



Harvard Women's Health Watch

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Getting your vitamins and minerals through diet

The benefits of multivitamins are looking doubtful. Can we do without them?

We all know that vitamin supplements are no substitute for a healthy diet, but nobody's perfect when it comes to healthful eating. It can be particularly challenging to get the nutrients you need if you're dieting or if you avoid animal or dairy products. So, many of us take a daily multivitamin as nutritional insurance. But recent research suggests that multivitamins may not be all they're cracked up to be. Moreover, many multivitamins contain some micronutrients in amounts in excess of those recommended in the government's *Dietary Guidelines for Americans* (www.health.gov/dietaryguidelines). In some cases, these levels may result in unsafe intakes.

In February, a study involving 161,808 postmenopausal women in the Women's Health Initiative (WHI) concluded that those who took multivitamins did not have a lower death rate than others and were just as likely to develop cardiovascular disease or cancers of the lung, colon/rectum, breast, and endometrium—the kinds that are most common in women. Granted, WHI participants were healthy to begin with, but these results are consistent with findings from other studies. There's been little or no evidence of protection against cardiovascular disease or cancers from a number of vitamin supplements, including vitamin E, vitamin C, beta carotene, and the B-vitamin trio—B₆, B₁₂, and folic acid. And three years ago, the National Institutes of Health (NIH) said there wasn't enough evidence for a recommendation about taking multivitamins.

Now research suggesting potential harm has been added to the mix. Last year, a Cochrane Collaboration review found that people in trials who were given supplements of vitamin A, vitamin E, and beta carotene had a higher death rate. And there's some evidence that excess folic acid (the synthetic version of folate, a vitamin found abundantly in vegetables, fruits, and grains) may be contributing to a recent uptick in colorectal cancer. Multivitamins contain the recommended daily amount—400 micrograms (mcg)—but folic acid is also added to breakfast cereals and enriched grain and cereal products, including breads, rice, and pasta. A person taking a multivitamin can easily exceed the recommended total intake, and maybe even the safe upper limit of 1,000 mcg. (Excess isn't a problem with folate found naturally in foods.)

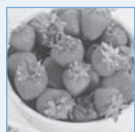
These findings raise questions about the use of multivitamins as a safety net. Experts agree that the best way to get the nutrients

IN THIS ISSUE

- Surviving the suicide of a loved one** 4
The grief process is always difficult, but it can be especially complicated after death from suicide.
- In the journals** 7
Ovary removal during hysterectomy is ill-advised for most women; average hot flash duration is longer than previously thought.
- By the way, doctor** 8
Is taking calcium a problem if you have pseudogout? What can you tell me about peppermint oil?

Some nutrient-dense foods*

- Avocados
- Chard, collard greens, kale, mustard greens, spinach
- Bell peppers
- Brussels sprouts
- Mushrooms (crimini and shiitake)
- Baked potatoes
- Sweet potatoes
- Cantaloupe, papaya, raspberries, strawberries
- Low-fat yogurt
- Eggs
- Seeds (flax, pumpkin, sesame, and sunflower)
- Dried beans (garbanzo, kidney, navy, pinto)
- Lentils, peas
- Almonds, cashews, peanuts
- Barley, oats, quinoa, brown rice
- Salmon, halibut, cod, scallops, shrimp, tuna
- Lean beef, lamb, venison
- Chicken, turkey



*Foods that have a lot of nutrients relative to the number of calories.

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Vitamins and minerals through diet continued

we need is through food. A balanced diet—one containing plenty of fruits, vegetables, and whole grains—offers a mix of vitamins, minerals, and other nutrients (some yet to be identified) that collectively meet the body's needs. Maybe what counts is the synergistic interactions of these nutrients—which might also help explain why trials of single nutrients often don't pan out.

But many of us doubt whether we can get all the nutrients we need from food alone. For one thing, the “percent daily values” featured on food labels are based on a 2,000-calories-a-day diet. Many of us can't eat that much without gaining weight. What if your energy needs are closer to 1,500 calories a day? What if you're dieting? Can you eat enough to take in the recommended micronutrients without falling back on a multivitamin? To find out, we consulted two nutrition experts, clinical dietitian Ellen di Bonaventura, R.D., at Massachusetts General Hospital in Boston, and Helen Delichatsios, M.D., nutrition educator at Harvard Medical School and Massachusetts General Hospital. Dr. Delichatsios is also on the editorial board of the *Harvard Women's Health Watch*.

