

Appendix 1: Medline Search Strategy

- 1 exp Breast Neoplasms/
- 2 ((breast* or mamma or mammar*) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw,kw.
- 3 exp Prostatic Neoplasms/
- 4 ((prostate or prostatic) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw,kw.
- 5 or/1-4
- 6 Hot Flashes/
- 7 (hot flash* or hot flush*).tw,kw.
- 8 night sweat*.tw,kw.
- 9 ((vasomotor or vaso-motor) adj5 (disorder* or disturbance* or instabilit* or symptom*)).tw,kw.
- 10 ((climacteri* or menopaus* or premenopaus* or pre-menopaus* or postmenopaus* or postmenopaus*) adj5 (disorder* or disturbance* or instabilit* or symptom*)).tw,kw.
- 11 or/6-10
- 12 5 and 11
- 13 (controlled clinical trial or randomized controlled trial).pt.
- 14 clinical trials as topic.sh.
- 15 (randomi#ed or randomly or RCT\$1 or placebo*).tw.
- 16 ((singl* or doubl* or trebl* or tripl*) adj (mask* or blind* or dumm*)).tw.
- 17 trial.ti.
- 18 or/13-17
- 19 12 and 18
- 20 exp Animals/ not (exp Animals/ and Humans/)
- 21 19 not 20
- 22 (comment or editorial or interview or news).pt.
- 23 (letter not (letter and randomized controlled trial)).pt.
- 24 21 not (22 or 23)
- 25 24 use prmz [MEDLINE]
- 26 exp breast tumor/
- 27 ((breast* or mamma or mammar*) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw,kw.
- 28 exp prostate tumor/
- 29 ((prostate or prostatic) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw,kw.
- 30 or/26-29
- 31 hot flush/
- 32 (hot flash* or hot flush*).tw,kw.
- 33 night sweat*.tw,kw.
- 34 vasomotor disorder/
- 35 ((vasomotor or vaso-motor) adj5 (disorder* or disturb* or instabilit* or symptom*)).tw,kw.

36 ((climacteri* or menopaus* or premenopaus* or pre-menopaus* or postmenopaus* or postmenopaus*) adj5 (disorder* or disturb* or instabilit* or symptom*)).tw,kw.
 37 or/31-36
 38 30 and 37
 39 randomized controlled trial/ or controlled clinical trial/
 40 exp "clinical trial (topic)"/
 41 (randomi#ed or randomly or RCT\$1 or placebo*).tw.
 42 ((singl* or doubl* or trebl* or tripl*) adj (mask* or blind* or dumm*)).tw.
 43 trial.ti.
 44 or/39-43
 45 38 and 44
 46 exp animal experimentation/ or exp models animal/ or exp animal experiment/ or nonhuman/ or exp vertebrate/
 47 exp humans/ or exp human experimentation/ or exp human experiment/
 48 46 not 47
 49 45 not 48
 50 editorial.pt.
 51 letter.pt. not (letter.pt. and randomized controlled trial/)
 52 49 not (50 or 51)
 53 52 use emczd [EMBASE]
 54 exp Breast Neoplasms/
 55 ((breast* or mamma or mammar*) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw.
 56 exp Prostatic Neoplasms/
 57 ((prostate or prostatic) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw.
 58 or/54-57
 59 Hot Flashes/
 60 (hot flash* or hot flush*).tw,kw.
 61 night sweat*.tw.
 62 ((vasomotor or vaso-motor) adj5 (disorder* or disturbance* or instabilit* or symptom*)).tw.
 63 ((climacteri* or menopaus* or premenopaus* or pre-menopaus* or postmenopaus* or postmenopaus*) adj5 (disorder* or disturbance* or instabilit* or symptom*)).tw.
 64 or/59-63
 65 58 and 64
 66 (controlled clinical trial or randomized controlled trial).pt.
 67 exp Clinical Trials/
 68 (randomi#ed or randomly or RCT\$1 or placebo*).tw.
 69 ((singl* or doubl* or trebl* or tripl*) adj (mask* or blind* or dumm*)).tw.
 70 trial.ti.
 71 or/66-70
 72 65 and 71
 73 exp Animals/ not (exp Animals/ and Humans/)

74 72 not 73
75 (comment or editorial or interview or news).pt.
76 (letter not (letter and randomized controlled trial)).pt.
77 74 not (75 or 76)
78 77 use amed [AMED]
79 breast neoplasms/
80 ((breast* or mamma or mammar*) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw.
81 Prostate/ and exp Neoplasms/
82 ((prostate or prostatic) adj3 (cancer* or carcinoid* or carcinoma* or carcinogen* or adenocarcinoma* or adeno-carcinoma* or malignan* or neoplasia* or neoplasm* or sarcoma* or tumour* or tumor*)).tw.
83 or/79-82
84 (hot flash* or hot flush*).tw,kw.
85 night sweat*.tw.
86 ((vasomotor or vaso-motor) adj5 (disorder* or disturb* or instabilit* or symptom*)).tw,kw.
87 ((climacteri* or menopaus* or premenopaus* or pre-menopaus* or postmenopaus* or postmenopaus*) adj5 (disorder* or disturb* or instabilit* or symptom*)).tw,kw.
88 or/84-87
89 83 and 88
90 clinical trials/
91 (randomi#ed or randomly or RCT\$1 or placebo*).tw.
92 ((singl* or doubl* or trebl* or tripl*) adj (mask* or blind* or dumm*)).tw.
93 trial.ti.
94 or/90-93
95 89 and 94
96 exp Animals/ not (exp Animals/ and Humans/)
97 95 not 96
98 97 use prmz
99 97 use emezd
100 97 use amed
101 97 not (98 or 99 or 100) [PSYCINFO]
102 25 or 53 or 78 or 101
103 remove duplicates from 102 [UNIQUE RECORDS]
104 103 use prmz [MEDLINE UNIQUE RECORDS]
105 103 use emezd [EMBASE UNIQUE RECORDS]
106 103 use amed [AMED UNIQUE RECORDS]
107 103 not (104 or 105 or 106) [PSYCINFO UNIQUE RECORDS]

Appendix 2: Overview of Study Selection Criteria

Selection criteria were originally described in the published protocol for this review. A summary of these criteria is provided in the table below.

Criteria	Description of Eligibility
Population	Studies that enrolled patients with a history of breast or prostate cancer who are experiencing hot flashes. No restrictions on age or cancer stage were employed.
Intervention and Comparators	Studies assessing non-hormonal pharmacologic, behavioral/physical, and natural health product interventions were of interest. Pharmacologic interventions of interest included anti-depressants from the selective serotonin reuptake inhibitors class (including sertraline, escitalopram, citalopram, etc) and from the selective norepinephrine reuptake inhibitor class (including duloxetine, venlafaxine, etc), and certain neuroleptic agents (gabapentin, clonidine) and anti-hypertensive medications. All doses and formulations were considered to be eligible. Physical and behavioral interventions of interest consisted of yoga, exercise programs, hypnosis, acupuncture, relaxation approaches, and cognitive behavioral therapy. Nutritional healthcare products of interest consisted of ginseng, black cohosh, flax, isoflavones, menherba, soy and vitamin E. Placebo (and other representations of inactive treatment) were also considered of interest as key sources of indirect evidence.
Outcomes	Changes in the severity and frequency of hot flashes were of primary interest. Changes in quality of life (both overall and for specific symptoms) were also of interest. The reporting format of frequency of hot flashes was known prior to starting the review to be variable amongst trials (e.g. % change from baseline, mean number per day, % of patients remaining free of hot flashes during the study); all formats were sought during data collection. Data from all validated symptom-specific and generic quality of life (QoL) scales (and their different forms of reporting) were also of interest. Secondary outcomes included measures related to adherence to cancer therapies and harms associated with each treatment (e.g., adverse drug effects, discontinuation from the study, etc).
Study Design	Randomized controlled trials were sought, with both parallel group and crossover designs being of interest. For crossover trials, data from the initial study period was considered a priori to be of focus in order to avoid bias from carryover.

Appendix 3: Additional Details, Statistical Methods for NMA

For two outcomes with enough data for NMA (hot flash score and frequency), and several included studies reported medians and interquartile ranges (IQR) as opposed to means and with standard deviations (SD), standard errors (SE) or confidence intervals (CI). Medians and related IQRs were converted to means and SDs according to methods described elsewhere by Wan et al 2014.(Wan et al., 2014) About half of the included studies reported percentage change from baseline and the other half reported the absolute values. We transformed absolute/percentage changes from baseline into the difference of log mean changes from baseline across two arms and the corresponding SEs, such that the percentages were cancelled out during pre-processing:

$$\delta_{t_{i1},t_{ik}} = \ln(y_{ik}) - \ln(y_{i1}) = \ln(y_{ik}/y_{i1}), \quad k > 1,$$
$$SE\{\delta_{t_{i1},t_{ik}}\} = SE\{\ln(y_{ik}) - \ln(y_{i1})\} = \sqrt{\{SE(y_{i1})/y_{i1}\}^2 + \{SE(y_{ik})/y_{ik}\}^2}$$

where y_{i1} and y_{ik} are the absolute/percentage mean change from baseline in the 1st and k th arm of the i th study, $SE(y_{i1})$ and $SE(y_{ik})$ are the corresponding standard errors.

A contrast-based NMA model on the difference of log mean changes from baseline across two arms and the corresponding SEs following transformation was used. Both fixed effects (FE) and random effects (RE) models with Normal likelihood and the identity link were fit to the data.(Dias et al., 2011) As such, the mean difference of two interventions in the log scale can be interpreted as the log ratio of means (log RoM); when transformed back to the natural scale, estimates can be interpreted as the RoM of two interventions. We present comparisons between interventions in terms of ratios of means (RoM) with 95% credible intervals (CrI).

The probability of each intervention to be the best (referred to from here on as ‘P(best)’), the corresponding surface under the cumulative ranking curve (SUCRA) values, and the mean rank of each intervention (with 2.5% and 97.5% quantiles) were also estimated.(Salanti et al., 2011) P(best) and SUCRA values range between 0 and 1, with values nearer 1 indicative of preferred treatments. Smaller values of the mean rank also suggest preferred treatments. Further details regarding the methods and implementation of NMA are provided in the supplementary materials.

R2OpenBUGS Code Modified for Ratio of Means Network Meta-Analysis (Contrast-based)

Part A. Contrast-based random effects consistency model, modified for ratio of means analysis

```
#=====
# Set up data for R2OpenBUGS
# Pre-processing of data specifically for ratio of means NMA modeling
#=====

setwd("C:\\Hot Flash\\HF freq\\Doses combined\\RE\\")
WD <- getwd()

# A total of 100,000 iterations, among which half were burn-in
NITER = 100000
NBURNIN = 50000

# LOAD DATA
# read in study-by-treatment data
data1 = read.csv("C:\\Hot Flash\\HF freq\\Doses
combined\\study_data_incl_percent.csv", header=TRUE)

data2 = read.csv("C:\\Hot Flash\\HF freq\\Doses
combined\\treatments_incl_percent.txt", header=TRUE, sep="\t")
treatment = data2[,1]
txNames = data2[,2]
txColors = matrix(data2[,3])

# Required R package needed to call OpenBUGS
library(R2OpenBUGS)

maxnarms <- max(data1$na)
nt = length(txNames) # or, = max(treatment)
na = data1$na
ns2 = sum(na==2)
ns3 = sum(na==3)
ns4 = sum(na==4)
ns = ns2+ns3+ns4

t = matrix(NA, ns, maxnarms)
t[,1] = data1$t1
t[,2] = data1$t2
t[,3] = data1$t3
t[,4] = data1$t4

y = matrix(NA, ns, maxnarms)
y[,2] = log(data1$y2)-log(data1$y1)
y[,3] = log(data1$y3)-log(data1$y1)
y[,4] = log(data1$y4)-log(data1$y1)

sesq = matrix(NA, ns, maxnarms)
sesq[,2] = (data1$se2/data1$y2)^2 + (data1$se1/data1$y1)^2
sesq[,3] = (data1$se3/data1$y3)^2 + (data1$se1/data1$y1)^2
sesq[,4] = (data1$se4/data1$y4)^2 + (data1$se1/data1$y1)^2

V = rep(NA, ns2+ns3+ns4)
V[na>2] = (data1$se1[na>2]/data1$y1[na>2])^2
```

```

dat <- list("nt", "ns2", "ns3", "ns4", "t", "y", "sesq", "V", "na")

#=====
===
# Normal likelihood, identity link, trial-level data given as treatment differences
# Contrast-based random effects consistency model, modified for ratio of means
analysis
#=====
===

trt_diff_norm_consist <- function(){                                     # ***
PROGRAM STARTS
  for (i in 1:ns2){                                                    # LOOP
THROUGH 2-ARM STUDIES
  y[i,2] ~ dnorm(delta[i,2], prec[i,2])                                #
Normal likelihood for 2-arm trials
  resdev[i] <- (y[i,2]-delta[i,2])*(y[i,2]-delta[i,2])*prec[i,2]      #
Deviance contribution for trial i
  resdev.contrast[i,1] <- resdev[i]
  }

  for (i in (ns2+1):(ns2+ns3)){                                         # LOOP
THROUGH 3-ARM STUDIES
  for (k in 1:(na[i]-1)){                                               # set
variance-covariance matrix
  for (j in 1:(na[i]-1)){
    Sigma[i,j,k] <- V[i]*(1>equals(j,k)) + sesq[i,k+1]*equals(j,k)
  }
  Omega[i,1:(na[i]-1),1:(na[i]-1)] <- inverse(Sigma[i,,])           #
Precision matrix
  y[i,2:na[i]] ~ dnorm(delta[i,2:na[i]], Omega[i,1:(na[i]-1),1:(na[i]-1)]) #
Normal likelihood for 3-arm trials
  for (k in 1:(na[i]-1)){                                               #
multiply vector & matrix
  ydiff[i,k] <- y[i,(k+1)] - delta[i,(k+1)]
  z[i,k] <- inprod(Omega[i,k,1:(na[i]-1)], ydiff[i,1:(na[i]-1)])
  resdev.contrast[i,k] <- ydiff[i,k] * z[i,k]
  }
  resdev[i] <- inprod(ydiff[i,1:(na[i]-1)], z[i,1:(na[i]-1)])         #
Deviance contribution for trial i
  }

  for (i in (ns2+ns3+1):(ns2+ns3+ns4)){                                 # LOOP
THROUGH 4-ARM STUDIES
  for (k in 1:(na[i]-1)){                                               # set
variance-covariance matrix
  for (j in 1:(na[i]-1)){
    Sigma2[i,j,k] <- V[i]*(1>equals(j,k)) + sesq[i,k+1]*equals(j,k)
  }
  Omega2[i,1:(na[i]-1),1:(na[i]-1)] <- inverse(Sigma2[i,,])          #
Precision matrix
  y[i,2:na[i]] ~ dnorm(delta[i,2:na[i]], Omega2[i,1:(na[i]-1),1:(na[i]-1)]) #
Normal likelihood for 4-arm trials
  for (k in 1:(na[i]-1)){                                               #
multiply vector & matrix

