

A quarterly newsletter for clinicians

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Many of the topics featured in this newsletter are also covered from a patient perspective in *Women's Health Today*, the point-of-care magazine of the Women's Health Experience. We hope you'll find the publications fulfill their mission of working together to improve dialogue with your patients.



Women's Health Experience
Presented by the Foundation for Female Health Awareness

WHICH CAME FIRST:

Insomnia, depression, or menopause?

■ **Lois E. Krahn, MD**

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This companion article for your patients appears in *Women's Health Today*.

THE PATIENT

Mrs B is a 51-year-old woman with 2 children in college. She works part time in a retail store and is married to a sales executive who travels extensively. She says she cannot sleep and is chronically tired. She has tried a variety of over-the-counter sleep aids without success. She has initial insomnia, wakes in the middle of the night with night sweats, and cannot go back to sleep.

THE DIALOGUE

The first thing I ask this patient is "What's on your mind?" She responds that she worries about the challenges her children face in college and about her husband's future with his company. Her thoughts focus on worst-case scenarios and bad outcomes. She acknowledges that she does not enjoy many activities, has stopped exercising, and spends a great deal of time watching television.

I ask her which came first, the pessimism and worry or the sleeplessness? She answers, "It all seems to have started at the same time." She says her husband is away a great deal but that he is a good and supportive partner. She reports that she has hot flashes and is very restless. I ask if she

snores or has crawly feelings in her legs, which she denies, to rule out obstructive sleep apnea and restless leg syndrome.

We talk about the physical, psychological, and social changes menopause can bring. Mrs B tells me her primary care physician wants her to consider hormone therapy (HT) but she has heard too many negative things about it. I discuss the practical role of HT, explaining that despite possible risks it offers benefits, including the reduction of hot flashes and night sweats. Also, HT may improve her sleep quality, which will help alleviate her anxiety and mood alterations. I acknowledge

continued on page 8

Talking with your patients about...

Menopause and moods

To alleviate the emotional and physical symptoms of menopause your patients may ask:

- Are there any natural menopausal remedies you can suggest?
- Should I consider making changes to my diet and level of physical activity?
- Based on my age and overall health, would a short-term regimen of hormone therapy help manage my symptoms?

Practical Strategies in WOMEN'S HEALTH

The clinical newsletter of the Women's Health Experience

Presented by the **FOUNDATION FOR FEMALE HEALTH AWARENESS**
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A MESSAGE FROM THE FOUNDER



Offering your patients a brighter, healthier future

One of the goals of *Practical Strategies in Women's Health* is to bring you the latest information on innovations in health care for your patients. In this issue, we will report on a number of medical advances to improve women's health. Two recently approved extended-cycle contraceptives offer new ways for women to conform their menstrual cycles with their busy lives. Three new oral therapies and one device for overactive bladder add options that allow you to more closely tailor treatment choices to individual patients. You will also find a brief overview of Gardasil, the recently approved vaccine for cervical cancer that will protect future generations of women from this dangerous and often deadly disease.

Medical advances like these are providing tools to help you improve the health of your patients so that they may look forward to a brighter future. I hope you will use the information in this issue of *Practical Strategies in Women's Health* and on our Web site, www.womenshealthexperience.com, to keep the dialogue with your patients informative and exciting.

Sincerely,

Mickey Karram, MD

Co-Founder, Foundation for Female Health Awareness

Dr Karram and his wife, Mona, are founders of the Women's Health Experience, the flagship program of the Foundation for Female Health Awareness. The Foundation is a nonprofit organization dedicated to educating women on all aspects of their health and funding unbiased gender-specific medical research.

Correction

Through an editing change, the article, "The dilemma of diagnosing vaginal infections," on page 7 of the Summer 2006 issue of *Practical Strategies in Women's Health* may give the misleading impression that Elizabeth G. Stewart, MD, has reviewed, recommended, or endorsed the use of a particular product. We regret the error. The following is the original text approved by Dr. Stewart:

Q. There are now several over-the-counter tests for elevated pH. These can help women tell if they have a bacterial infection or trichomoniasis rather than a yeast infection. Are these useful tools for women?

A. I think this is a step in the right direction, but I find it ironic that patients will be using pH kits when many physicians do not do the test themselves during an office visit. A pH test is the very first thing I do after taking an extensive history and physical examination, because it is going to eliminate or identify 2 of the 3 most common conditions for vaginitis: a bacterial infection or trichomoniasis.