Careful planning and extra D

Both di Bonaventura and Dr. Delichatsios say that a woman can meet her nutri-

ent needs through food alone even if she eats 1,500 calories (or less) per day. “It's not an issue of food quantity but rather food quality. Even a low-calorie diet can have the needed vitamins and minerals,” says Dr. Delichatsios. The only exception is vitamin D. Most experts now recommend a daily intake of 1,000 international units (IU), an amount that's difficult to get through foods or sun exposure (unless you live in the lower half of the United States and spend time outdoors). So plan to take a vitamin D supplement.

Getting the rest of your micronutrients through diet requires planning, patience, and knowledge about the foods that will help you meet your daily requirements. Such nutrient-dense foods, as they're called, are packed with vitamins and minerals and have relatively few calories. (See examples of nutrient-dense foods on page 1.)

Nutrient-dense foods are the foundation of the sample menu (see box on page 3) that di Bonaventura devised at our request to meet the daily vitamin and mineral needs of a healthy postmenopausal woman consuming 1,500 calories or less a day. “You'd probably eat more salmon on this diet than most people. You'd have an occasional egg, because that's the easiest way to get a lot of vitamins for a low

Daily amounts of basic food groups meeting recommended nutrient intakes at four different calorie levels

Calorie level	1,200	1,400	1,600	1,800
Fruits+	1 cup	1.5 cups	1.5 cups	1.5 cups
Vegetables+	1.5 cups	1.5 cups	2 cups	2.5 cups
Grains	4 ounce equivalents*	5 ounce equivalents	5 ounce equivalents	6 ounce equivalents
Lean meat and beans	3 ounce equivalents**	4 ounce equivalents	5 ounce equivalents	5 ounce equivalents
Dairy (choose fat-free or low-fat)	2 cups***	2 cups	3 cups	3 cups
Oils	17 g	17 g	22 g	24 g
Discretionary calories	171	171	132	195

+ Choose a wide variety of colorful fruits and vegetables.

* 1 ounce equivalent = ½ cup cooked rice, pasta, or cooked cereal; 1 ounce dry pasta or rice; 1 slice bread; 1 small muffin; 1 cup ready-to-eat cereal flakes.

** 1 ounce equivalent = 1 ounce of lean meat, poultry, or fish; 1 egg; ¼ cup cooked dry beans or tofu; 1 tablespoon peanut butter; ½ ounce nuts or seeds.

*** 1 cup = 1 cup milk or yogurt; 1.5 ounces natural cheese or 2 ounces processed cheese.

Source: USDA Food Guide, Appendix A-2, *Dietary Guidelines for Americans*, 2005, www.health.gov/dietaryguidelines.

number of calories,” says di Bonaventura. Our menu covers all the bases at about 1,200 calories. This leaves some discretionary calories for additional nutrient-dense foods and a treat—say, a piece of chocolate, a dish of sorbet, or a glass of wine. Notice that the menu provides more than 1,200 mg of calcium, the amount recommended for women over age 50—thanks to the calcium in nutrient-dense foods such as nonfat dairy products and bok choy (Chinese cabbage).

What you can do

One way to set up a plan that precisely meets your nutritional needs is to work with a registered dietitian, who can take into account your food preferences and allergies or other health issues (such as lactose intolerance). Many dietitians have access to computer programs and databases that ease the most difficult calculations, such as nutrient analyses of menus. You can ask your clinician for a referral (check to see if your insurance covers the cost of nutritional counseling), or ask at a local hospital or medical center. But if you have the time and the inclination to do the work yourself, there are free tools and calculators on the Web that can help. Here are some questions you’ll need to ask and some of the Web sites where you can find the answers:

How much of what vitamins and minerals do I need?