```

```

ydiff[i,k] <- y[i,(k+1)] - delta[i,(k+1)]
z[i,k] <- inprod(Omega2[i,k,1:(na[i]-1)], ydiff[i,1:(na[i]-1)])

resdev.contrast[i,k] <- ydiff[i,k] * z[i,k]
}
resdev[i] <- inprod(ydiff[i,1:(na[i]-1)], z[i,1:(na[i]-1)]) #
Deviance contribution for trial i
}

for (i in 1:(ns2+ns3+ns4)){ # LOOP THROUGH ALL STUDIES
  w[i,1] <- 0 # adjustment for multi-arm trials
  is 0 for control arm
  delta[i,1] <- 0 # treatment effect is 0 for
  control arm
  for (k in 2:na[i]){ # LOOP THROUGH ARMS
    prec[i,k] <- 1/sesq[i,k] # set precisions
  }

  for (k in 2:na[i]){ # LOOP THROUGH ARMS
    delta[i,k] ~ dnorm(md[i,k], taud[i,k]) # trial-specific treatment
  effects distributions
    md[i,k] <- d[t[i,k]] - d[t[i,1]] + sw[i,k] # mean of trmt effects
  distributions (with multi-arm correction)
    taud[i,k] <- tau *2*(k-1)/k # precision of effects
  distributions (with multi-arm correction)
    w[i,k] <- (delta[i,k] - d[t[i,k]] + d[t[i,1]]) # adjustment for multi-arm RCTs
    sw[i,k] <- sum(w[i,1:k-1])/(k-1) # cumulative adjustment for
  multi-arm trials
  }
  }
  totesdev <- sum(resdev[]) # total residual deviance
  d[1] <- 0 # treatment effect is 0 for
  reference treatment
  for (k in 2:nt){
    d[k] ~ dnorm(0, 0.01) # vague priors for treatment
  effects
  }
  sd ~ dunif(0, 3) # vague prior for between-trial
  SD
  tau <- pow(sd, -2) # between-trial precision =
  (1/between-trial variance)

# Output
# pairwise treatment effect for all possible pair-wise comparisons, if nt>2
for (c in 1:(nt-1)) {
  for (k in (c+1):nt) {
    logRoM[c,k] <- d[k] - d[c]
    logRoM[k,c] <- d[c] - d[k]
    RoM[c,k] <- exp(logRoM[c,k])
    better[c,k] <- step(logRoM[c,k]) # assumes a positive result
  }
  is "good"
}

# ranking on relative scale
for (k in 1:nt) {
  rk[k] <- nt+1-rank(d[,k]) # assumes events are "good"
}

```



```

    best[k] <- equals(rk[k],1) # calculate probability that
  treat k is best
    for (i in 1:nt){
      prk[i,k] <- equals(rk[k],i) # calculate probability of
  treat k being each rank i
    }
  }

  for (k in 1:nt) {
    for (h in 1:nt){
      cumeffectiveness[k,h] <- sum(prk[1:h,k]) # Cumulative ranking prob of
  trmt k to be among the h best
    }
    SUCRA[k] <- sum(cumeffectiveness[k, 1:(nt-1)])/(nt-1) # Surface Under the
  Cumulative RANKings for treatment k
  }
} # *** PROGRAM ENDS

write.model(trt_diff_norm_consist, "trt_diff_norm_consist.txt")
MODELFILE <- c("trt_diff_norm_consist.txt")

# Initial Values
inits <- NULL

parameters <- c("d", "sd", "delta", "logRoM", "RoM",
               "best", "better", "prk", "rk", "SUCRA",
               "resdev.contrast", "resdev", "totresdev")

NMA.sim <- bugs(dat, inits, parameters, model.file = MODELFILE,
               n.chains = 2, n.iter = NITER, n.burnin = NBURNIN,
               DIC = TRUE, debug = FALSE, save.history = FALSE,
               codaPkg = FALSE, working.directory = WD, clearWD = FALSE)

```

Part B. Contrast-based random effects unrelated means model, modified for ratio of means analysis

```

=====
===
# Normal likelihood, identity link, trial-level data given as treatment differences
# Contrast-based random effects unrelated means model, modified for ratio of means
analysis
=====
===

trt_diff_norm_unrelat <- function() { # ***
PROGRAM STARTS
  for (i in 1:ns2){ # LOOP
THROUGH 2-ARM STUDIES
  y[i,2] ~ dnorm(delta[i,2], prec[i,2]) #
Normal likelihood for 2-arm trials
  resdev[i] <- (y[i,2]-delta[i,2])*(y[i,2]-delta[i,2])*prec[i,2] #
Deviance contribution for trial i
  resdev.contrast[i,1] <- resdev[i]
}

```

```

    for (i in (ns2+1):(ns2+ns3)){ # LOOP
THROUGH 3-ARM STUDIES
    for (k in 1:(na[i]-1)){ # set
variance-covariance matrix
    for (j in 1:(na[i]-1)){
        Sigma[i,j,k] <- V[i]*(1>equals(j,k)) + sesq[i,k+1]*equals(j,k)
    }
    }
    Omega[i,1:(na[i]-1),1:(na[i]-1)] <- inverse(Sigma[i,,]) #
Precision matrix
    y[i,2:na[i]] ~ dnorm(delta[i,2:na[i]], Omega[i,1:(na[i]-1),1:(na[i]-1)]) #
Normal likelihood for 3-arm trials
    for (k in 1:(na[i]-1)){ #
multiply vector & matrix
        ydiff[i,k] <- y[i,(k+1)] - delta[i,(k+1)]
        z[i,k] <- inprod(Omega[i,k,1:(na[i]-1)], ydiff[i,1:(na[i]-1)])
        resdev.contrast[i,k] <- ydiff[i,k] * z[i,k]
    }
    resdev[i] <- inprod(ydiff[i,1:(na[i]-1)], z[i,1:(na[i]-1)]) #
Deviance contribution for trial i
    }

    for (i in (ns2+ns3+1):(ns2+ns3+ns4)){ # LOOP
THROUGH 4-ARM STUDIES
    for (k in 1:(na[i]-1)){ # set
variance-covariance matrix
    for (j in 1:(na[i]-1)){
        Sigma2[i,j,k] <- V[i]*(1>equals(j,k)) + sesq[i,k+1]*equals(j,k)
    }
    }
    Omega2[i,1:(na[i]-1),1:(na[i]-1)] <- inverse(Sigma2[i,,]) #
Precision matrix
    y[i,2:na[i]] ~ dnorm(delta[i,2:na[i]], Omega2[i,1:(na[i]-1),1:(na[i]-1)]) #
Normal likelihood for 4-arm trials
    for (k in 1:(na[i]-1)){ #
multiply vector & matrix
        ydiff[i,k] <- y[i,(k+1)] - delta[i,(k+1)]
        z[i,k] <- inprod(Omega2[i,k,1:(na[i]-1)], ydiff[i,1:(na[i]-1)])
        resdev.contrast[i,k] <- ydiff[i,k] * z[i,k]
    }
    resdev[i] <- inprod(ydiff[i,1:(na[i]-1)], z[i,1:(na[i]-1)]) #
Deviance contribution for trial i
    }

    for (i in 1:(ns2+ns3+ns4)){ # LOOP THROUGH ALL STUDIES
        w[i,1] <- 0 # adjustment for multi-arm trials
is 0 for control arm
        delta[i,1] <- 0 # treatment effect is 0 for
control arm
        for (k in 2:na[i]){ # LOOP THROUGH ARMS
            prec[i,k] <- 1/sesq[i,k] # set precisions
        }

        for (k in 2:na[i]){ # LOOP THROUGH ARMS
            delta[i,k] ~ dnorm(md[i,k], taud[i,k]) # trial-specific treat effects
distributions
    }

