

A photograph of a woman with long brown hair lying in bed, holding her newborn baby. The woman is looking towards the camera with a slight smile. The baby is wearing a white long-sleeved shirt and grey pants. The background shows a white headboard and a bedside table with a lamp.

A new mother with night sweats

Commentary by

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A 35-year-old woman has been experiencing night sweats since the birth of her second child nine months previously.

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CASE SCENARIO

Sally is a 35-year-old woman who presents for her three-monthly contraceptive injection of depot medroxyprogesterone. She mentions in passing that since the birth of her second child, nine months previously, she has been experiencing night sweats three or four times a week. She has no obvious focus of infection, no pain and no other systemic symptoms, although she says she often feels very tired. She also reports that she is still producing some breast milk despite having stopped breastfeeding six months previously.

Sally recalls that about two years ago, before she conceived her second child, she was quite sick with an 'ovarian infection' and then an ectopic pregnancy.

Sally's pelvic ultrasound results are normal, as are the results of urine and blood tests, including a full blood count, erythrocyte sedimentation rate, C-reactive protein level, thyroid function and serum prolactin level. Her serum follicle-stimulating hormone and other reproductive hormone levels are in the normal range for the luteal phase of the menstrual cycle.

What could be causing Sally's night sweats?

COMMENTARY

Hot flushes and sweats are not unusual in women who are having regular menstrual cycles, especially during the bleeding phase when oestrogen levels are low. Hot flushes and sweats are also

common after the birth of a baby, especially during breastfeeding as this is a low-oestrogen state. Most women do not complain about these symptoms because of their focus on the new baby and its care. Vaginal dryness is also common at this time.

Nevertheless, it is important to make sure that Sally's night sweats do not have a more sinister cause. Sally should take her temperature by mouth when she is woken by sensations of heat. 'Hormonal' causes of hot flushes raise skin temperature but not central temperature. If she finds her mouth temperature is raised on a few occasions then she will need further investigations to determine the cause of this fever.

More likely, her mouth temperature will be normal, suggesting a hormonal cause for the night sweats. Hormonal causes of flushes include low-oestrogen states, hyperthyroidism, calcium disorders (e.g. hyperparathyroidism), medullary thyroid cancer, mast cell tumours, pheochromocytomas and carcinoid syndrome. Each of these has a specific presentation that should be considered.

Depot medroxyprogesterone induces a low-oestrogen state and might also be the cause of the hot flushes. In most cases, women using depot medroxyprogesterone do not experience flushes because the moderate dose of progestin has an anti-flushing effect, but this is not always so.

A treatment strategy would be to withhold the medroxyprogesterone, perhaps replacing it with a combined oral contraceptive, and to assess whether the flushes disappear.

Another possible treatment strategy is illustrated by a case of my own that was similar to Sally's case. My patient was referred for treatment of severe hot flushes after the birth of her third child. She had experienced similar flushes after the birth of each of her children, but the flushes settled within a few months after the first child and six months after the second. However, she was still experiencing severe

flushes 12 months after the birth of her third child.

Her gynaecologist had prescribed a combined oral contraceptive, which had no effect on the flushes. I suggested she try citalopram (for its antinflusing rather than antidepressant effect) at a dose of 10 to 20 mg for a month. The flushes ceased within one to two weeks. Citalopram was continued for six months and she was then weaned off it. At the time of writing, she was waiting to see whether the flushes returned. I postulate that the oestrogen withdrawal that occurred after each birth disturbed the serotonin balance in her temperature-regulating system.¹

Clonidine and gabapentin also have antinflusing effects and might be worth trying to treat postpartum hot flushes. The dose of clonidine needed to reduce hot flushes is usually 100 µg twice daily, which has the side effect of hypotension. Most trials of gabapentin for hot flushes have used a dose of 900 mg daily.

KEY POINTS

- Hot flushes can occur in premenopausal women during low-oestrogen states, such as after giving birth.
- It is important to differentiate hormonal hot flushes from fever, and also to exclude hormonal causes other than low oestrogen, such as hyperthyroidism.
- Treatment strategies include a combined oral contraceptive or nonhormonal therapies with specific antinflusing effects, such as citalopram, clonidine or gabapentin. **MT**

REFERENCE

1. Nelson HD, Vesco KK, Haney E, et al. Nonhormonal therapies for menopausal hot flashes: systematic review and meta-analysis. *JAMA* 2006; 295: 2057-2071.

COMPETING INTERESTS: Professor Eden donates any honoraria received from pharmaceutical companies to a charity, Glory Reborn, in the Philippines.