**Review: most herbal treatments have no benefit for menopausal symptoms**


**QUESTION:** In women with menopausal symptoms, are complementary and alternative medicine (CAM) treatments effective and safe?

**Data sources**

Studies were identified by searching Medline (1966 to March 2002), the Alternative and Complementary Medicine Database (AMED) (1985 to 2000), and personal files.

**Study selection**

Studies in any language were selected if they were randomised controlled trials (RCTs) of CAM treatments in menopausal women. Studies of single symptoms or conditions that were not associated with menopause were excluded.

**Data extraction**

Data were extracted on study year, country, design, patient characteristics, dose and duration of treatment, outcome measures, and results. Study quality was not assessed.

**Main results**

29 RCTs were included. The table summarises the RCT findings, 3 of 4 short term RCTs on black cohosh reported no difference in symptoms compared with control, 6 of 11 RCTs with dietary phyto-oestrogens (soy or isoflavone supplementation) showed some improvement in hot flashes or menopausal symptoms. Red clover, evening primrose oil, ginseng, dong quai, a Chinese herbal formula, vitamin E, and wild yam cream did not reduce hot flashes. For non-drug therapies, unblinded trials suggest acupuncture was not effective, paced respiration was superior to biofeedback, and relaxation therapy was more beneficial than reading (4 small trials).

The product, dosage, scoring systems for hot flashes, and variable follow up were identified as methodological weaknesses.

**Conclusions**

No consistent evidence exists that complementary therapies benefit women with menopausal symptoms. Harm has not been studied.

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**COMMENTARY**

Although the use of CAM has increased dramatically over the past decade in North America,1,2 the evidence supporting its efficacy for menopausal symptoms is sparse. Kronenberg and Fugh-Berman identified black cohosh and soy as promising treatments in their systematic review. Few studies examined symptoms, such as vaginal dryness, sleep, or mood disturbances. The studies’ methodological weaknesses include lack of placebo control, short duration, no reporting of statistical significance, high dropout rates, and no intention to treat analysis. The 1 placebo controlled trial that found black cohosh to be effective for hot flashes did not find oestrogen to be effective, which casts doubt on the study’s validity. Most soy studies were reported as placebo controlled and double blind; however, the blinding is questionable because soy and rice beverages taste different. Many studies also found an effect in the placebo groups, which emphasises the importance of placebo controlled trials.

Menopausal women commonly use CAM treatments, and many use herbal treatments for long term periods as alternatives to hormone therapy. In view of recent data from the Women’s Health Initiative,3 it is crucial to establish the long term safety of herbal treatments, especially compounds that may have oestrogenic activity. Of interest, relaxation techniques, such as paced respiration, decreased hot flashes and were safe.

The review’s take home message is that paced respiration may be effective and safe for management of menopausal symptoms; most herbal treatments do not have efficacy or safety data supporting their use. Soy and soy extracts are promising but require further studies. Currently, many herbal therapies are expensive and have no guarantee that they contain the supposed active ingredient or that contaminants do not exist. As healthcare providers and researchers, we should advocate for more standardisation and regulation of CAM therapies and more vigorous research into their long term efficacy and safety.4

Angela M Cheung, MD, PhD

Rishma Walji, BSc, ND

University of Toronto, Toronto, Ontario, Canada

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**Table**

<table>
<thead>
<tr>
<th>CAM treatment</th>
<th>Number of RCTs</th>
<th>Length of follow up</th>
<th>Results for menopausal symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black cohosh</td>
<td>4</td>
<td>2–6 months</td>
<td>3 RCTs showed no difference between black cohosh and control</td>
</tr>
<tr>
<td>Red clover</td>
<td>2</td>
<td>3; 7.5 months</td>
<td>No difference between red clover and placebo</td>
</tr>
<tr>
<td>Dong quai</td>
<td>1</td>
<td>6 months</td>
<td>No difference between dong quai and placebo</td>
</tr>
<tr>
<td>EPO</td>
<td>1</td>
<td>6 months</td>
<td>Placebo better than EPO for hot flashes</td>
</tr>
<tr>
<td>Ginseng</td>
<td>1</td>
<td>4 months</td>
<td>No difference between ginseng and placebo</td>
</tr>
<tr>
<td>Chinese herbal formula</td>
<td>1</td>
<td>3 months</td>
<td>No difference between the Chinese herbal formula and placebo</td>
</tr>
<tr>
<td>Soy and soy extracts</td>
<td>11</td>
<td>6–28 weeks</td>
<td>6 RCTs showed some difference in hot flashes (eg, severity, frequency, or symptom score)</td>
</tr>
<tr>
<td>Vitamin E</td>
<td>2</td>
<td>3 years; 4 weeks</td>
<td>1 RCT (3 y) showed no difference; 1 RCT showed clinically insignificant benefit</td>
</tr>
<tr>
<td>Wild yam cream</td>
<td>1</td>
<td>3 months</td>
<td>No difference between wild yam cream and placebo</td>
</tr>
</tbody>
</table>

*EPO = evening primrose oil; RCT = randomised controlled trial.*