Most healthy postmenopausal women ages 51 to 70 require the same amounts of vitamins and minerals. The government’s nutrient recommendations are called dietary reference intakes (DRIs); these replace the old RDAs, or Recommended Dietary Allowances. The quantities listed on the label of a multivitamin bottle may be more than you need, so don’t use them for guidance. Instead, consult the DRI tables found at www.iom.edu/Object.File/Master/21/372/0.pdf. Or use the “daily nutrition calculator” at www.ahealthyme.com/topic/rdacalc.

How many calories do I need? It depends on your age, height, weight, and activity level. You can calculate the number of calories you need per day at several Web sites, including these: www.caloriecontrol.org/healthy_calculators.html, www.calorieking.com/tools, and www.bmi-calculator.net/bmr-calculator. (The last of these Web sites takes a two-step approach, first calculating your basal metabolic rate—the number of calories you’d need if you did nothing but rest—then linking you to a second page that takes your activity level into account.)

What do I eat? For a list of nutrient-dense foods you can incorporate into your meal plan, go to www.whfoods.com/foodstoc.php. To look up the nutrient and calorie content of specific foods—or to find out which foods contain specific nutrients—go to the U.S. Department of Agriculture (USDA) National Nutrient Database for Standard Reference, www.nal.usda.gov/fnic/foodcomp/search. Another good source of information on specific foods (including brand-name and fast-food items) is Calorie King, www.calorieking.com. To get an idea of how much you’ll need daily from

1,200-calorie sample menu that meets the daily DRIs* for a woman 51 to 70 years of age

Breakfast

8 oz nonfat yogurt
½ cup sliced papaya
½ cup sliced kiwi
1 oz (14 halves) walnuts
4 oz skim milk

Dinner

4 oz broiled wild salmon and yogurt sauce (1 tbsp. Greek-style nonfat yogurt, 1 tsp. lemon juice, 1 clove chopped garlic)
¼ cup cooked barley and ¼ cup cooked lentils with spices to taste
1 cup steamed baby bok choy

Lunch

1 small whole-wheat pita
Green salad:
1 cup dark green lettuce
1 red or orange pepper
1 cup grape tomatoes
½ cup edamame beans
1 tbsp. unsalted sunflower seeds.
Salad dressing made with 1 tbsp. olive oil, balsamic vinegar, and pepper

*Menu provides 1,155 calories:
33% of calories from fat,
40% from carbohydrate, and
27% from protein*

*Dietary reference intakes.

Vitamins and minerals and their amounts in the sample menu, above (DRIs are listed in parentheses)

- Vitamin A, 1,031 mcg (700 mcg)
- Vitamin C, 383 mg (75 mg)
- Vitamin D, 12 mcg (10 mcg)
- Vitamin E, 11 mg (15 mg)
- Vitamin K, 156 mcg (90 mcg)
- Thiamin, 1.3 mg (1.1 mg)
- Riboflavin, 1.8 mg (1.1 mg)
- Niacin, 14 mg (14 mg)
- Vitamin B₆, 2.23 mg (1.5 mg)
- Folate, 556 mcg (400 mcg)
- Vitamin B₁₂, 10.6 mcg (2.4 mcg)
- Pantothenic acid, 5.5 mg (5 mg)
- Calcium, 1,222 mg (1,200 mg)
- Copper, 900 mcg (1,156 mcg)
- Iron, 11 mg (8 mg)
- Magnesium, 355 mg (320 mg)
- Manganese, 2.8 mg (1.8 mg)
- Phosphorus, 1,530 mg (700 mg)
- Selenium, 90 mcg (55 mcg)
- Zinc, 8.6 mg (8 mg)
- Potassium, 4.7 g (4.7 g)

Note: Biotin, choline, and chromium are not precisely measured in foods and thus not included in our analysis.

Source: Ellen di Bonaventura, R.D., clinical dietitian, Massachusetts General Hospital, Boston, MA.

each of the basic food groups, see the chart on page 2.

How do I know if my diet provides what I need? You can track your daily intake and have it analyzed at the USDA’s My Pyramid Tracker, www.mypyramidtracker.gov. (This program is free, but you’ll need to register first.) Entering everything you eat can be cumbersome, but if you try it for just a few days, you’ll learn a lot about food quality and how to get the best nutritional return on the calories you consume. All in all, if you avoid saturated and trans fat, take a daily 1,000 IU vitamin D supplement, and eat a balanced diet—one that contains a variety of colorful fruits and vegetables, whole grains, legumes, and nonfat dairy products—you probably don’t need a multivitamin on your plate. ♥

Left behind after suicide

People bereaved by a suicide often get less support because it's hard for them to reach out—and because others are unsure how to help.