```

```

    md[i,k] <- di[t[i,1],t[i,k]] + sw[i,k]           # mean of trmt effects
distributions (with multi-arm correction)
    taus[i,k] <- tau *2*(k-1)/k                     # precision of effects
distributions (with multi-arm correction)
    w[i,k] <- delta[i,k] - di[t[i,1],t[i,k]]       # adjustment for multi-arm RCTs
    sw[i,k] <- sum(w[i,1:k-1])/(k-1)               # cumulative adjustment for
multi-arm trials
    }
    }
    totesdev <- sum(resdev[])                        # total residual deviance

    for (c in 1:(nt-1)) {                            # priors for all mean treatment
effects
    for (k in (c+1):nt) {
        di[c,k] ~ dnorm(0, 0.01)
    }
    }

    sd ~ dunif(0, 3)                                 # vague prior for between-trial
SD
    tau <- pow(sd, -2)                               # between-trial precision =
(1/between-trial variance)
    }                                                # *** PROGRAM ENDS

write.model(trt_diff_norm_unrelat, "trt_diff_norm_unrelat.txt")
MODELFILE <- c("trt_diff_norm_unrelat.txt")

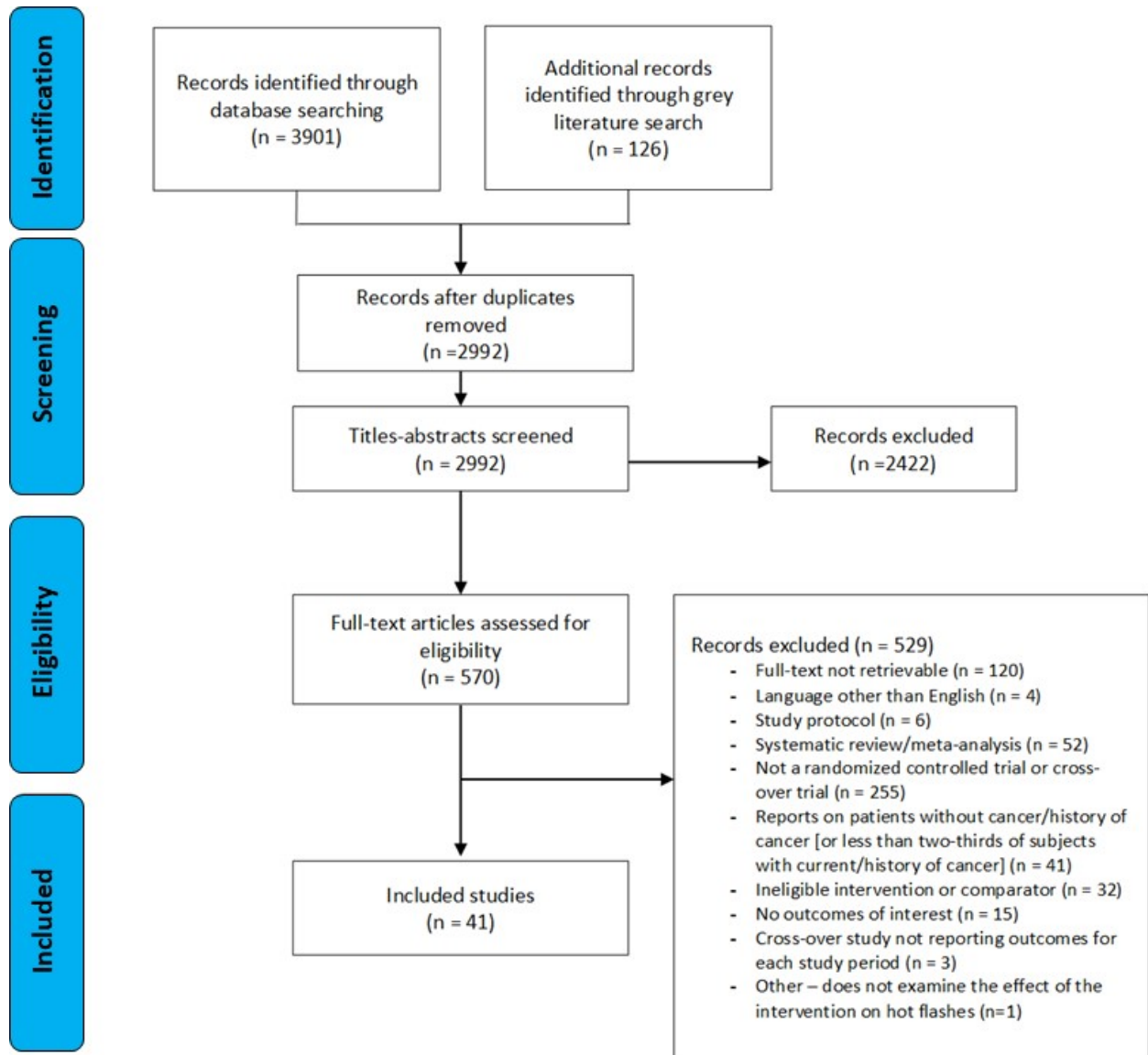
# Initial Values
inits <- NULL

parameters <- c("di", "sd", "delta", "resdev.contrast", "resdev", "totesdev")

NMA.sim <- bugs(dat, inits, parameters, model.file = MODELFILE,
    n.chains = 2, n.iter = NITER, n.burnin = NBURNIN,
    DIC = TRUE, debug = FALSE, save.history = FALSE,
    codaPkg = FALSE, working.directory = WD, clearWD = FALSE)

```

Appendix 4: Flow Diagram of Study Selection Process



Appendix 5: Studies Excluded During Full Text Screening (With Reasons)

Full-text not retrievable (n=120)

Absenger Cancer Education Foundation. A Pilot Study To Assess Guidance in and Subsequent Use of Mind-Body Techniques on the Quality of Life of Cancer Patients.

<http://clinicaltrials.gov/show/NCT01586546> 2012.

Allais, G., Gabellari, I. C., Rolando, S., Borgogno, P., Cormio, M., and Benedetto, C. Use of acupuncture in the treatment of climacteric disorders. *Giornale Italiano di Ostetricia e Ginecologia* 2009. 31 (1-2): 68-69.

Alliance for Clinical Trials in Oncology. Soy Protein Supplement In Treating Hot Flashes in Postmenopausal Women Receiving Tamoxifen for Breast Disease.

<https://clinicaltrials.gov/ct2/show/NCT00031720> 2015.

Arneil, M., Anderson, D., Alexander, K., and McCarthy, A. Investigating the impact of physical activity on cognition-related quality of life in younger women after breast cancer treatment. *Asia-Pacific Journal of Clinical Oncology* 2017. 13 (Supplement 4): 207-208.

Bakker, S. M., Eekhof, J. A. H., Lagro-Jansen, A. L. M., and Neven, A. K. Hot flashes. *Huisarts en Wetenschap* 2006. 49 (13): 677-681.

Banks, E. Raloxifene and breast cancer risk. *Breast Cancer Research* 1999. 1 (1): 64-65.

Bertelli, G., Venturini, M., Mastro, L., Costantini, M., Bergaglio, M., Pastorino, S., Biglia, N., Sismondi, P., Venturini, S., and Pronzato, P. Depot intramuscular medroxyprogesterone acetate (MAP) vs oral megestrol acetate (MA) for the treatment of hot flashes in breast cancer survivors: results of GONO (Gruppo Oncologico Nord Ovest) MIG-4 phase III trial [abstract]. *Proceedings of the American Society of Clinical Oncology* 1999. 18, 592a, Abstract.

Beuth, J., Van, Leendert R., Pempelfort, K., Schneider, B., Grund, C., and Engelmann, U. Complementary medicine down-regulates side-effects of hormone therapy in prostate cancer patients. *In Vivo* 2014. 28 (5): 979-982. Bicalutamide shows promise as early treatment in prostate cancer. *Pharmaceutical Journal* 2002. 269 (7211): 207.

Blackstein, M., Fyles, A., Goss, P., and Olsson, S. The role of aromatase inhibitors in breast cancer: A discussion. *Current Oncology* 1999. 6 (4): 211-216.

Bliss, J. Randomized Study of Hormone Replacement Therapy for Relieving Menopausal Symptoms in Postmenopausal Women With Prior Stage I or II Breast Cancer. *Physician Data Query (PDQ)* 2004.

Bock, K., Hadji, P., Schulz, K.-D., Jackisch, C., and Wagner, U. Concepts for the therapy of climacteric complaints in oncologic patients. *Gynakologe* 2003. 36 (6): 479-486.

Bounous, V. E., Biglia, N., Moggio, G., Barrera, M., D'Alonzo, M., Torta, R., and Sismondi, P. Duloxetine and escitalopram for treatment of hot flashes in breast cancer survivors. *Climacteric, the journal of the International Menopause Society* 2011. 14, 113.

Borgelt, L. M., Liston, R., Giacomini, K., and Dickinson, M. Evaluation of shared decision making between patients and providers to improve menopause health outcomes. *Menopause (New York, N.Y.)* 2015. 22 (12): 1399.

Campos, M. P., Riechelmann, R., Martins, L. C., Hassan, B. J., Casa, F. B., and Del, Giglio A. Effect of guarana (*Paullinia cupana*) on fatigue in breast cancer patients undergoing systemic chemotherapy. *Journal of Clinical Oncology* 2010. 28 (15 SUPPL. 1).

CAMSTRAND Conference 2016 Abstracts. *European Journal of Integrative Medicine* 2016. 8 (4).

Cappai, E. and Magno, S. M. Reflexology in breast cancer patients receiving chemotherapy: Results from a single center pilot study. *Supportive Care in Cancer* 2013. 21, S233.

Castelo-Branco, C. *Cimicifuga racemosa* for non-hormonal treatment of climacteric complaints-an overview. *Climacteric: the journal of the International Menopause Society* 2016. 19 (Supplement 1): 83.

Chen, Shih Ping, Horng, Chen Fang, Hsieh, Ling Ling, Hsu, Kai Hsin, Chu, Chen Shin, Tsai, Shu Yi, Chan, Yu Hui, Shih, Shih Ming, and Cheng, Chun Chiu. A randomized controlled study for the long term follow-up of breast cancer survivors: A primary care physician (PCP) coordinated care delivery model. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology* 2016. 34 (3_suppl): 36.

Cobleigh, M. A. Hormone replacement therapy and nonhormonal control of menopausal symptoms in breast cancer survivors. *Cancer treatment and research* 1998. 94, 209-230.

Cobleigh, M. A. Managing menopausal problems. *Cancer treatment and research* 2000. 103, 1-23.

Cumins, S. M. and Brunt, A. M. Does acupuncture influence the vasomotor symptoms experienced by breast cancer patients taking tamoxifen? *Acupuncture in Medicine* 2000. 18 (1): 28.

D'Andrea, G. and Xiao, H. Acupuncture for the treatment of hot flashes in breast cancer patients 1562. Pdq, 1 R21 Ca098565 01, Nct00081965. 2004.

Darmasetiawan, M. Is there a place for isoflavones and black cohosh in menopausal management. *Climacteric: the journal of the International Menopause Society* 2016. 19 (Supplement 1): 4-5.

Daub, EA, Gerhard, I, and Bastert, G. Homeopathic antimesis for chemotherapy, a prospective randomised trial [Homoopathische Antiemetika bei hemothérapie, eine prospektiv, randomisierte Studie]. *Geburtshilfe und Frauenheilkunde* 2005. 60, S157.

Davies, F. M. The effect of acupuncture treatment on the incidence and severity of hot flashes experienced by women following treatment for breast cancer: a comparison of traditional and minimal acupuncture [abstract]. *European Journal of Cancer* 2001. 37 (Suppl 6): S438.

Desiderio, F., Rudnas, B., Panzini, I., Pini, E., Gianni, L., Tamburini, E., Ravaioli, A., Drudi, G., and Tassinari, D. Homeopathy in the treatment of menopausal symptoms in patients with early breast cancer. *Annals of Oncology* 2015. 26: vi25.

Dijkman, G. A., Debruyne, F. M. J., Fernandez Del, Moral P., Plasman, J. W. M. H., Hoefakker, J. W., Idema, J. G., and Sykes, M. A phase III randomized trial comparing the efficacy and safety of the 3-monthly 10.8-mg depot of Zoladex with the monthly 3.6-mg depot in patients with advanced prostate cancer. *European Urology* 1994. 26 (SUPPL. 1): 1-2.

Dooley, W. C., Hendricks, C., Gusev, Y., and Shockney, L. Internet based double-blind cross-over clinical trial to test efficacy of high dose isoflavone soy in controlling breast cancer survivor hot flashes. *Journal of Clinical Oncology* 2006. 24 (18 Suppl): 36s.

Druckmann, R. Non-hormonal treatment of vasomotor symptoms in female patients with and after breast carcinoma. *Maturitas* 2015. 81 (1): 160.

Duramed Research. A Clinical Trial to Study DR-2031 for the Treatment of Hot Flashes in Prostate Cancer Patients.

<https://clinicaltrials.gov/ct2/show/NCT00196339?term=NCT00196339&rank=1> 2013.

Ee, C., Xue, C., Chondros, P., Myers, S., French, S., Teede, H., and Pirotta, M. Acupuncture for menopausal hot flashes: A randomised sham-controlled trial. *Advances in Integrative Medicine* 2015. 2 (2): 115-116.

Elkins, G. Hypnosis for Hot Flashes in Breast Cancer Survivors 1557. Pdq, Ca100594 01A1. 2004.

Emory University. Efficacy of Acupuncture for Hot Flashes in Women Treated With Hormonal Therapy for Breast Cancer.

<https://clinicaltrials.gov/ct2/show/NCT00209001?term=NCT00209001&rank=1> 2015.

European Organisation for Research and Treatment of Cancer - EORTC. Moxifloxacin Compared With Ciprofloxacin/Amoxicillin in Treating Fever and Neutropenia in Patients With Cancer. <https://clinicaltrials.gov/ct2/show/NCT00062231> 2012.

Fath, R. Rethinking the use of hormone replacement therapy. *Deutsche Medizinische Wochenschrift* 2003. 128 (43): 2236.

Forbes, M., Wong, R., Sagar, S. M., Julian, J. A., Levine, M. N., and Hayward, J. Lifestyle interventions combined with acupuncture-like transcutaneous electrical nerve stimulation in managing vasomotor symptoms induced by breast cancer treatment: Results of a phase 2 randomized controlled trial. *Cancer Research* 2015. 75 (9 SUPPL. 1): no.

Gajra, A., Akbar, S. A., and Din, N. U. Management of Lung Cancer in the Elderly. *Clinics in Geriatric Medicine* 2016. 32 (1): 81-95.

Geethakumari, P. R., Cookson, M. S., and Do, W. K. K. The evolving biology of castration-resistant prostate cancer: Review of recommendations from the prostate cancer clinical trials working group 3. *ONCOLOGY (United States)* 2016. 30 (2): no.

Goldberg, R. M., Loprinzi, C. L., Gerstner, J., Miser, A., O'Fallon, J., Mailliard, J., Michalak, J., and Dose, A. M. Prospective trial of transdermal Clonidine in breast cancer patients suffering from Tamoxifen-induced hot flashes: a Mayo Clinic and North Central Cancer Treatment Group trial [abstract]. *Proceedings of the American Society of Clinical Oncology* 1992. 11, 378, Abstract.