EDITORIAL INQUIRIES: The editor invites letters, article ideas, and other input from readers.

Write to: Editor, *Practical Strategies in Women's Health*, 110 Summit Avenue, Montvale, NJ 07645; Call: (201) 930-5861; or e-mail info@womenshealthexperience.com.

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Creating a roadmap for fertility



This companion article for your patients appears in *Women's Health Today*.

THE PATIENT

Mrs Y is a 36-year-old attorney who suffered from significant pelvic pain in her 20s due to endometriosis. At that time, under the care of another physician, she had lesions removed with laser therapy, with questionable results. Five years ago, I removed more lesions laparoscopically followed by 6 months of treatment with GnRH agonists. She has been relatively pain-free since then and has been on oral contraceptives for 15 years. Recently married, she now desperately wants to have children but fears she is infertile.

THE DIALOGUE

Mrs Y is panicked. The worst thing I could do would be to tell her not to worry, that everything will be OK. I'm going to tell her the truth; we are going to work together as a team to help her achieve her goal of pregnancy.

This woman is smart but afraid. She knows that endometriosis can lead to infertility. We need to find out if this is true in her case. I explain that endometriosis and infertility are not definitively linked, so we will begin by doing a fertility workup. First, I ask how long she's been having unprotected sex. If it hasn't been 6 months, I can encourage her that it's too soon to tell. With a younger woman, I would wait a year before diagnosing infertility.

We discuss the anatomic distortions that can result from endometriosis. I tell her that I do not recommend another laparoscopic surgery at this

point. Whether or not such surgery enhances fertility is still debatable.^{1,2} I tell her we will do a hysterosalpingography, injecting dye through the cervix into the uterus to see if the fallopian tubes are blocked. She asks about risks. I tell her that rarely an infection or allergic reaction will develop, but that she should anticipate menstrual-type cramping during or after the test.

Taking steps toward a resolution

If the tubes are blocked, we will move directly to in vitro fertilization rather than attempting to unblock them. Time is of the essence and such delays should be avoided for this patient.

“If the tubes are blocked, we will move directly to in vitro fertilization rather than attempting to unblock them. Time is of the essence.”

Mrs Y again expresses the fear that she won't be able to have a child. A highly educated woman, she steadies herself by gathering information, so I continue laying out a clear roadmap. I tell her we will do additional fertility assessments, including a sperm analysis on her partner. We talk about the importance of appropriate timing of intercourse and the methodology for determining ovulation and maximum fertility.

Because she has been having unprotected sex for only 3 months, we agree to wait another 3 months to see if she becomes pregnant. After that time we will need to start talking about fertility enhancements because the chance of having infertility increases after 6 months of unprotected sex.

We discuss the fact that infertility declines rapidly after age 35 and that

infertility can be caused by many factors other than endometriosis. I explain that the link between endometriosis and infertility is poorly understood, and that the connection is definitive only when endometrial deposits block the fallopian tubes. She knows that the disease progresses differently in each individual and we simply do not know when, or if, endometriosis might cause infertility in her case. I remind her that many women with endometriosis have no symptoms and no fertility issues.

Providing a positive example

To calm her fears, I tell her about another patient, an unnamed executive in her late 30s who had an ovary

removed because of a fairly aggressive form of recurrent endometriosis. After in vitro fertilization, this patient had a baby boy and now has another baby on the way.

I tell Mrs Y that there may come a time when she might want to consider inducing ovulation or undergoing in vitro fertilization. I don't tell her to relax or take a vacation; she won't. She leaves my office encouraged and hopeful, as she should be.

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This companion article
for your patients appears
in *Women's Health Today*.



EAT, DRINK, BREATHE:

The environment and cancer risks

Today, 1 in 3 Americans will hear the words, "You have cancer." More than 1 in 4 will die of the disease.¹ At the current rate, by the year 2050, half of all Americans will have cancer, in part due to exposure to environmental toxins. It is essential that we, as clinicians, become aware of the dangers that are present in our environment and create solutions that help protect and preserve the health of our patients.

Woman are increasingly at risk

Currently, 1 in 7 women develop breast cancer, the leading cause of death among American women between 44 and 55 years of age. In 1960, the rate was only 1 in 22 women. Between 1979 and 1988, the risk of melanoma increased 132%. The incidence of lymphoma has tripled since 1950, and brain cancer in children increased 40% since 1970.