Every year in the United States, 33,000 people take their own lives. Every one of these deaths leaves an estimated six or more “suicide survivors”—people who’ve lost someone they care about deeply and are left grieving and struggling to understand.

The grief process is always difficult, but a loss through suicide is like no other, and the grieving can be especially complex and traumatic. People coping with this kind of loss often need more support than others, but may get less. There are various explanations for this. Suicide is a difficult subject to contemplate. Survivors may be reluctant to confide that the death was self-inflicted. And when others know the circumstances of the death, they may feel uncertain about how to offer help. Grief after suicide is different, but there are many resources for survivors, and many ways you can help the bereaved.

“Some people who I thought would offer solace remained quiet. And most people just said nothing [after my son’s death. They] seemed to try to avoid any discussion. It was as if my son never existed.”

— PARENT WHOSE SON DIED OF SUICIDE

What makes suicide different

The death of a loved one is never easy to experience, whether it comes without warning or after a long struggle with illness. But several circumstances set death by suicide apart and make the process of bereavement more challenging. For example:

A traumatic aftermath. Death by suicide is sudden, sometimes violent, and usually unexpected. Depending on the situation, survivors may need to deal with the police or handle press inquiries. While you are still in shock, you may be asked whether you want to visit the death scene. Sometimes officials will discourage the visit as too upsetting; at other times, you may be told you’ll be grateful that you didn’t leave it to your imagination. “Either may be the right decision for an individual. But it can add to the trauma if people feel that they don’t have a choice,” says Jack Jordan, Ph.D., clinical psychologist and co-author of *After Suicide Loss: Coping with Your Grief*.

You may have recurring thoughts of the death and its circumstances, replaying the final moments over and over in an effort to understand—or simply because you can’t get the thoughts out of your head. Some suicide survivors develop post-traumatic stress disorder (PTSD), an anxiety disorder that can become chronic if not treated. In PTSD, the trauma is involuntarily re-lived in intrusive images that can create

anxiety and a tendency to avoid anything that might trigger the memory.

Stigma, shame, and isolation. Suicide can isolate survivors from their community and even from other family members. There’s still a powerful stigma attached to mental illness (a factor in most suicides), and many religions specifically condemn the act as a sin, so survivors may understandably be reluctant to acknowledge or disclose the circumstances of such a death. Family differences over how to publicly discuss the death can make it difficult even for survivors who want to speak openly to feel comfortable doing so. The decision to keep the suicide a secret from outsiders, children, or selected relatives can lead to isolation, confusion, and shame that may last for years or even generations. In addition, if relatives blame one another—thinking perhaps that particular actions or a failure to act may have contributed to events—that can greatly undermine a family’s ability to provide mutual support.

Mixed emotions. After a homicide, survivors can direct their anger at the perpetrator. In a suicide, the victim is the perpetrator, so there is a bewildering clash of emotions. On one hand, a person who dies by suicide may appear to be a victim of mental illness or intolerable circumstances. On the other hand, the act may seem like an assault on or rejection of those left behind. So the feelings of anger, rejection, and abandonment that occur after many deaths are especially intense and difficult to sort out after a suicide.

Need for reason. “What if” questions may arise after any death. What if we’d gone to a doctor sooner? What if we hadn’t let her drive to the basketball game? After a suicide, these questions may be extreme and self-punishing—unrealistically condemning the survivor for failing to predict the death or to intervene effectively or on time. Experts tell us that in such circumstances, survivors tend to greatly overestimate their own contributing role—and their ability to affect the outcome.

“Suicide can shatter the things you take for granted about yourself, your relationships, and your world,” says Dr. Jordan. Many survivors need to conduct a psychological “autopsy,” finding out as much as they can about the circumstances and factors leading to the suicide, in order to develop a narrative that makes sense to them. While doing this, they can benefit from the help of professionals or friends who are willing to listen—without attempting to supply answers—even if the same questions are asked again and again.