Goldberg, R. M., Loprinzi, C. L., O'Fallon, J. R., Veeder, M. H., Miser, A. W., Mailliard, J. A., Michalak, J. C., Dose, A. M., Rowland, K. M. J., and Burnham, N. L. Transdermal clonidine for ameliorating tamoxifen-induced hot flashes. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 1994. 12 (1): 155-158.

Grazia, L., Giorgia, R., Chiara, P., Paolo, P., Fabrizio, A., Ermanno, R., Bernadette, L. M., Laura, S., Alberto, B., Annagiulia, G., Benedetta, B., Cristina, C., and Francesco, C. Acupuncture as an Integrated intervention for the control of symptoms of climacteric syndrome in patients affected by breast cancer: The AcCliMaT projects. *European Journal of Integrative Medicine* 2012. 4, 14-15.

Hayes, D. F. and Padnos, S. B. Who needs extended endocrine therapy. *Breast cancer research and treatment* 2018. 167 (1): 318.

Heidelberg University. Hydrotherapy Against Menopausal Symptoms in Breast Cancer Survivors. <https://clinicaltrials.gov/ct2/show/NCT00243607> 2015.

Hervik, J. and Mjaland, O. Acupuncture for the treatment of hot flashes in breast cancer patients, a randomized, controlled trial, with long-term quantitative and qualitative follow up. *Maturitas* 2015. 81 (1): 143.

Heudel, Pierre Etienne, Van Praagh, Isabelle, Duvert, Bernard, Cauvin, Isabelle, Hardy-Bessard, Anne Claire, Jacquin, Jean Philippe, Stefani, Laetitia, Belliere, Aurelie, Vincent, Lionel, and Dramais, Dominique. Can a homeopathic medicine complex reduce hot flashes induced by adjuvant endocrine therapy in localized breast cancer patients? Results of a randomized placebo-controlled phase III trial. *ASCO Annual Meeting Proceedings* 2015. 33 (15_suppl): 9627.

Hsu, I.-P., Chia, S.-L., Lin, C.-T., and Jou, H.-J. The effect of isoflavones from red clover on hot flushes in menopausal women - A systemic review of randomized, placebo-controlled trials. *Nutritional Sciences Journal* 2004. 29 (4): 184-190.

Hunter, Myra and Smith, Melanie. Managing hot flushes with group cognitive behaviour therapy: An evidence-based treatment manual for health professionals. 2015.

Institute of Cancer Research United Kingdom. Hormone Replacement Therapy in Relieving Menopausal Symptoms in Postmenopausal Women With Previous Stage I or Stage II Breast Cancer. <https://clinicaltrials.gov/ct2/show/NCT00079248> 2015.

Jack, B., Milch, V., Norris, S., Soh, N., Hart, R., and Zorbas, H. Clinical practice guidelines for the management of menopausal symptoms in women with a history of breast cancer. *Asia-Pacific Journal of Clinical Oncology* 2016. 12: 140.

Jacobs, J., Dawson, P., and Bowden, R. Homeopathy for hot flashes in breast cancer survivors. Era of Hope Department of Defense Breast Cancer Research program meeting Sep 25 28, 2002 2002. 3, 57-3.

Jancin, B. T-DM1 trial points way to de-escalation of breast cancer therapy. *Oncology Report* 2016. 12 (2): 31.

Jeri, AR. The use of an isoflavone supplement to relieve hot flashes. http://www.femalepatient.com/html/arc/sig/comp/articles/article_5.asp 2015.

Joffe, H. Randomized study of venlafaxine with versus without zolpidem for hot flushes and associated sleep disorders in women receiving hormonal therapy for treatment or prevention of breast cancer. *Physician Data Query (PDQ)* 2004.

Jonsson Comprehensive Cancer Center. Levofloxacin Compared With Cefepime in Treating Cancer Patients With Fever and Neutropenia. <https://clinicaltrials.gov/ct2/show/NCT00020865> 2015.

Jubelirer, S. J. The management of menopausal symptoms in women with breast cancer. *The West Virginia medical journal* 1995. 91 (2): 54-56.

Kanadys, W. M. The effects of soy products and preparations on health issues of menopausal women in the light of randomized clinical studies (part 1). *Przegląd Menopauzalny* 2005. 4 (3): 15-24.

Kanadys, Wieslaw Maciej, Leszczynska-Gorzela, Bozena, and Oleszczuk, Jan. [Efficacy and safety of Black cohosh (*Actaea/Cimicifuga racemosa*) in the treatment of vasomotor symptoms--review of clinical trials]. *Ginekologia polska* 2008. 79 (4): 287-296.

Keck, C. and Tempfer, C. Hormone replacement therapy in breast cancer survivors. *Geburtshilfe und Frauenheilkunde* 2002. 62 (11): 1053-1059.

Khan, M., Cheung, A. M., and Khan, A. A. Drug-Related Adverse Events of Osteoporosis Therapy. *Endocrinology and metabolism clinics of North America* 2017. 46 (1): 181-192.

Krychman, M. and Portman, D. Physicians perceptions of estrogen agonist/antagonists in menopausal health: An opportunity to address a triad of concerns in menopause and breast cancer survivorship. *Cancer Research* 2017. 77 (4 Supplement 1).

Kutyneec, C. L., Olivotto, I. A., Prior, J. C., Hislop, T. G., Chambers, K. G., Gelmon, K. A., and Templeton, E. A randomized, placebo-controlled, double-blinded clinical trial of a soy beverage in the treatment of hot flashes in breast cancer survivors. *Breast cancer research and treatment* 2000. 64 (1): 50-50.

Kuznar, W. In head-to-head comparison, continuous beats intermittent hormonal therapy for metastatic prostate cancer. *American Health and Drug Benefits* 2012. 5 (SPL.ISS. 5).

Lara, Ma del Carmen, Plancarte, Ricardo, and De la Fuente, Juan Ramon. *La amitriptilina como coanalg+*. 2013.

Li, P. The assessment of randomized double blind clinical trial of Shugan-liangxue prescription used for the treatment of hot flashes in breast cancer patients. *Journal of Clinical Oncology* 2006. 24 (18 Suppl).

Lohrisch, C. A., McKenzie, D., Truong, P., Jespersen, D., Gelmon, K. A., Premji, S., and Kennecke, H. F. Randomized trial of exercise versus control for musculoskeletal symptoms from adjuvant anastrozole (A) for postmenopausal early breast cancer (PEBC). *Journal of Clinical Oncology* 2011. 29 (15 SUPPL. 1).

Look, R. M., Morris, K. T., Homer, L., Arnold, K., Purdy, C., Walts, D., Hudson, T., Johnson, N., and Weinstein, R. E. Randomized controlled trial of venlafaxine versus black cohosh as a treatment for menopausal symptoms in women with breast cancer [abstract]. *Proceedings of the American Society of Clinical Oncology* 2001. 20 (Pt 2), 305b, Abstract.

Lopes, Jr, Prado Da Cruz, L. A. C., Campos, F. R. C., Leopoldo, V. C., Almeida, A. M. C., and De Campos Pereira Silveira, R. C. Traditional Chinese acupuncture versus sham acupuncture in the treatment of hot flashes in menopausal women with breast cancer: A systematic review. *Cancer nursing* 2015. 38 (4 SUPPL. 1): S18.

Loprinzi, C. and Barton, D. Phase III randomized study of gabapentin with versus without antidepressants for the management of hot flashes in women with a history of breast cancer or a concern about taking hormonal therapy due to a fear of developing breast cancer. *Physician Data Query (PDQ)* 2004.

Loprinzi, C. L., Goldberg, R. M., O'Fallon, J. R., Quella, S. K., Miser, A. W., Mynderse, L. A., Brown, L. D., Tschetter, L. K., Wilwerding, M. B., and Dose, M. Transdermal clonidine for ameliorating post-orchietomy hot flashes. *The Journal of urology* 1994. 151 (3): 634-636.

Lorente, D., Fizazi, K., Sweeney, C., and De Bono, J. S. Optimal Treatment Sequence for Metastatic Castration-resistant Prostate Cancer. *European Urology Focus* 2016. 2 (5): 488-498.

Ludtke, R., Jacobs, J., and Thompson, E. A. Classical homeopathy - Much dispute about its benefits in breast cancer survivors. *Forschende Komplementarmedizin und Klassische Naturheilkunde* 2005. 12 (5): 296-297.

Marshall-McKenna, R., Morrison, A., Armstrong, A., Hutchison, C., McCartney, E., Hewitt, C., Robertson, M., McIlroy, P., Rice, A. M., and MacPherson, I. Does a cooling 'pillow topper' reduce hot flushes and sleep disturbance in women receiving adjuvant endocrine therapy for breast cancer? *European Journal of Cancer* 2014. 50, S90.

McCall, G. A randomised trial of the use of hypnosis to affect menopausal vasomotor symptoms in women with early stage breast cancer, using a waiting list control. <http://www.controlled-trials.com/ISRCTN33947463> 2012.

Modarresi, M. Phytoestrogens and their beneficial role in women's health. *Iranian Journal of Reproductive Medicine* 2014. 12 (6 SUPPL. 1): 78.

Monteiro, N., Pedro, A. O., Queiros, L. D., Lopes, D. B., and Macedo, G. A. Impact of microbiota on use and effects of isoflavones in the relief of climacteric symptoms and additional benefits in menopausal women. *Menopause (New York, N.Y.)* 2017. 24 (12): 1456.

Morris, K., Look, R. M., Hudson, V., Toth-Fejel, S., Pommier, R., and Walts, D. The efficacy and safety of black cohosh for managing menopausal symptoms in breast cancer survivors. 2003.

Mukherjee, S. D. and Strohm, S. Meta-analysis examining the efficacy of serotonin and/or norepinephrine reuptake inhibitors in the treatment of women with hot flashes. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology* 2008. 26 (15 suppl): 20606.

O'Connell, M. J. Phase III placebo-controlled study of soy phytoestrogens in the management of hot flashes in women with a history of breast cancer. *Pdq, Nctg 969258, Nci P97 0126*. 1998.

Orlandini, A. effect of a herbal product made ??from red clover on the symptoms of menopause caused by adjuvant therapy in women who were diagnosed with breast cancer. <http://apps.who.int/trialsearch/Trial2.aspx?TrialID=EUCTR2011-005518-12-IT> 2015.

Palacios, S. A non-hormonal pollen extract for VMS: Is there credible data. *Climacteric: the journal of the International Menopause Society* 2016. 19 (Supplement 1): 4.

Palacios, S. and Coronado, P. J. New options for menopausal symptoms after 15 years of WHI Study. *Minerva ginecologica* 2017. 69 (2): 160-170.

Pandya, K. J. Randomized study of gabapentin for the control of hot flashes and other vasomotor symptoms in women with breast cancer. *Pdq, Urcc U2101, Nci P01 0183*. 2001.

Pandya, K. J., Loughner, J., Robertas, R., and Bennett, J. M. A double-blind placebo-controlled trial of clonidine for vasomotor symptoms in breast cancer patients on tamoxifen [abstract]. *Proceedings of the American Society of Clinical Oncology* 1990. 9, 340, Abstract.

Pinkerton, J. V. Beyond hormone therapy: Innovative options for treatment of hot flashes. *Menopause (New York, N.Y.)* 2013. 20 (12): 1312.

Pinkerton, J. New treatment options: Risks and benefits. *Climacteric: the journal of the International Menopause Society* 2016. 19 (Supplement 1): 21.

Piotrowska, K., Wang, C., Swerdloff, R. S., and Liu, P. Y. Male hormonal contraception: hope and promise. *The lancet diabetes and endocrinology* 2017. 5 (3): 214-223.

Pockaj, B. A., Gallagher, J., Loprinzi, C. L., Stella, P. J., Barton, D. L., Sloan, J. A., Rao, R., Fitch, T. R., Rowland, K. M., and Novotny, P. J. Phase III double-blinded, randomized trial to evaluate the use of black cohosh in the treatment of hot flashes: A North Central Cancer Treatment Group study. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology* 2005. 23 (16_suppl): 8013.

Powles, T. Use of tamoxifen plus estrogen. *Obstetrical and Gynecological Survey* 1998. 53 (10 SUPPL.): S67-S68.

Powles, T. J., Coombes, R. C., and Smith, I. E. A double blind randomised clinical trial of adjuvant aminoglutethimide versus placebo given to post menopausal patients with histologically confirmed stage II breast cancer. *Breast cancer research and treatment* 1986. 7 (SUPPL.): 37-40.

PregLem SA. PGL4001 Versus GnRH-agonist in Uterine Myomas (PEARLII). <https://clinicaltrials.gov/ct2/show/NCT00740831> 2012.

Prockaj, B. A. Phase III Randomized Study of Black Cohosh (Remifemin. *Pdq, Ncctg N01Cc*. 2003.