Landmark research indicates that women who were born after 1940 have

substantially higher risks of cancer. We now know that women with inherent mutations of the tumor suppressor genes BRCA1 and BRCA2 have an increased risk (82%) for breast cancer. For mutation carriers, the risk was 24% for those born before 1940, and was 67% for those born after 1940.² In the same study, lifetime risks of ovarian cancer more than doubled for BRCA1-mutation carriers born after 1940.²

Since 1976, the Environmental Protection Agency has been measuring toxins in fatty tissue gathered from autopsies and elective surgery samples. Twenty toxins have been found in 75% of all sampled tissue. Polychlorinated biphenyls (PCBs) were found in 99% of breast tissue samples, with 25% of those being higher than the legal limit for commercially sold cow's milk, or 2.5 parts per million.

For infants and fetuses, these exposures can be catastrophic. A woman's lifetime accumulation of toxins can be passed in utero or through breast-feeding at a concentration 10% to 40% greater than adult exposures. While this risk does not outweigh the benefits of breast-feeding (cow's milk carries the same toxins), information about prevention and detoxification should be provided to female patients.

Four of the top 6 toxins are metals: mercury, lead, cadmium and arsenic.³ These concentrate in the kidneys, liver, brain, skeleton, hair, and nails. Hormone-disrupting chemicals persist in the body for years, including DDT, arsenic, dioxin, lead, mercury, chlordane, dieldrin, cadmium, PCBs, and bisphenol A. For women, exposure to endocrine-disrupting chemicals creates a heightened risk for breast cancer.⁴ Women are especially vulnerable to bioaccumulation, particularly in the fat tissue in breasts, liver, bone marrow, and brain tissue.

Clinicians need to advise patients of the links between their exposure to environmental toxins and cancer. In addition, we need to advise patients about the way nutrients affect genes that contribute to promoting or preventing cancer. That is not to say we should not continue to use every current resource to detect and treat cancer. But prevention is every bit as important as a mammogram.

Diet can make a difference

The health of our patients is at stake, and nutritional changes can lower their risk. Antioxidants not only protect against toxin-induced free radical damage, but also are critical for proper function of the immune system. Antioxidants bind with antioxidant-response elements in DNA and increase the production of detoxification enzymes. Some phytochemicals found in soy and cruciferous vegetables induce, at a transcriptional level, detoxification enzymes. Green tea is a powerful antioxidant and I recommend at least 2 cups a day. Other antioxidants are ginger, broccoli, garlic, and vitamins A, C, and E. There are thousands of studies on enzymes, antioxidants, phytonutrients, and other compounds that prevent cancer. My philosophy for prevention is that we must feed the part of our bodies capable of fighting cancer and starve the body of those ingredients, like refined sugar and saturated fat, that leave the body most receptive to it.

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Common cancer risks

According to the National Cancer Institute, the most common risk factors for cancer are:

- Advanced age
- Tobacco use
- Exposure to ultraviolet radiation
- Exposure to ionizing radiation
- Chemical exposures (e.g. asbestos, benzene, benzidine, cadmium, nickel, or vinyl chloride in the workplace)
- Certain viral and bacterial infections (e.g. human papillomavirus, hepatitis B and C, human T-cell leukemia/lymphoma virus, HIV, Epstein-Barr virus, human herpesvirus 8, *H. pylori*)
- Menopausal hormone therapy
- Family history
- Alcohol consumption

Cervical cancer vaccine approved

A new vaccine that prevents most forms of cervical cancer is now available nationwide after a federal advisory committee recommended it for the vaccination of all young women.

On June 8, the FDA approved the use of GARDASIL® (Quadrivalent Human Papillomavirus [Types 6, 11, 16, 18] Recombinant Vaccine) for girls and young women from 9 to 26 years of age. Two weeks later, the US Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices recommended the vaccination of all young women 11 to 26 years of age.

"If women are widely inoculated as anticipated through private and federal vaccination programs, there should be a significant drop in the numbers of new cases within 20 years," says Thomas Herzog, MD, Director of the Division of Gynecologic Oncology at Columbia University Medical Center in New York.

"This is a new era in which we have an opportunity to eradicate a common cancer," Dr Herzog says. "That is what is really exciting. Through the discoveries of what powers the immune system, we are able to prevent a cancer from even occurring. That is remarkable."

Cervical cancer kills more than 4,000 women every year in the United States. Another 10,000 women are diagnosed with invasive cervical cancer annually. Cervical cancer is the second most common cancer among women worldwide and the third most fatal, causing approximately 290,000 deaths each year.