Sometimes a person with a disabling or terminal disease chooses suicide as a way of gaining control or hastening the



end. When a suicide can be understood that way, survivors may feel relieved of much of their what-if guilt. “It doesn’t mean someone didn’t love their life,” says Holly Prigerson, Ph.D., associate professor of psychiatry at Harvard Medical School. Adds Dr. Prigerson, “The grieving process may be very different than after other suicides.”

A risk for survivors. People who’ve recently lost someone through suicide are at increased risk for thinking about, planning, or attempting suicide. After any loss of a loved one, it’s not unusual to wish you were dead; that doesn’t mean you’ll act on the wish. But if these feelings persist or grow more intense, confide in someone you trust, and seek help from a mental health professional.

Support from other survivors

Research suggests that suicide survivors find individual counseling (see “Getting professional help”) and suicide support groups to be particularly helpful. There are many general grief support groups, but those focused on suicide appear to be much more valuable. In a small pilot study that surveyed 63 adult suicide survivors about their needs and the resources they found helpful, 94% of those who had participated in a suicide grief support group found it moderately or very helpful, compared with only 27% of those who had attended a general grief group. The same study found that every survivor who had the opportunity to talk one-on-one with another suicide survivor found it beneficial. These results were published in the journal *Suicide and Life-Threatening Behavior* (July 2008).

“Some people also find it helpful to be in a group with a similar kinship relationship, so parents are talking to other parents. On the other hand, it can be helpful for parents to be in a group where they hear from people who have lost a sibling—they may learn more about what it’s like for their other children,” says Dr. Jordan.

Some support groups are facilitated by mental health professionals; others by laypersons. “If you go and feel comfortable and safe—[feel] that you can open up and won’t be judged—that’s more important than whether the group is led by a professional or a layperson,” says Dr. Prigerson. Lay leaders of support groups are often themselves suicide survivors; many are trained by the American Foundation for Suicide Prevention, which has a support group locator on its Web site (see “Selected resources,” page 6).

For those who don’t have access to a group or feel uncomfortable meeting in person, Internet support groups are a growing resource. A 2008 study comparing parents who made use of Internet and in-person groups found that Web users liked the unlimited time and 24-hour availability of Internet support. Survivors who were depressed or felt stigmatized by the suicide were more likely to gain help from Internet support services. Interestingly, people in urban areas were just as likely to make use of the Internet as those in more isolated places.

You can join a support group at any time: soon after the death, when you feel ready to be social, or even long after the suicide if you feel you could use support, perhaps around a holiday or an anniversary of the death.

“I was consumed, almost obsessed, with the thought of having people looking at me and feeling sorry but at the same time thinking, “What a nut case he must have been to do this.”

— TAMMY, WHOSE FATHER DIED OF SUICIDE

Getting professional help

Suicide survivors are more likely than other bereaved people to seek the help of a mental health professional. Look for a skilled therapist who is experienced in working with grief after suicide. The therapist can support you in many ways, including these:

- helping you make sense of the death and better understand any psychiatric problems the deceased may have had
- treating you, if you’re experiencing PTSD
- exploring unfinished issues in your relationship with the deceased
- aiding you in coping with divergent reactions among family members
- offering support and understanding as you go through your unique grieving process.

Immediately after the suicide, assistance from a mental health professional may be particularly beneficial if you experience any of the following:

- increased depression (or if you have a history of depression).
- flashbacks, anxiety, or other symptoms of PTSD.
- unwillingness of family or friends to continue talking about the loss.
- suicidal thoughts or plans.
- physical symptoms, such as ongoing sleep problems, significant weight gain or loss, or increasing dependency on tobacco or alcohol.
- feelings of being stuck or unable to move forward (however slowly and painfully) in the grieving process.
- discomfort in discussing troubling aspects of your relationship with the deceased.
- little improvement after several months.

The value of family therapy after a suicide has not been well studied, but a family therapist can sometimes help rela-

tives communicate better and manage feelings of guilt and anger. However, it may not be possible to work through your own feelings in the presence of family members who are concerned mainly with finding someone to blame.

“I spent hours trying to rework my reality in my mind—trying to find answers to questions that had no answers—as though the answers would somehow change the outcome. ‘If only I had,’ ‘If only I hadn’t,’ and ‘Why?’ were my constant thought companions.”