Rajyaguru, D. and Rosenstein, L. Treatment of biochemical recurrence after prostatectomy: A step forward. *Journal of Clinical Outcomes Management* 2017. 24 (3): 109-113.

Rockwell, L., Makari-Judson, G., Moran, J., Varner, J., Barham, R., and Mertens, W. C. A randomized pilot study of acupuncture for control of treatment-induced menopausal symptoms in breast cancer patients. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology* 2008. 26 (15_suppl): 20543.

Roe, K., Visovatti, M. K., Brooks, T., Baydoun, M., Clark, P., and Barton, D. L. Use of

complementary therapies for side effect management in breast cancer: Evidence and rationale. *Breast Cancer Management* 2016. 5 (3): 125-138.

Rosso, K. J., Weiss, A., and Thompson, A. M. Are There Alternative Strategies for the Local Management of Ductal Carcinoma in Situ. *Surgical Oncology Clinics of North America* 2018. 27 (1): 69-80.

Salehian, T. and Dehcheshmeh, F. S. Effects of isoflavones on the climacteric period in women. *Avicenna Journal of Phytomedicine* 2015. 5: 133-134.

Sancuso (Granisetron transdermal delivery system): A new formulation for chemotherapy-induced nausea and vomiting. *P and T* 2008. 33 (10 PART 2): 2-27.

Sathyapalan, T., Rigby, A. S., Thatcher, N. J., Kilpatrick, E. S., and Atkin, S. L. The isoflavone component of soy is essential to modify glycemc and cardiovascular risk markers in patients with type 2 diabetes. *Diabetes* 2016. 65 (Supplement 1): A560.

Schilsky, R. L. Phase II randomized study of soy protein in postmenopausal women with breast cancer taking tamoxifen and experiencing hot flashes. *Physician Data Query (PDQ)* 2002.

Shekar, P. A., Singh, S., Kumar, S., and Mandal, A. Effect of isoflavones on vasomotor symptoms and metabolic profiles in patients of carcinoma prostate on androgen deprivation therapy: A prospective, randomized and placebo controlled study. *Urology* 2013. 82 (3 SUPPL. 1): S48.

Sicking, I. and Schmidt, M. Therapy of hot flashes after breast cancer. Which non-hormonal options are available for patients? *Gynakologische Praxis* 2013. 37 (2): 255-261.

Smith, J. A. J. A prospective comparison of treatments for symptomatic hot flashes following endocrine therapy for carcinoma of the prostate. *The Journal of urology* 1994. 152 (1): 132-134.

Strickland, C. Benefits of tamoxifen for breast cancer prevention do not always outweigh overall risks. *Journal of Family Practice* 2002. 51 (12): 1016.

Struble EJ Dice YG Ornstein DL Mody. Gabapentin versus venlafaxine for the treatment of menopausal symptoms: a preliminary report. 2004.

Sun, Hong, Xue, Dong, and Gao, Fei. [Effect of shugan liangxue compound for relieving hot flashes in breast cancer patients]. *Zhongguo Zhong xi yi jie he za zhi Zhongguo Zhongxiyi jiehe zazhi = Chinese journal of integrated traditional and Western medicine / Zhongguo Zhong xi yi jie he xue hui, Zhongguo Zhong yi yan jiu yuan zhu ban* 2009. 29 (1): 30-33.

Teleni, L., Chan, R., Chan, A., Isenring, E. A., Vela, I., Inder, W. J., and McCarthy, A. L. Dietary and exercise interventions to improve quality of life, metabolic risk factors and androgen deficiency symptoms in men with prostate cancer undergoing androgen deprivation therapy. *Supportive Care in Cancer* 2015. 23 (1 SUPPL. 1): S171.

Turner LE McDowell, G. Parker. Does flaxseed relieve vasomotor symptoms? 2004.

University of Kansas. Soy Derivatives for Control of Hot Flashes in Men on Androgen Deprivation Therapy. <https://clinicaltrials.gov/ct2/show/NCT00594620> 2011.

University of Pittsburgh. Menopause and Meditation for Breast Cancer Survivors. <https://clinicaltrials.gov/ct2/show/NCT00156416> 2014.

University of Wisconsin Madison. Quality of Life Study Using Gabapentin Versus Venlafaxine in Treating Hot Flashes in Patients With Prostate Cancer. <https://clinicaltrials.gov/show/NCT01533753> 2014.

Updated casodex labeling includes data from major clinical trial confirming clinical benefits. *Comprehensive Therapy* 1998. 24 (3): 160.

Vogel, V. G. Breast cancer prevention trial. *Cancer Bulletin* 1992. 44 (4): 335-340.

Wendling, P. Anastrozole provides alternative option for DCIS. *Oncology Report* 2015. 11 (6): 30-31.

Wolters, Maike and Hahn, Andreas. [Soy isoflavones--a therapy for menopausal symptoms?]. *Wiener medizinische Wochenschrift (1946)* 2004. 154 (13-14): 334-341.

Wuttke, W., Jarry, H., Emons, G., Viereck, V., and Seidlova-Wuttke, D. Phytoestrogens - A substitute for hormone substitution therapy? *Tagliche Praxis* 2005. 46 (3): 513-521.

Wuttke, W., Jarry, H., Emons, G., Viereck, V., and Seidlove-Wuttke, D. Phytoestrogens - A substitute for hormone substitution therapy? *Gynakologische Praxis* 2004. 28 (4): 691-699.

Zarkadoulis, A., Sokolakis, I., Kazanas, K., Kazantzidis, S., Giakoumelos, A., and Hatzimouratidis, K. Evaluation of the efficacy and safety of paroxetine for the treatment of hot flashes in prostate cancer patients under androgen deprivation therapy with LHRH antagonist. *European Urology, Supplements* 2014. 13 (7): e1501.

Zittermann, A. [Phytoestrogens]. *Zentralblatt fur Gynakologie* 2003. 125 (6): 195-201. 21st Annual International Integrative Medicine Conference. *Advances in Integrative Medicine* 2015. 2 (2): no.

Language other than English (n=4)

Akhavan, H.. A review of pomegranate functional compounds and their role in human health in laboratory and clinical trials. *Journal of Kerman University of Medical Sciences* 2015. 22 (5): 569-591.

Drapier-Faure, E. Soybean isoflavones. *Reproduction Humaine et Hormones* 2004. 17 (4): 299-331.

Kwon, S.-J. and Song, B.-H. Meta-analysis for effect of dietary isoflavones on breast density and hot flush suppression. *Korean Journal of Microbiology and Biotechnology* 2011. 39 (3): 224-237.

Wolters, M. and Hahn, A. Soy isoflavones in the treatment of menopausal symptoms. *Ernahrungs Umschau* 2004. 51 (11): 440.

Study protocol (n=6)

Anderson, Debra, Seib, Charlotte, Tjondronegoro, Dian, Turner, Jane, Monterosso, Leanne, McGuire, Amanda, Porter-Steele, Janine, Song, Wei, Yates, Patsy, King, Neil, Young, Leonie, White, Kate, Lee, Kathryn, Hall, Sonj, Krishnasamy, Mei, Wells, Kathy, Balaam, Sarah, and McCarthy, Alexandra L. The Women's wellness after cancer program: a multisite, single-blinded, randomised controlled trial protocol. *BMC Cancer* 2017. 17 (1): 98.

Atema, Vera, van Leeuwen, Marieke, Oldenburg, Hester S. A., Retel, Valesca, van Beurden, Marc, Hunter, Myra S., and Aaronson, Neil K. Design of a randomized controlled trial of Internet-based cognitive behavioral therapy for treatment-induced menopausal symptoms in breast cancer survivors. *BMC Cancer* 2016. 16 (1): 920.

Ayers, Beverley, Mann, Eleanor, and Hunter, Myra S. A randomised controlled trial of cognitive-behavioural therapy for women with problematic menopausal hot flushes: MENOS 2 trial protocol. *BMJ open* 2011. 1 (1): e000047.

Hummel, Susanna B., van Lankveld, Jacques J. D. M., Oldenburg, Hester S. A., Hahn, Daniela E. E., Broomans, Eva, and Aaronson, Neil K. Internet-based cognitive behavioral therapy for sexual dysfunctions in women treated for breast cancer: design of a multicenter, randomized controlled trial. *BMC Cancer* 2015. 15, 321.

McDonald, Cameron, Bauer, Judy, Capra, Sandra, and Coll, Joseph. The muscle mass, omega-3, diet, exercise and lifestyle (MODEL) study - a randomised controlled trial for women who have completed breast cancer treatment. *BMC Cancer* 2014. 14, 264.

Reeves, Marina M., Terranova, Caroline O., Erickson, Jane M., Job, Jennifer R., Brookes, Denise S. K., McCarthy, Nicole, Hickman, Ingrid J., Lawler, Sheleigh P., Fjeldsoe, Brianna S., Healy, Genevieve N., Winkler, Elisabeth A. H., Janda, Monika, Veerman, J. Lennert, Ware, Robert S., Prins, Johannes B., Vos, Theo, Demark-Wahnefried, Wendy, and Eakin, Elizabeth G. Living well after breast cancer randomized controlled trial protocol: evaluating a telephone-delivered weight loss intervention versus usual care in women following treatment for breast cancer. *BMC Cancer* 2016. 16 (1): 830.

Systematic review/meta-analysis (n=52)

Bardia, Aditya, Novotny, Paul, Sloan, Jeff, Barton, Deb, and Loprinzi, Charles. Efficacy of nonestrogenic hot flash therapies among women stratified by breast cancer history and tamoxifen use: a pooled analysis. *Menopause (New York, N.Y.)* 2009. 16 (3): 477-483.

Carlos, Luis Lopes-Junior, Cruz, Loris Aparecida Prado da, Leopoldo, Vanessa Cristina, Campos, Fabricio Ribeiro de, Almeida, Ana Maria de, and Silveira, Renata Cristina de Campos Pereira. Effectiveness of Traditional Chinese Acupuncture versus Sham Acupuncture: a Systematic Review. *Revista latino-americana de enfermagem* 2016. 24: e2762.

Cassidy, Aedin, Albertazzi, Paola, Lise Nielsen, Inge, Hall, Wendy, Williamson, Gary, Tetens, Inge, Atkins, Steve, Cross, Heide, Manios, Yannis, Wolk, Alicja, Steiner, Claudia, and Branca, Francesco. Critical review of health effects of soyabean phyto-oestrogens in post-menopausal women. *The Proceedings of the Nutrition Society* 2006. 65 (1): 76-92.

Chen, Yu Pei, Liu, Tong, Peng, Yuan Yuan, Wang, Yan Ping, Chen, Huan, Fan, Yi Fan, and Zhang, Li. Acupuncture for hot flashes in women with breast cancer: A systematic review. *Journal of cancer research and therapeutics* 2016. 12 (2): 535-542.

Cheng Karis, Kin Fong, Lim Yee, Ting Ethel, Koh, Zhi Min, Tam Wilson, Wai San, and Cochrane Database of Systematic Reviews. Home-based multidimensional survivorship programmes for breast cancer survivors. 2017. (8).

Chien, Tsai Ju, Hsu, Chung Hua, Liu, Chia Yu, and Fang, Ching Ju. Effect of acupuncture on hot flush and menopause symptoms in breast cancer- A systematic review and meta-analysis. *PloS one* 2017. 12 (8): e0180918.

Chiu, Hsiao Yean, Shyu, Yuh Kae, Chang, Pi Chen, and Tsai, Pei Shan. Effects of Acupuncture on Menopause-Related Symptoms in Breast Cancer Survivors: A Meta-analysis of Randomized Controlled Trials. *Cancer nursing* 2016. 39 (3): 228-237.

Chiu, H. Y., Pan, C. H., Shyu, Y. K., Han, B. C., and Tsai, P. S. Effects of acupuncture on menopause-related symptoms and quality of life in women in natural menopause: a meta-analysis of randomized controlled trials. *Menopause* 2015. 22 (2): 234-244.

Cramer, Holger, Lauche, Romy, Paul, Anna, Langhorst, Jost, Kummel, Sherko, and Dobos, Gustav J. Hypnosis in breast cancer care: a systematic review of randomized controlled trials. *Integrative Cancer Therapies* 2015. 14 (1): 5-15.

Cormie, P., Zopf, E. M., Zhang, X., and Schmitz, K. H. The impact of exercise on cancer mortality, recurrence, and treatment-related adverse effects. *Epidemiologic Reviews* 2017. 39 (1): 71-92.

Dodin, Sylvie, Blanchet, Claudine, Marc, Isabelle, Ernst, Edzard, Wu, Taixiang, Vaillancourt, Caroline, Paquette, Joalee, and Maunsell, Elizabeth. Acupuncture for menopausal hot flushes. *The Cochrane database of systematic reviews* 2013. 7, CD007410.