Human papillomavirus (HPV), the most common sexually transmitted virus, causes about 70% of cervical cancers and about 90% of genital warts. An estimated 80% of women have been exposed to HPV by age 50, though most don't develop cancer.

GARDASIL®, manufactured by Merck & Co., Inc., prevents the types of HPV most likely to cause cervical cancer, precancerous and low-grade lesions, and genital warts. GARDASIL® is a ready-to-use, intramuscular vaccine administered in the upper arm or upper thigh in 3 doses over a 6-month period.

Because the vaccine is only effective prior to infection, young women should be vaccinated before becoming sexually active. Older patients should continue getting annual Pap tests since the vaccine does not prevent all cervical cancers. It is not yet known how long the vaccine will last or whether booster shots will be required. Adverse effects of the vaccine, which has been tested on 27,000 women, include redness and tenderness at the vaccination site, headaches, and fever.

The cost of the vaccine is \$120 per injection, or \$360 for the series. The federal government and private insurance companies are expected to cover the costs of inoculation. Merck is also initiating a program to ensure inoculation for low-income populations.

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- ▶ How do we code for the new HPV vaccine?
- ▶ When we start giving the new HPV vaccine, how do we bill for it?

On June 8, 2006, the Food and Drug Administration officially licensed the HPV vaccine for use in girls and women ages 9 to 26.

90649 is the vaccine product code (human papillomavirus [HPV] vaccine, types 6, 11, 16, 18 [quadrivalent], 3-dose schedule, for intramuscular use). A 3-dose schedule means you will be billing for the procedure 3 times during a 6-month period.

90471 can also be reported for the administration of the vaccine. (immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; one vaccine [single or combination vaccine/toxoid]).

▶ **Counseling.** Since counseling will be important prior to administering the vaccine, it may be coded for separately using the time-based preventive counseling codes 99401-99404.

▶ **Adding modifiers.** CPT guidelines state that a modifier -51 (multiple procedure) would not be added to either of these codes. Of course, if you provide a significant and separate evaluation and management (E/M) service for a problem at the time the vaccine is given, you may also bill an E/M code with a modifier -25 added to let the payer know that the E/M service was separate.

Note that almost no payers will pay separately for the E/M code 99211 plus an injection procedure because it represents a minimal, not a significant, E/M service.

▶ **Diagnosis coding.** At present there is not precise diagnostic code for this vaccine. Coding options include: V04.89 (need for prophylactic vaccination and inoculation; other viral diseases) or V.05.8 (need for prophylactic vaccination and inoculation against single diseases; other specified disease). Be sure to check with the payer to determine if they have a preference. The diagnosis code for counseling will be V65.45, counseling on other sexually transmitted diseases.

▶ **Insurance coverage.** Insurance plans can be expected to cover the cost of the vaccine based on the CDC Advisory Committee on Immunization Practices recommendation of HPV vaccination as standard.

Merck, the company that produces the quadrivalent vaccine, has stated that the price will be \$120 per injection. The company has indicated that they have created a new program to provide free vaccines, including HPV vaccine, for uninsured adults unable to pay.

OVERACTIVE BLADDER: A brief look at new agents



This companion article for your patients appears in *Women's Health Today*.

Overactive bladder (OAB) remains an under-reported, under-diagnosed, and under-treated disorder that undermines the quality of life for approximately 33 million adult men and women in the United States.¹ Women have a higher incidence than men, and prevalence increases with age.¹ An estimated one third of women older than age 65 years experience some degree of incontinence, with 12% experiencing incontinence daily.^{2,3}

OAB is characterized by urgency, with or without urge urinary incontinence, usually with frequency and nocturia.⁴ Patients with a history of pelvic surgery, dementia, or diabetes may be at increased risk of developing OAB.⁵

Interventions and new agents

Behavioral training and pelvic muscle rehabilitation remain first line treatments. When indicated, anticholinergic medications are the mainstay of drug therapy. Often the best results are obtained through a combination of these approaches.

Talking with your patients about...

Overactive bladder

Patients who are struggling with the problem of overactive bladder now have additional options for treatment. They may want to ask:

- Do Kegel exercises really work?
- What medications are available for this condition and what are the side effects?
- What lifestyle changes do you recommend for better bladder control?
- What is InterStim Therapy, and is it safe?