— LINDA, WHOSE SON DIED OF SUICIDE AT AGE 25

A friend in need

Knowing what to say or how to help after a death is always difficult, but don't let fear of saying or doing the wrong thing prevent you from reaching out to suicide survivors. Don't hold back. Just as you would after any other death, express your concern, pitch in with practical tasks, and listen to whatever the person wants to tell you. Here are some special considerations:

Stay close. Families often feel stigmatized and cut off after a suicide. If you avoid contact because you don't know what to say or do, family members may feel blamed and isolated. Whatever your doubts, make contact. Survivors learn to forgive awkward behaviors or clumsy statements, as long as your support and compassion are evident.

Avoid hollow reassurance. It's not comforting to hear well-meant assurances that “things will get better” or “at least he's no longer suffering.” Instead, the bereaved may feel that you don't want to acknowledge or hear them express their pain and grief.

Don't ask for an explanation. Survivors often feel as though they're being grilled: Was there a note? Did you suspect anything? The survivor may be searching for answers, but your role for the foreseeable future is simply to be supportive and listen to what they have to say about the person, the death, and their feelings.



Remember his or her life. Suicide isn't the most important thing about the person who died. Share memories and stories; use the person's name (“Remember when Brian taught my daughter how to ride a two-wheeler?”). If suicide has come at the end of a long struggle with mental or physical illness, be aware that the family may want to recognize the ongoing illness as the true cause of death.

Acknowledge uncertainty. Survivors are not all alike. Even if you are a suicide survivor yourself, don't assume that another person's feelings and needs will be the same as yours. It's fine to say you can't imagine what this is like or how to help. Follow the survivor's lead when broaching sensitive topics: “Would you like to talk about what happened?” (Ask only if you're willing to listen to the details.) Even a survivor who doesn't want to talk will appreciate that you asked.

Help with the practical things. Offer to run errands, provide rides to appointments, or watch over children. Ask if you can help with chores such as watering the garden, walking the dog, or putting away groceries. The survivor may want you to sit quietly, or perhaps pray, with him or her. Ask directly, “What can I do to help?”

Be there for the long haul. Dr. Jordan calls our culture's standard approach to grief the “flu model”: grief is unpleasant but is relatively short-lived; after a stay at home, the bereaved person will jump back into life. Unfortunately, that means that once survivors are back at work and able to smile or socialize again, they quickly get the message that they shouldn't talk about their continuing grief.

Even if a survivor isn't bringing up the subject, you can ask how she or he is coping with the death and be ready to listen (or respect a wish not to talk about it). Be patient and willing to hear the same stories or concerns repeatedly. Acknowledging emotional days such as a birthday or anniversary of the death—by calling or sending a card, for example—demonstrates your support and ongoing appreciation of the loss. ♥

Selected resources

American Association of Suicidology
202-237-2280
www.suicidology.org (Click on “Suicide loss survivors.”)

American Foundation for Suicide Prevention
888-333-2377 (toll-free)
www.afsp.org (Click on “Surviving Suicide Loss.”)

After Suicide Loss: Coping With Your Grief, by Bob Baugher, Ph.D., and Jack Jordan, Ph.D. (available through Web site above)

Aftershock: Help, Hope, and Healing in the Wake of Suicide, by Arrington Cox (B & H Publishing, 2003).

Dying to Be Free: A Health Guide for Families after a Suicide, by Beverly Cobain and Jean Larch (Hazelden Foundation, 2006).

My Son... My Son: A Guide to Healing After Death, Loss, or Suicide, by Iris Bolton and Curtis Mitchell (The Bolton Press, 1995).

No Time to Say Goodbye, by Carla Fine (Main Street Books, 1999).

Silent Grief: Living in the Wake of Suicide, by Christopher Lukas and Henry Seiden (Jessica Kingsley Publishers, 2007).

Understanding Your Suicide Grief: Ten Essential Touchstones for Finding Hope and Healing Your Heart, by Alan D. Wolfelt, Ph.D. (Companion Press, 2009).