Flower, G., Fritz, H., Balneaves, L. G., Verma, S., Skidmore, B., Fernandes, R., Kennedy, D., Cooley, K., Wong, R., Sagar, S., Fergusson, D., and Seely, D. Flax and breast cancer: A systematic review. *Integrative Cancer Therapies* 2014. 13 (3): 181-192.

Frisk, Jessica. Managing hot flushes in men after prostate cancer--a systematic review. *Maturitas* 2010. 65 (1): 15-22.

Frisk, Jessica W., Hammar, Mats L., Ingvar, Martin, and Spetz Holm, Anna Clara. How long do the effects of acupuncture on hot flashes persist in cancer patients? Supportive care in cancer, official journal of the Multinational Association of Supportive Care in Cancer 2014. 22 (5): 1409-1415.

Fritz, H., Seely, D., Flower, G., Skidmore, B., Fernandes, R., Vadeboncoeur, S., Kennedy, D., Cooley, K., Wong, R., Sagar, S., Sabri, E., and Fergusson, D. Soy, red clover, and isoflavones and breast cancer: A systematic review. *PloS one* 2013. 8 (11)

Fritz, Heidi, Seely, Dugald, Flower, Gillian, Skidmore, Becky, Fernandes, Rochelle, Vadeboncoeur, Sarah, Kennedy, Deborah, Cooley, Kieran, Wong, Raimond, Sagar, Stephen, Sabri, Elham, and Fergusson, Dean. Soy, red clover, and isoflavones and breast cancer: a systematic review. *PloS one* 2013. 8 (11): e81968.

Fritz, Heidi, Seely, Dugald, McGowan, Jessie, Skidmore, Becky, Fernandes, Rochelle, Kennedy, Deborah A., Cooley, Kieran, Wong, Raimond, Sagar, Stephen, Balneaves, Lynda G., and Fergusson, Dean. Black cohosh and breast cancer: a systematic review. *Integrative Cancer Therapies* 2014. 13 (1): 12-29.

Garcia, M. Kay, Graham-Getty, Leslie, Haddad, Robin, Li, Yisheng, McQuade, Jennifer, Lee, Richard T., Spano, Michael, and Cohen, Lorenzo. Systematic review of acupuncture to control hot flashes in cancer patients. *Cancer* 1-8-2015, 1-11.

Greenlee, H., DuPont-Reyes, M. J., Balneaves, L. G., Carlson, L. E., Cohen, M. R., Deng, G., Johnson, J. A., Mumber, M., Seely, D., Zick, S. M., Boyce, L. M., and Tripathy, D. Clinical practice guidelines on the evidence-based use of integrative therapies during and after breast cancer treatment. *CA Cancer Journal for Clinicians* 2017. 67 (3): 194-232.

Hervik, Jill Brook and Stub, Trine. Adverse effects of non-hormonal pharmacological interventions in breast cancer survivors, suffering from hot flashes: A systematic review and meta-analysis. *Breast cancer research and treatment* 2016. 160 (2): 223-236.

Johns, Claire, Seav, Susan M., Dominick, Sally A., Gorman, Jessica R., Li, Hongying, Natarajan, Loki, Mao, Jun James, and Su, H. Irene. Informing hot flash treatment decisions for breast cancer survivors: a systematic review of randomized trials comparing active interventions. *Breast cancer research and treatment* 2016. 156 (3): 415-426.

Kaplan, Marcelle and Mahon, Suzanne. Hot flash management: update of the evidence for patients with cancer. *Clinical Journal of Oncology Nursing* 2014. 18 Suppl, 59-67.

Kaplan, Marcelle, Mahon, Suzanne, Cope, Diane, Keating, Elizabeth, Hill, Stacey, and Jacobson, Marcie. Putting evidence into practice: evidence-based interventions for hot flashes resulting from cancer therapies. *Clinical Journal of Oncology Nursing* 2011. 15 (2): 149-157.

Kassab, Sosie, Cummings, Mike, Berkovitz, Saul, van Haselen, Robbert, and Fisher, Peter. Homeopathic medicines for adverse effects of cancer treatments. *The Cochrane database of systematic reviews* 2009. (2): CD004845.

Kim, Woojin, Lee, Won Bock, Lee, Jung Woo, Min, Byung Il, Baek, Sun Kyung, Lee, Hyang Sook, and Cho, Seung Hun. Traditional herbal medicine as adjunctive therapy for breast cancer: A systematic review. *Complementary therapies in medicine* 2015. 23 (4): 626-632.

Koopman, F. S., Beelen, A., Gilhus, N. E., de, Visser M., and Nollet, F. Treatment for postpolio syndrome. *Cochrane Database of Systematic Reviews* 2015. 2015 (5): CD007818.

L'Esperance, Sylvain, Frenette, Suzanne, Dionne, Anne, Dionne, Jean Yves, and Comite de l'evolution des pratiques en oncologie (CEPO). Pharmacological and non-hormonal treatment of hot flashes in breast cancer survivors: CEPO review and recommendations. *Supportive care in cancer, official journal of the Multinational Association of Supportive Care in Cancer* 2013. 21 (5): 1461-1474.

Lee, M. S., Shin, B.-C., and Ernst, E. Acupuncture for treating menopausal hot flushes: A systematic review. *Climacteric, the journal of the International Menopause Society* 2009. 12 (1): 16-25.

Lee, Myeong Soo, Kim, Kun Hyung, Choi, Sun Mi, and Ernst, Edzard. Acupuncture for treating hot flashes in breast cancer patients: a systematic review. *Breast cancer research and treatment* 2009. 115 (3): 497-503.

Lee, Myeong Soo, Kim, Kun Hyung, Shin, Byung Cheul, Choi, Sun Mi, and Ernst, Edzard. Acupuncture for treating hot flushes in men with prostate cancer: a systematic review. *Supportive care in cancer, official journal of the Multinational Association of Supportive Care in Cancer* 2009. 17 (7): 763-770.

Li, Yuanqing, Zhu, Xiaoshu, Bensussan, Alan, Li, Pingping, Moylan, Eugene, Delaney, Geoff, and McPherson, Luke. Herbal Medicine for Hot Flushes Induced by Endocrine Therapy in Women with Breast Cancer: A Systematic Review and Meta-Analysis. *Evidence-based complementary and alternative medicine: eCAM* 2016. 2016: 1327251.

Lopes-Junior, Luis Carlos, da Cruz, Loris Aparecida Prado, Leopoldo, Vanessa Cristina, de Campos, Fabricio Ribeiro, de Almeida, Ana Maria, and Silveira, Renata Cristina de Campos

Pereira. Effectiveness of Traditional Chinese Acupuncture versus Sham Acupuncture: A Systematic Review. *Revista latino-americana de enfermagem* 2016. 24.

Loprinzi, C. L., Sloan, J., Stearns, V., Slack, R., Iyengar, M., Diekmann, B., Kimmick, G., Lovato, J., Gordon, P., Pandya, K., Guttuso, Jr, Barton, D., and Novotny, P. Newer antidepressants and gabapentin for hot flashes: An individual patient pooled analysis. *Journal of Clinical Oncology* 2009. 27 (17): 2831-2837.

Milazzo, S., Russell, N., and Ernst, E. Efficacy of homeopathic therapy in cancer treatment. *European Journal of Cancer* 2006. 42 (3): 282-289.

Nedrow, A., Miller, J., Walker, M., Nygren, P., Huffman, L. H., and Nelson, H. D. Complementary and alternative therapies for the management of menopause-related symptoms: A systematic evidence review. *Archives of internal medicine* 2006. 166 (14): 1453-1465.

Nelson, H. D., Vesco, K. K., Haney, E., Fu, R., Nedrow, A., Miller, J., Nicolaidis, C., Walker, M., and Humphrey, L. Nonhormonal therapies for menopausal hot flashes: systematic review and meta-analysis. *JAMA* 3-5-2006. 295 (17): 2057-2071.

Rada, Gabriel, Capurro, Daniel, Pantoja, Tomas, Corbalan, Javiera, Moreno, Gladys, Letelier, Luz M., and Vera, Claudio. Non-hormonal interventions for hot flashes in women with a history of breast cancer. *The Cochrane database of systematic reviews* 2010. (9): CD004923.

Ramaswami, Ramya, Villarreal, Marcos Daniel, Pitta, Dina Marie, Carpenter, Janet S., Stebbing, Justin, and Kalesan, Bindu. Venlafaxine in management of hot flashes in women with breast cancer: a systematic review and meta-analysis. *Breast cancer research and treatment* 2015. 152 (2): 231-237.

Reid, Robert, Abramson, Beth L., Blake, Jennifer, Desindes, Sophie, Dodin, Sylvie, Johnston, Shawna, Rowe, Timothy, Sodhi, Namrita, Wilks, Penny, Wolfman, Wendy, Menopause and Osteoporosis Working Group, Fortier, Michel, Reid, Robert, Abramson, Beth L., Blake, Jennifer, Desindes, Sophie, Dodin, Sylvie, Graves, Lisa, Guthrie, Bing, Khan, Aliya, Johnston, Shawna, Rowe, Timothy, Sodhi, Namrita, Wilks, Penny, Wolfman, Wendy, Menopause and Osteoporosis Working Group, and Society of Obstetricians and Gynaecologists of Canada. Managing menopause. *Journal of obstetrics and gynaecology Canada, JOGC = Journal d'obstetrique et gynecologie du Canada, JOGC* 2014. 36 (9): 830-838.

Riblet, N., Larson, R., Watts, B. V., and Holtzheimer, P. Reevaluating the role of antidepressants in cancer-related depression: A systematic review and meta-analysis. *General Hospital Psychiatry* 2014. 36 (5): 466-473.

Rozenberg, S. and Caroline, A. Treatment for menopausal symptoms in breast cancer survivors. *Climacteric, the journal of the International Menopause Society* 2011. 14, 21.

Seib, C., Porter-Steele, J., McGuire, A., McCarthy, A., Balaam, S., and Anderson, D. J. Menopausal symptom clusters and their correlates in women with and without a history of breast

cancer: A pooled data analysis from the Women's Wellness Research Program. *Menopause* (New York, N.Y.) 2017. 24 (6): 624-634.

Shell, Judith A. Evidence-based practice for symptom management in adults with cancer: sexual dysfunction. *Oncology nursing forum* 2002. 29 (1): 53-59.

Spetz, Holm A. C., Frisk, J., and Hammar, M. How long do effects of acupuncture persist on hot flushes in breast cancer and prostate cancer patients? *Menopause* (New York, N.Y.) 2012. 19 (12): 1398.

Stefanopoulou, Evgenia and Grunfeld, Elizabeth Alice. Mind-body interventions for vasomotor symptoms in healthy menopausal women and breast cancer survivors. A systematic review. *Journal of psychosomatic obstetrics and gynaecology* 2016. : 1-16.

Tao, Wei Wei, Jiang, Hua, Tao, Xiao Mei, Jiang, Ping, Sha, Li Yan, and Sun, Xian Ce. Effects of Acupuncture, Tuina, Tai Chi, Qigong, and Traditional Chinese Medicine Five-Element Music Therapy on Symptom Management and Quality of Life for Cancer Patients: A Meta-Analysis. *Journal of pain and symptom management* 2016. 51 (4): 728-747.

Tao, Wei Wei, Tao, Xiao Mei, and Song, Chun Li. Effects of non-pharmacological supportive care for hot flushes in breast cancer: a meta-analysis. *Supportive care in cancer: official journal of the Multinational Association of Supportive Care in Cancer* 2017. 25 (7): 2335-2347.

Teleni, L., Chan, R. J., Chan, A., Isenring, E. A., Vela, I., Inder, W. J., and McCarthy, A. L. Exercise improves quality of life in androgen deprivation therapy-treated prostate cancer: Systematic review of randomised controlled trials. *Endocrine-Related Cancer* 2016. 23 (2): 101-112.

Toulis, Konstantinos A., Tzellos, Thrasivoulos, Kouvelas, Dimitrios, and Goulis, Dimitrios G. Gabapentin for the treatment of hot flashes in women with natural or tamoxifen-induced menopause: a systematic review and meta-analysis. *Clinical therapeutics* 2009. 31 (2): 221-235.

Tremblay, Anouk, Sheeran, Lisa, and Aranda, Sanchia K. Psychoeducational interventions to alleviate hot flashes: a systematic review. *Menopause* (New York, N.Y.) 2008. 15 (1): 193-202.

van Driel, Cmg, Stuursma, A. S., Schroevers, M. J., Mourits, Mje, and de Bock, G. H. Mindfulness, cognitive behavioural and behaviour-based therapy for natural and treatment-induced menopausal symptoms: a systematic review and meta-analysis. *BJOG: an international journal of obstetrics and gynaecology* 2018.