New drugs continue to expand the physician's arsenal in treating OAB. Three recently approved oral agents are darifenacin hydrobromide, solifenacin, and trospium chloride. Darifenacin and solifenacin belong to a new class of drug, competitive muscarinic 3 (M3) receptor antagonists. Trospium is a quaternary ammonium derivative with antimuscarinic and antispasmodic action. All 3 products are indicated for the treatment of OAB with symptoms of urge urinary incontinence, urgency, and urinary frequency.

Bladder contraction is controlled primarily by the parasympathetic nervous system. The motor nerve supply to the bladder via the parasympathetic nervous system is mediated by acetylcholine acting on muscarinic receptors.⁶ The bladder contains 5 subtypes of muscarinic receptors, with a predominance of M2 and M3 subtypes; M2 subtype creates an inhibition to muscle relaxation and M3 subtype causes muscles to contract. Muscarinic receptors are also found in other parts of the body, such as salivary glands, the gut, and tear ducts.⁶

How the new agents work

Anticholinergic drugs abolish or reduce the intensity of detrusor muscle contraction, thereby reducing the urgency and frequency associated with urinary incontinence. Traditionally, the 2 most commonly prescribed drugs are oxybutynin and tolterodine. However, lack of specificity for bladder muscarinic receptors often results in side effects like dry mouth, constipation, and blurry vision.⁷ This leads to a high rate of discontinued therapy.⁸

Darifenacin and solifenacin, both of which have a stronger affinity for the M3 receptor than some older anticholinergic agents, were shown in clinical trials to decrease the number of micturitions and incontinence episodes

per day compared with placebo.⁹ As would be expected, the incidence of anticholinergic side effects was higher in patients taking either medication compared to placebo. In clinical trials, trospium reduced the frequency of voids and episodes of urge incontinence compared with placebo.¹⁰

Both darifenacin and solifenacin are extensively metabolized in the liver. Therefore, their serum concentrations may rise when taken with CYP3A4 inhibitors. Both are contraindicated in patients with urinary retention, gastric retention, uncontrolled narrow-angle glaucoma, or a known hypersensitivity to either compound.

As with any pharmacologic intervention for OAB, statistical differences in clinical trials in comparison with placebo are significant. It is important, however, to individualize therapy for each patient, remembering the patient's past treatment successes and failures. When initiating a new course of therapy, the value of patient education in understanding and managing symptoms cannot be overestimated.

For more on this topic, see "Novel options" on page 8.

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An evolution in contraception

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This companion article for your patients appears in *Women's Health Today*.

Q Recent media attention has focused on extended-cycle oral contraceptives that reduce menstrual periods to 4 times per year. Does this herald the end of the menstrual cycle for women?

A DR KAUNITZ: This is really part 2 of the sexual revolution. The first was in the 1960s when women gained control over fertility. Now, they have control over bleeding as well.

Q What are the benefits of the extended-cycle agents?

A DR SULAK: Many women cannot tolerate the 21-7 regimen because of the side effects of hormonal withdrawal. My research has shown that nearly all of the symptoms women complain about—including headaches, bloating, heavy bleeding, depression, and mood disorders—improve with extended-cycle contraceptives.

Q Haven't extended-cycle contraceptives been used for years?

A DR KAUNITZ: Ob/Gyns have prescribed them for endometriosis and fibroids. Female physicians have used them for their own convenience; essentially, they just skipped the placebos and started a new pack of pills.

Q Is there any downside to the extended-cycle regimen?

A DR SULAK: Breakthrough bleeding and spotting occurs for some women. In one clinical trial, during the first 90 days of Seasonale® (levonorgestrel/ethinyl estradiol) therapy, 65% of users had more than 7 days of bleeding or spotting and 35% had more than 20 days. During the last quarter of the study, 42% had more than 7 days of bleeding or spotting and 15% had more than 20 days.¹

Q Did the same effects occur in studies with Seasonique?

A DR SULAK: Yes. The literature for Seasonique® (0.15 mg levonorgestrel/0.03 mg ethinyl estradiol and 0.01 mg ethinyl estradiol) states, "the convenience of fewer planned menses (4 per year instead of 13 per year) should be weighed against the inconvenience of increased intermenstrual bleeding and/or spotting."² In Seasonique's clinical trial, about 8% of the women discontinued usage, at least in part because of bleeding or spotting.

Q What does the research show about breakthrough bleeding?