Note: Source of quote on page 4 is Feigelman B, et al. “Surviving after suicide loss: the healing potential of suicide survivor support groups,” *Illness, Crisis & Loss* (2008), Vol. 16, No. 4, pp. 285–304. The quotes on pages 5 and 6 are reprinted with permission from the American Foundation for Suicide Prevention.



Routine ovary removal during hysterectomy ill-advised for most women

Every year, about 600,000 women in the United States undergo hysterectomy—mostly for noncancerous conditions, such as fibroids and endometriosis. More than half will have both ovaries removed as well, in a procedure called bilateral oophorectomy, which is performed chiefly to reduce the risk for ovarian cancer. Women at high risk for breast cancer may also undergo bilateral oophorectomy to eliminate the ovarian production of estrogen, which fuels the growth of most breast cancers. A new study calls these routine oophorectomies into question. Its conclusion: while almost eliminating ovarian cancer risk and reducing breast cancer risk, ovary removal increases the likelihood of fatal and nonfatal heart disease, lung cancer, and death from all causes. These findings add to the growing body of evidence that ovarian hormones are important to a woman's health as she ages and that oophorectomy should not be routinely recommended, particularly for women at no more than average risk for ovarian or breast cancer.

A group of researchers led by Dr. William H. Parker of the John Wayne Cancer Institute at St. John's Health Center in Santa Monica, Calif., analyzed data on 29,380 women participating in the Nurses' Health Study. All of the women had undergone hysterectomy for noncancerous conditions; more than half (16,345) had both ovaries removed, while the rest kept their ovaries. The investigators analyzed health changes over a 24-year period, focusing on chronic conditions, such as heart disease, stroke, hip fracture, and various cancers. They also evaluated causes of death and calculated overall death rates for the two groups. Multiple

risk factors and estrogen use were taken into account.

Compared with women who kept their ovaries, those who underwent bilateral oophorectomy had a 17% higher risk of developing heart disease and a 28% increased risk of dying from it; they also had a 26% greater likelihood of getting lung cancer and a 31% higher risk of dying from it (an unexpected finding that the authors can't explain). Among the women whose ovaries were removed before age 50 and who didn't take supplemental estrogen, the increased risks of lung cancer and stroke were considerably greater—109% and 85%, respectively. Not surprisingly, oophorectomy was associated with a nearly-zero risk of developing or dying from ovarian cancer and a 25% reduced risk of developing breast cancer. Overall, the risk of death from any cause was higher by 12% in women who had oophorectomies. That meant one additional death in the 35 years after surgery for every nine oophorectomies performed. Results were published in the May 2009 issue of *Obstetrics and Gynecology*.

This study doesn't prove that bilateral oophorectomy causes harm, but the results are consistent with other recent findings of links between ovary removal and elevated risks for various later-life ills and premature death. If you're at high risk for ovarian and breast cancer because of family history or a gene mutation, such as BRCA1 or BRCA2, the benefits of oophorectomy may outweigh the risks. But for women at average risk, oophorectomy could cause problems down the road. Certainly discuss the matter with your clinician, but unless there's a clear benefit, there's no reason to have your ovaries removed during hysterectomy. ♥

Average duration of hot flashes may be longer than previously thought

Hot flashes—also known as vasomotor symptoms—affect up to 75% of women during the menopausal transition. For some women, these symptoms are no more than mildly annoying; for others, they can be extremely bothersome and may involve drenching sweats day and/or night, palpitations, anxiety, and confusion. Certain lifestyle measures may help—keeping the thermostat turned down, dressing in loose layers, drinking ice water, and avoiding hot or spicy foods, for example. But severe symptoms may require medication. The most effective treatment is hormone therapy (HT)—estrogen with or without a progestin. But in light of well-publicized health risks connected with certain hormone preparations, HT is currently prescribed at the lowest dose for the shortest period of time.

Deciding whether to start HT might be easier if women knew how long they were likely to be experiencing hot flashes. Current health information suggests that symptoms

typically go on for six months to two years, but no investigation has actually lasted long enough to collect data on these symptoms—from start to finish—in a given cohort of women. Until now. A recent Australian study, published in the journal *Menopause* (May/June 2009), tracked women from premenopause through the menopausal transition and reported that hot flash duration averaged more than five years—well above previous estimates.