Yamaguchi, N., Okajima, Y., Fujii, T., Natori, A., and Kobayashi, D. The efficacy of nonestrogenic therapy to hot flashes in cancer patients under hormone manipulation therapy: A systematic review and meta-analysis. *Journal of Cancer Research and Clinical Oncology* 2013. 139 (10): 1701-1707.

Not a randomized controlled trial or cross-over trial (n = 255)

A phase III randomized trial of anastrozole versus anastrozole and fulvestrant as first-line therapy for postmenopausal women with metastatic breast cancer: SWOG S0226. *Clinical Advances in Hematology and Oncology* 2012. 10 (2): 14-15.

Abderrahman, B. and Craig, Jordan, V. Assessing the safety of hormonal replacement therapy. *Clinical Pharmacist* 2016. 8 (11): no.

Abraham, J. Enzalutamide in castrate-resistant prostate cancer after chemotherapy. *Community Oncology* 2013. 10 (5): 135-137.

Abraham, J. Exemestane for postmenopausal women at increased risk of breast cancer. *Community Oncology* 2011. 8 (7): 301-303.

Acupuncture. *Focus on Alternative and Complementary Therapies* 2010. 15 (2): 163-169.

Ades, T., Gansler, T., Miller, M., and Rosenthal, D. S. PC-SPES: Current evidence and remaining questions. *Ca-A Cancer Journal for Clinicians* 2001. 51 (3): 199-204.

Anderson, J. Prostate Cancer Treatment on Trial. Satellite Symposium held during the XVIIIth Congress of the EAU 13 March 2003, Madrid, Spain: Introduction. *European Urology, Supplement* 2003. 2 (9): 1-6.

Antoine, C., Liebens, F., Carly, B., Pastijn, A., and Rozenberg, S. Safety of alternative treatments for menopausal symptoms after breast cancer: a qualitative systematic review. *Climacteric, the journal of the International Menopause Society* 2007. 10 (1): 23-26.

Arslan, D., Tural, D., and Akar, E. Herbal administration and interaction of cancer treatment. *Journal of palliative medicine* 2013. 16 (11): 1466-1476.

Ashamalla, H., Jiang, M., and Guirguis, A. Phase I study of acupuncture as treatment of hot flashes for men with prostate cancer. *ASCO Annual Meeting Proceedings* 2008. 26 (15_suppl): 20678.

Baber, Rodney, Hickey, Martha, and Kwik, Michelle. Therapy for menopausal symptoms during and after treatment for breast cancer, safety considerations. *Drug safety* 2005. 28 (12): 1085-1100.

Balabanovic, Janet, Ayers, Beverley, and Hunter, Myra S. Women's experiences of Group Cognitive Behaviour Therapy for hot flushes and night sweats following breast cancer treatment: an interpretative phenomenological analysis. *Maturitas* 2012. 72 (3): 236-242.

Bander, Milowsky, M. I., Nanus, D. M., Kostakoglu, L., Vallabhajosula, S., and Goldsmith, S. J. Radiolabeled J591 antibody delivers lethal hit to advanced prostate cancers in a Phase I trial. *Cancer Biology and Therapy* 2004. 3 (8): 699-700.

Barba, M., Pizzuti, L., Sergi, D., Maugeri-Sacca, M., Vincenzoni, C., Conti, F., Tomao, F., Vizza, E., Di, Lauro L., Di, Filippo F., Carpano, S., Mariani, L., and Vici, P. Hot flushes in women with breast cancer: State of the art and future perspectives. *Expert review of anticancer therapy* 2014. 14 (2): 185-198.

Barentsen, Ronald. Red clover isoflavones and menopausal health. *The journal of the British Menopause Society* 2004. 10 Suppl 1, 4-7.

Barlow, D. H. Developments in the management of menopause and hormone replacement therapy: A presentation given at the symposium to honour the retirement of Professor Martin Vessey. *Pharmacoepidemiology and drug safety* 2001. 10 (1): 29-32.

Barros, B. and Thiboutot, D. Hormonal therapies for acne. *Clinics in Dermatology* 2017. 35 (2): 168-172.

Bicalutamide for prostate cancer. *American family physician* 1996. 53 (1): 399.

Bokmand, S., Flyger, H., and Bollig, G. Acupuncture relieves menopausal discomfort in breast cancer patients: A prospective, double blinded, randomized study. *Deutsche Zeitschrift fur Akupunktur* 2013. 56 (2): 25.

Bolla, M., De Reijke, T. M., Zurlo, A., and Collette, L. Adjuvant hormone therapy in locally advanced and localized prostate cancer: three EORTC trials. *Frontiers of radiation therapy and oncology* 2002. 36, 81-86.

Bonanni, B., Macis, D., Maisonneuve, P., Johansson, H. A., Gucciardo, G., Oliviero, P., Travaglini, R., Muraca, M. G., Rotmensz, N., Veronesi, U., and Decensi, A. U. Polymorphism in the CYP2D6 tamoxifen-metabolizing gene influences clinical effect but not hot flashes: Data from the Italian tamoxifen trial [1]. *Journal of Clinical Oncology* 2006. 24 (22): 3708-3709.

Bordeleau, Louise, Pritchard, Kathleen, Goodwin, Pamela, and Loprinzi, Charles. Therapeutic options for the management of hot flashes in breast cancer survivors: an evidence-based review. *Clinical therapeutics* 2007. 29 (2): 230-241.

Borrelli, F. Phytoestrogens for the menopausal woman. *Maturitas* 2012. 71, S13-S14.

Boutet, G. [Management of hot flashes for breast cancer survivors]. *Gynecologie, obstetrique & fertilité* 2012. 40 (4): 241-254.

Brennan, M. E. and Houssami, N. Overview of long term care of breast cancer survivors. *Maturitas* 2011. 69 (2): 106-112.

Brown, D. Black cohosh extract found ineffective in treating hot flashes in women with a history of breast cancer. *Herbalgram*. 2002. 55, 18.

Brown, Jamie N. and Wright, Betsy R. Use of gabapentin in patients experiencing hot flashes. *Pharmacotherapy* 2009. 29 (1): 74-81.

Brown, P. Prevention: Targeted therapy - Anastrozole prevents breast cancer. *Nature Reviews Clinical Oncology* 2014. 11 (3): 127-128.

Bunyaratavej, N. and Songpatanasilp, T. Application of Gabapentin in Thai women with menopausal syndrome. *J Med Assoc Thai* 2005. 88 Suppl 5, S21-S23.

CME Multiple Choice Questions. *Journal of Sexual Medicine* 2012. 9 (1): 14-15.

Caan, Bette J., Emond, Jennifer A., Su, H. Irene, Patterson, Ruth E., Flatt, Shirley W., Gold, Ellen B., Newman, Vicky A., Rock, Cheryl L., Thomson, Cynthia A., and Pierce, John P. Effect of postdiagnosis weight change on hot flash status among early-stage breast cancer survivors. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 2012. 30 (13): 1492-1497.

Cancer Control Program. http://ncctg.mayo.edu/thebook/Books/Fall_2006/control.pdf 2006.

Capodice, Jillian L., Jin, Zhezhen, Stone, Brian A., McKiernan, James M., Olsson, Carl A., and Katz, Aaron E. Results of a prospective pilot clinical trial administering acupuncture for hot flashes in patients undergoing hormonal therapy for prostate cancer. *The Journal of Urology* 2008. 179 (4): 184-185.

Carpenter, Janet S., Wu, Jingwei, Burns, Debra S., and Yu, Menggang. Perceived control and hot flashes in treatment-seeking breast cancer survivors and menopausal women. *Cancer nursing* 2012. 35 (3): 195-202.

Carroll, Dana G. Nonhormonal therapies for hot flashes in menopause. *American family physician* 2006. 73 (3): 457-464.

Carroll, Dana G., Lisenby, Katelin M., and Carter, Tracy L. Critical appraisal of paroxetine for the treatment of vasomotor symptoms. *International journal of women's health* 2015. 7: 615-624.

Case Comprehensive Cancer Center. Menopausal Symptoms in Women With Breast Cancer or At High Risk of Breast Cancer Treated on Another Clinical Trial. <https://clinicaltrials.gov/ct2/show/NCT00666913> 2010.

Casper, R. F. Is paroxetine an effective treatment for hot flashes? *Nature Clinical Practice Endocrinology and Metabolism* 2006. 2 (5): 250-251.

Cassileth, B. Integrative oncology - Yoga. *Oncology* 2010. 24 (9)

Castelo-Branco, C. Comment. *Climacteric, the journal of the International Menopause Society* 2011. 14 (6): 689-690.

Chapter 9 Complementary and Alternative Medicine (CAM). *Journal of Obstetrics and Gynaecology Canada* 2014. 36 (9 Supplement2): S74-S80.

Cheema, Deepti, Coomarasamy, Arri, and El-Toukhy, Tarek. Non-hormonal therapy of post-menopausal vasomotor symptoms: a structured evidence-based review. *Archives of gynecology and obstetrics* 2007. 276 (5): 463-469.

Chien, Tsai Ju, Liu, Chia Yu, and Hsu, Chung Hua. Integrating acupuncture into cancer care. *Journal of traditional and complementary medicine* 2013. 3 (4): 234-239.

Chlebowski, Rowan T., Kim, Jung A., and Col, Nananda F. Estrogen deficiency symptom management in breast cancer survivors in the changing context of menopausal hormone therapy. *Seminars in oncology* 2003. 30 (6): 776-788.

Clarkson, T. B., Utian, W. H., Barnes, S., Gold, E. B., Basaria, S. S., Aso, T., Kronenberg, F., Frankenfeld, C. L., Cline, J. M. A., Landgren, B.-M., Gallagher, J. C., Weaver, C. M., Hodis, H. N., Brinton, R. D., Maki, P. M., Setchell, K. D. R., Setchell, D. R., Allmen, T. I., Messina, M. J., Shu, X.-O., Ishimi, Y., Wong, W. W., and Kim, H. The role of soy isoflavones in menopausal health: Report of the North American Menopause Society/Wulf H. Utian Translational Science Symposium in Chicago, IL (October 2010). *Menopause (New York, N.Y.)* 2011. 18 (7): 732-753.

Clemons, M., Clamp, A., and Anderson, B. Management of the menopause in cancer survivors. *Cancer treatment reviews* 2002. 28 (6): 321-333.

Clonidine, gabapentin, and some SSRIs effective for hot flashes. *Journal of Family Practice* 2006. 55 (8): 662.

Clonidine, gabapentin, and some SSRIs effective for hot flashes. *South African Family Practice* 2006. 48 (6): 13.

Cobin, Rhoda H., Goodman, Neil F., and AACE Reproductive Endocrinology Scientific Committee. AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS AND AMERICAN COLLEGE OF ENDOCRINOLOGY POSITION STATEMENT ON MENOPAUSE-2017 UPDATE. *Endocrine practice: official journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists* 2017. 23 (7): 869-880.

Coory, M. D., Baber, R. J., O'Hara, J. L., and Boyle, F. M. Hormone replacement therapy: To use or not to use? (multiple letters). *Medical Journal of Australia* 2003. 179 (7): 391-392.

Cramer, H. Yoga in the supportive therapy for breast cancer: Scientific evidence. *Deutsche Zeitschrift fur Onkologie* 2014. 46 (4): 152-156.

Curran, M. P. Lapatinib in postmenopausal women with hormone receptor-positive, HER2-Positive metastatic breast cancer. *BioDrugs* 2011. 25 (1): 53-54.

Cusack, Leila, Brennan, Meagan, Baber, Rodney, and Boyle, Frances. Menopausal symptoms in breast cancer survivors: management update. *The British journal of general practice, the journal of the Royal College of General Practitioners* 2013. 63 (606): 51-52.

Cuzick, J. Aromatase inhibitors for breast cancer prevention. *Journal of Clinical Oncology* 2005. 23 (8): 1636-1643.

D'Orazio, A. and O'Shaughnessy, J. A. What is the role of ovarian function suppression in the treatment of premenopausal breast cancer patients? *Clinical breast cancer* 2003. 4 (2): 101-103.

Davey, D. A. Menopause and HRT - Keeping perspective. *South African Medical Journal* 2004. 94 (1): 23-25.

Day, S. and Bevers, T. B. Breast cancer incidence in the randomized PEARL trial of lasofoxifene in postmenopausal osteoporotic women: LaCroix AZ, Powles T, Osborne CK, et al (Fred Hutchinson Cancer Res Ctr, Seattle, WA; Parkside Oncology Clinic, Wimbledon, London; Baylor College of Medicine, Houston, TX; et al) *J Natl Cancer Inst* 102:1706-1715, 2010. *Breast Diseases* 2011. 22 (2): 178-180.