A DR SULAK: The 7 days off in oral contraceptives is slowly going to be discontinued. Either it is being reduced, eliminated, or replaced with a low-dose hormone, as is the case with Seasonique. In February, the FDA approved Loestrin® 24 Fe (norethindrone/ethinyl estradiol), and in March it approved YAZ® (3 mg drospirenone/20 mcg ethinyl estradiol). Both provide 24 days of active hormonal therapy followed by 4 days of placebo pills, shortening the duration of monthly bleeding and reducing the symptoms of hormonal withdrawal.³

Q Are there serious side effects with any of these agents?

A DR KAUNITZ: They are the same as any for any oral contraceptive: blood clots, and in high-risk women (e.g. smokers), stroke, and heart attack.⁴

Q What about long-term studies? Do they show benefits or risks?

A DR SULAK: Benefits. Long-term studies are still in the works, but extended-cycle pills may be expected to decrease pelvic inflammatory disease, endometrial cancer, ovarian cancer, and a host of other disorders. The suspension of ovulation may also decrease ovarian cysts.

Q Is this option of interest to all ovulating women?

A DR KAUNITZ: We have to respect that some women prefer to bleed monthly, despite medical evidence that there is no need for it.

Q Do most women who try extended-cycle contraception continue using it?

A DR SULAK: In my extensive research, women with hormone withdrawal symptoms are willing to try the new approach and most of them stick with it. Of 292 patients, 25 (9%) chose not to extend, with a preference for monthly menses as the most common reason. Of 267 patients who initiated an extended regimen, 57 stopped using oral contraceptives, 38 returned to a standard regimen, and 172 continued the extended regimen at the time of last follow-up.⁵

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Novel options for bladder control therapy

■ Steven Kleeman, MD

When a combination of physical rehabilitation of pelvic muscles, behavior modification, and pharmacotherapy is ineffective for treating bladder control problems, and the patient chooses not to have invasive surgical intervention, several other strategies are available.

The InterStim System was shown to provide sustained long-term benefit for urge incontinence for an average of 30 months in one clinical trial.¹ The system consists of an implantable pulse generator, a transforamenally placed quadripolar lead, and an extension that connects these 2 devices for unilateral stimulation of the S3 or S4 sacral nerve.

A randomized controlled trial involving 120 patients found that approximately 80% achieved continence or symptom improvement of more than 50%, compared with 3% for controls.² Adverse events included pain, lead migration, and infection. Although adverse events occurred in about half of the cases, and one-third required surgical revision, no irreversible complications were noted. Another study concluded that when the device fails, revision should be attempted, since 70% of the study participants who had revision achieved success.³

After a successful trial of therapy in which a stimulation lead is temporarily implanted and left in place for several days, a neurostimulator about the size of a pocket watch is implanted under the skin of the buttocks or abdomen. Both procedures are done on an outpatient basis under local anesthesia.

Another therapy that is proving effective for detrusor overactivity and incontinence (as yet unapproved by the FDA) is off-label use of botulinum-A toxin (BTX-A), which acts by blocking the release of acetylcholine at nerve endings in the bladder. Results lasting up to 9 months can be achieved with injections of BTX-A under the mucosa of the bladder, done as an office procedure. Recent clinical trials have documented the efficacy of this therapy in small patient samples.^{4,5} Additional studies, including some to determine the most effective dose, are underway.

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Which came first?

that making a decision about HT may be particularly hard right now. She expresses relief at my understanding and admits that she's far too scared to try HT. We decide to look at other options.

A diagnosis takes shape

At this point, I'm developing a diagnosis of dysthymia, a mild chronic depression fairly common in menopausal women. I tell her I believe she has a relatively mild-to-moderate mood disorder that is feeding into her worries. Since some antidepressants have been shown to reduce the frequency and intensity of hot flashes, I tell her there is a class of medication (SSRIs) that typically has good results. I believe citalopram would be a good choice for her because it is quite calming.^{1,2}

Mrs B asks if citalopram is addictive; I reassure her that it is not. She asks if she will gain weight. This probably will not happen, I reply, but she can be careful with her diet. I encourage her to resume exercise, not only for weight maintenance but to improve her moods and to help her get good-quality sleep.

We talk about the connection between menopause, night sweats, loss of sleep, and depression. I ask her to monitor her sleep patterns and to remain open to HT if problems continue. In addition, I tell her we can add a prescription sleep medication, such as zolpidem, eszopiclone, or ramelteon. I advise her that even an extra hour of sleep makes a difference for many women.

Mrs B's attitude seems to improve with the opportunity to take an active role in getting her life back on track. We have worked together to put the control of her future into her hands. Further counseling will allow her to explore her worries and put them in perspective.

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