA wins. Based on acute toxicity, MPA loses. Based on cost, MPA is cheaper,” Dr. Loprinzi said, balancing the price of a single dose of MPA against daily treatment with venlafaxine.

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Dr. Loibl, a gynecologist in Neu-Isenburg, Germany, told this newspaper that the superiority of MPA was not surprising. “But we want to treat, especially breast cancer patients, without hormonal therapy.”

The study showed that few patients who present with symptoms of straining, lumpy or hard stools, or a sensation of incomplete evacuation get a pelvic floor work-up as they should, because those with pelvic floor dysfunction probably could be helped by biofeedback training of the pelvic floor muscles. Median age was in the mid-50s for all three arms of the 6-week study. The poster report on the study included data on a total of 195 patients.

One group of 94 patients started on a 37.5-mg daily dose of venlafaxine, which increased after 1 week to 75 mg. A second group of 94 patients received a single 400-mg dose of MPA. A third group stopped accrual with seven patients because of enrollment difficulties. These patients received 500 mg of MPA every other week for 6 weeks. Their results were even better than the single-dose cohort, but their numbers were too small to compare meaningfully.

By the end of the trial, Dr. Loprinzi reported that 22 patients (24%) in the one-dose MPA arm were free of hot flashes compared with one patient (1%) on venlafaxine. In the MPA group, 90% reported residual hot flashes scores as 49% or less of baseline, compared with 41% of those on venlafaxine.

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Safety is the big unanswered question. The concern is whether MPA interferes with hormonal therapies such as tamoxifen and aromatase inhibitors, Dr. Loprinzi.

“There is not a definitive answer,” he said. “You find circumstantial evidence on both sides of the fence.”

His group recommended discussing risks and benefits with patients. Dr. Loprinzi said he believes that risk is minimal because MPA has a half-life of 50 days.

“It is a short-term thing,” he said. “I think it allows women to gradually go through menopause.”

Prevalence of IBS May Be Missed

Chicago — Many individuals diagnosed with irritable bowel syndrome could actually have pelvic floor dysfunction, a condition that can be much more remediable, according to a study conducted at the Mayo Clinic.

Considerable overlap exists in the symptoms of pelvic floor dysfunction and irritable bowel syndrome (IBS), particularly constipation-predominant irritable bowel syndrome, even though the Rome diagnostic criteria for functional bowel disorders considers the two distinctly separate entities, Christopher N. Andrews, M.D., the main investigator of the study, said in a poster presentation at the annual Digestive Disease Week.

The study showed that few patients who present with symptoms of straining, lumpy or hard stools, or a sensation of incomplete evacuation get a pelvic floor work-up as they should, because those with pelvic floor dysfunction probably could be helped by biofeedback training of the pelvic floor muscles. Dr. Andrews said in an interview.

The study included 450 patients being seen at the Mayo Clinic, Rochester, Minn.; 77% of participants were women. The patients either had diagnosed IBS or were undergoing a sigmoidoscopic GI transit study. The patients filled out a symptom questionnaire to help the investigators determine whether they had symptoms that matched the Rome criteria listed in conjunction with pelvic floor dysfunction.

Study investigators reviewed the patients’ medical records to see if the subjects had been given any anorectal defecation testing. A total of 194 of the patients had at least two symptoms of pelvic floor dysfunction as outlined by the Rome criteria. But only 50 patients (11%) had undergone pelvic floor dysfunction testing, usually balloon expulsion manometry. Of those 50 patients, 13 (26%) had an abnormal test result.

Patients with constipation predominant IBS were more likely to get testing, but they were also more likely to have overlapping symptoms and an abnormal test result. Of 40 patients with constipation predominant IBS, 76 had at least two symptoms of pelvic floor dysfunction. Of those patients, 24 (32%) underwent testing, and among those patients, 8 (33%) had an abnormal test result.

Anorectal defecation testing of patients with IBS-type symptoms is thought to have become more common at highly specialized centers in recent years, Dr. Andrews said in the interview. But if the rate of testing is so low at the Mayo Clinic, then it is probably not done often enough anywhere.

One problem that may discourage testing is that there are different tests but no real standards concerning which to use, he added.

The Rome criteria symptoms used to define pelvic floor dysfunction include: straining when defecating more than 25% of the time, lumpy or hard stools more than 25% of the time, incomplete evacuation more than 25% of the time, sensation of anorectal blockage more than 25% of the time, manual maneuvers to facilitate defecation more than 25% of the time, or one or fewer defecations per week.