Investigators with the Melbourne Women's Midlife Health Project analyzed data from 438 women ages 45 to 55 who were still menstruating when the study began in 1991. Subjects were interviewed annually and completed health questionnaires, including questions about bothersome hot flashes. After 13 years of follow-up, the researchers found that hot flashes lasted, on average, 5.8 years in HT users and 5.2 years in nonusers. They also noted links between high exercise levels and shorter hot flash duration. ♥



Is taking calcium a problem if you have pseudogout?

Q I've been diagnosed with pseudogout, which I understand is caused by a buildup of calcium crystals in the joints. Should I be concerned about taking a calcium supplement?

A Pseudogout is a type of inflammatory arthritis characterized by sudden attacks of pain and swelling in the joints. It closely resembles gout, hence the name. But gout usually affects a big toe, and pseudogout usually affects the knee, though both conditions can affect other joints as well. Gout is caused by sodium urate crystals, and pseudogout is caused by crystals of calcium salts—calcium pyrophosphate dihydrate, or CPPD.

CPPD crystals initially form in the cartilage and migrate into synovial fluid, stimulating inflammation in the joint. Most people with x-ray evidence of CPPD crystals never have symptoms, but some develop pseudogout, as well as chronic arthritis. We don't know why calcium crystals form in joints, but they may result from elevated levels of calcium or pyrophosphate or other factors that lead to supersaturation of calcium pyrophosphate in cartilage and bone.

Risk factors for pseudogout include family history, trauma to the joint, and older age.

As long as your body is metabolizing calcium normally, dietary calcium or a calcium supplement should not increase CPPD formation. Calcium metabolism is a tightly regulated system. Calcium from food or supplements is absorbed in the gut and transported into the blood for use in most cell functions, including bone formation. If we absorb more than we need, our kidneys excrete the excess. However, certain conditions can undermine these controls, causing high blood calcium levels and predisposing a person to forming CPPD crystals.

Conditions associated with pseudogout include causes of excessive calcium in the blood such as an overactive parathyroid gland (hyperparathyroidism); low blood levels of magnesium; an underactive thyroid gland (hypothyroidism); and excess iron in tissues (hemochromatosis). Your doctor can perform blood tests to check for these conditions. If those are normal, you can safely take the calcium (and vitamin D) you need to reduce your risk for osteoporosis.

What can you tell me about peppermint oil?

Q What are the pros and cons of taking peppermint oil?

A Peppermint oil is extracted from parts of the peppermint plant, an herb that's been used as a digestive aid since ancient times. Nowadays, it's a flavoring agent in many over-the-counter health products, including toothpastes and mouthwashes. Menthol, a component of peppermint, is an ingredient in topical preparations for conditions ranging from congestion to muscle aches.

Peppermint oil relaxes the smooth muscle cells that line much of the gastrointestinal tract. It has been most extensively studied as a treatment for irritable bowel syndrome (IBS) and indigestion. Although clinical studies in people with IBS have shown mixed results, two major analyses found a modest benefit. People with IBS who took peppermint oil reported less flatulence, abdominal pain, and bloating compared with those who took a placebo. Given by enema, peppermint oil can help relieve intestinal spasms in people undergoing a barium examination of the large intestine.

Unfortunately, peppermint also relaxes the sphincter between the esophagus and stomach

(the lower esophageal sphincter), so it can cause gastroesophageal reflux and heartburn. It can worsen reflux symptoms in people with hiatal hernia and—not surprisingly—those with gastroesophageal reflux disease (GERD). In studies of people with IBS, peppermint oil (generally 0.2 to 0.4 milliliters three times a day) is taken in enteric-coated capsules, which allow it to bypass the esophagus and stomach before it is broken down and metabolized.

Peppermint oil has other downsides besides its effects on the lower esophageal sphincter. At high doses, it can be toxic to the kidneys, and you should not take it if you have gallstones or active gallbladder inflammation. Finally, check with your doctor if you take any other medication, because peppermint oil can boost the blood level of some medications, including the antidepressant amitriptyline (Elavil, others) and the statin simvastatin (Zocor).

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Send us a question for By the way, doctor

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Because of the volume of mail we receive, we can't answer every letter, nor can we provide personal medical advice.