DeGrendele, H. and O'Shaughnessy, J. A. Benefit of letrozole in postmenopausal women after five years of tamoxifen therapy for early-stage breast cancer. *Clinical breast cancer* 2003. 4 (5): 311-312.

Deniz, G., Antoine, C., Liebens, F., Carly, B., Pastijn, A., and Rozenberg, S. Treatment of premature menopause in breast cancer patients. *Acta chirurgica Belgica* 2007. 107 (3): 263-266.

Desmarais, J. E. and Looper, K. J. Managing menopausal symptoms and depression in tamoxifen users: Implications of drug and medicinal interactions. *Maturitas* 2010. 67 (4): 296-308.

Dickson, G. M. Menopause management: How you can do better. *Journal of Family Practice* 2012. 61 (3): 138-145.

Dorsher, P. T. Acupuncture for Hot Flashes: Combining Traditional and Neurophysiologic Considerations for Effective Treatment. *Medical Acupuncture* 2012. 24 (4): 215-220.

Drugs for postmenopausal osteoporosis. *Medical Letter on Drugs and Therapeutics* 2014. 56 (1452): 91-96.

Dueregger, A., Heidegger, I., Ofer, P., Perktold, B., Ramoner, R., Klocker, H., and Eder, I. E. The use of dietary supplements to alleviate androgen deprivation therapy side effects during prostate cancer treatment. *Nutrients* 2014. 6 (10): 4491-4519.

Duffy, Christine, Perez, Kimberly, and Partridge, Ann. Implications of phytoestrogen intake for breast cancer. *CA: a cancer journal for clinicians* 2007. 57 (5): 260-277.

Dun, Yao Jun, Liu, Hui Xin, Yu, Lu Ping, Li, Qing, Zhang, Xiao Wei, Tang, Xu, Qin, Cai Peng, and Xu, Tao. Development and Initial Validation of the Novel Scale for Assessing Quality of Life of Prostate Cancer Patients Receiving Androgen Deprivation Therapy. *Chinese Medical Journal* 2017. 130 (17): 2082-2087.

Eden, J. The endometrial and breast safety of menopausal hormone therapy containing micronised progesterone: A short review. *Australian and New Zealand Journal of Obstetrics and Gynaecology* 2017. 57 (1): 12-15.

Elkins, Gary, Marcus, Joel, Palamara, Lynne, and Stearns, Vered. Can hypnosis reduce hot flashes in breast cancer survivors? A literature review. *The American journal of clinical hypnosis* 2004. 47 (1): 29-42.

Engstrom, C. A. Hot flashes in prostate cancer: State of the science. *American Journal of Men's Health* 2008. 2 (2): 122-132.

Exemestane for advanced breast cancer. *The Medical letter on drugs and therapeutics* 2000. 42 (1076): 35-36.

Fabian, C. J. and Kimler, B. F. Selective estrogen-receptor modulators for primary prevention of breast cancer. *Journal of Clinical Oncology* 2005. 23 (8): 1644-1655.

Fan, L., Liedke, P. E. R., Isakoff, S. J., St, Louis J., Ryan, P. D., and Goss, P. E. Intermittent letrozole therapy for metastatic breast cancer: Case reports and literature review. *Clinical breast cancer* 2014. 14 (2): e41-e45.

Fenner, A. Prostate cancer: GTX-758 reduces testosterone. *Nature Reviews Urology* 2014. 11 (8): 422.

Fisher, W. I., Johnson, A. K., Elkins, G. R., Otte, J. L., Burns, D. S., Yu, M., and Carpenter, J. S. Risk factors, pathophysiology, and treatment of hot flashes in cancer. *CA Cancer Journal for Clinicians* 2013. 63 (3): 167-192.

Fitzpatrick, L. A. and Santen, R. J. Hot flashes: The old and the new, what is really true? *Mayo Clinic proceedings* 2002. 77 (11): 1155-1158.

Flaxseed consumption reduces menopausal symptoms. *Oncology Report* 2005. (SPRING): 133.

Gadducci, A., Tana, R., Cosio, S., and Genazzani, A. R. Quality of life and symptoms of menopause among breast cancer survivors. *Reproduction Humaine et Hormones* 2008. 21 (2): 171-183.

Galbraith, S. M. and Duchesne, G. M. Androgens and prostate cancer: Biology, pathology and hormonal therapy. *European Journal of Cancer Part A* 1997. 33 (4): 545-554.

Ganz, P. A. What is the optimal way to evaluate quality of life in breast cancer trials. *Clinical Advances in Hematology and Oncology* 2015. 13 (9): 558-560.

Genazzani, A. R. and Simoncini, T. Pharmacotherapy: Benefits of menopausal hormone therapy-timing is key. *Nature Reviews Endocrinology* 2013. 9 (1): 5-6.

Germaine, L. M. and Freedman, R. R. Behavioral treatment of menopausal hot flashes: evaluation by objective methods. *J Consult Clin Psychol* 1984. 52 (6): 1072-1079.

Ghazanfarpour, M., Sadeghi, R., Roudsari, R. L., Khadivzadeh, T., Khorsand, I., Afiat, M., and Esmailizadeh, M. Effects of flaxseed and *Hypericum perforatum* on hot flash, vaginal atrophy and estrogen-dependent cancers in menopausal women: A systematic review and meta-analysis. *Avicenna Journal of Phytomedicine* 2016. 6 (3): 273-283.

Gibaldi, M. Hormone replacement therapy: Estrogen after menopause. *Pharmacotherapy* 1996. 16 (3 I): 366-375.

Gilligan, T. and Oh, W. Prospective trial of the herbal supplement PC-SPEC in patients with progressive prostate cancer: Herbal therapy PC-SPES: In vitro effects and evaluation of its efficacy in 69 patients with prostate cancer: Commentary. *Prostate Journal* 2001. 3 (1): 44-45.

GlaxoSmithKline. A Phase I/II, a Single Arm, Open-label Study of Ofatumumab (GSK1841157) in Patients With Previously Treated Chronic Lymphocytic Leukemia. <https://clinicaltrials.gov/ct2/show/NCT01077622> 2012.

Gold, Ellen B., Flatt, Shirley W., Pierce, John P., Bardwell, Wayne A., Hajek, Richard A., Newman, Vicky A., Rock, Cheryl L., and Stefanick, Marcia L. Dietary factors and vasomotor symptoms in breast cancer survivors: the WHEL Study. *Menopause (New York, N.Y.)* 2006. 13 (3): 423-433.

Goldstein, S. R., Espie, M., and Druckmann, R. Does relizen, a non-hormonal treatment for vasomotor symptoms, inhibit the CYP2D6 enzyme system? *Menopause (New York, N.Y.)* 2014. 21 (12): 1336.

Goss, P. E. and Willett, L. R. Exemestane prevented invasive breast cancer in postmenopausal women at moderately increased risk. *Annals of internal medicine* 2011. 155 (8): JC4-03.

Gradishar, W. J. Exemestane prevents 65% of invasive Ca post menopause: Commentary. *Oncology Report* 2011. (JULY-AUGUST): 12.

Greenhill, C. Reproductive endocrinology: Potential new therapy for hot flushes. *Nature Reviews Endocrinology* 2017. 13 (6): 314.

Greenlee, H., Hershman, D. L., and Jacobson, J. S. Use of antioxidant supplements during breast cancer treatment: A comprehensive review. *Breast cancer research and treatment* 2009. 115 (3): 437-452.

Grunfeld, E. A., Hunter, M. S., and Yousaf, O. Men's experience of a guided self-help intervention for hot flashes associated with prostate cancer treatment. *Psychology, health & medicine* 2017. 22 (4): 425-433.

Guirguis, M., Abdelmalak, J., Jusino, E., Hansen, M. R., and Girgis, G. E. Stellate ganglion block for the treatment of hot flashes in patients with breast cancer: A literature review. *Ochsner Journal* 2015. 15 (2): 162-169.

HRT reappraised: Initiate near the menopause. *Australian Journal of Pharmacy* 2012. 93 (1108): 26.

Hathirat, S. and Evans, M. F. Does raloxifene reduce risk of vertebral fractures? Is this another, brighter way to treat osteoporosis? *Canadian Family Physician* 2001. 47 (OCT.): 1982-1984.

Hede, K. Supportive care: Large studies ease yoga, exercise into mainstream oncology. *Journal of the National Cancer Institute* 2011. 103 (1).

Hickey, Martha, Saunders, Christobel M., and Stuckey, Bronwyn G. A. Management of menopausal symptoms in patients with breast cancer: an evidence-based approach. *The Lancet.Oncology* 2005. 6 (9): 687-695.

Hill, D. Ashley and Hill, Susan R. Counseling patients about hormone therapy and alternatives for menopausal symptoms. *American family physician* 2010. 82 (7): 801-807.

Hodis, H. N. Menopausal hormone therapy and prevention of chronic diseases: IMS members react to the recent JAMA paper. *Climacteric, the journal of the International Menopause Society* 2014. 17 (1): 99-100.

Hoffmann, P. and Schulman, C. Complications of androgen-deprivation therapy in prostate cancer: The other side of the coin. *BJU international* 2009. 103 (8): 1020-1023.

Hofstatter, E. W., Stavris, K., Horowitz, N. R., Killelea, B. K., Tsangaris, T., Lannin, D. R., Andrejeva, L., Cong, X., Yao, X., Rimm, D., and Chagpar, A. B. A pilot chemoprevention study of isopropanolic black cohosh extract in women with ductal carcinoma in situ. *Journal of Clinical Oncology* 2013. 31 (15 SUPPL. 1)

Horwich, A. Adjuvant treatments for locally advanced prostate cancer. *European Journal of Cancer* 2011. 47 (SUPPL. 3): S317-S318.

Howard-Anderson, Jessica, Ganz, Patricia A., Bower, Julianne E., and Stanton, Annette L.

Quality of life, fertility concerns, and behavioral health outcomes in younger breast cancer survivors: a systematic review. *Journal of the National Cancer Institute* 2012. 104 (5): 386-405.

Huang, L., Gomaa, H., Wolfman, W., and Alburiki, N. Efficacy and safety of transdermal estrogen and intermittent progesterone: A retrospective study. *Menopause (New York, N.Y.)* 2017. 24 (12): 1452.

Hunter, M. S. Cognitive behavioral interventions for the treatment of menopausal symptoms. *Expert Review of Obstetrics and Gynecology* 2012. 7 (4): 321-326.

Hutton, Brian, Yazdi, Fatemeh, Bordeleau, Louise, Morgan, Scott, Cameron, Chris, Kanji, Salmaan, Fergusson, Dean, Tricco, Andrea, Straus, Sharon, Skidmore, Becky, Hersi, Mona, Pratt, Misty, Mазzarello, Sasha, Brouwers, Melissa, Moher, David, and Clemons, Mark. Comparison of physical interventions, behavioral interventions, natural health products, and pharmacologics to manage hot flashes in patients with breast or prostate cancer: protocol for a systematic review incorporating network meta-analyses. *Systematic reviews* 2015. 4: 114.

IDM confirms significant results in bladder cancer program. *Expert review of anticancer therapy* 2001. 1 (4): 507-510.

Imai, A., Matsunami, K., Takagi, H., and Ichigo, S. New generation nonhormonal management for hot flashes. *Gynecological Endocrinology* 2013. 29 (1): 63-66.

Irani, J. Re: Disease Control Outcomes from Analysis of Pooled Individual Patient Data from Five Comparative Randomized Clinical Trials of Degarelix Versus Luteinising Hormone-releasing Hormone Agonists. *European Urology* 2015. 68 (2): 339.

J R.B. Patient-reported symptoms and quality of life during treatment with tamoxifen or raloxifene for breast cancer prevention. The NSABP Study of Tamoxifen and Raloxifene (STAR) P-2 trial: Commentary. *Obstetrical and Gynecological Survey* 2006. 61 (10): 651-653.

Jacobsen, P., Muchnick, S., Marcus, S., Amheiser, P., Reiersen, P., Gonzalez, B., Gomez, M., Jim, H., Minton, S., and Bower, J. Yoga for management of aromatase inhibitor-associated joint pain in women with breast cancer: A pilot study. *Psycho-oncology* 2014. 23, 234.

Jaffe, R. B. Effects of raloxifene on cardiovascular events and breast cancer in postmenopausal women: Commentary. *Obstetrical and Gynecological Survey* 2006. 61 (12): 787-789.

Jan, A. The role of acupuncture in the management of prostate cancer. *Medical Acupuncture* 2015. 27 (3): 168-178.

Jankowitz, R. C. and Davidson, N. E. Breast cancer primary prevention: 'SERM-mounting' existing obstacles and future directions. *Breast Diseases* 2012. 23 (1): 19-23.

Jassim, G. A. Strategies for managing hot flashes. *Journal of Family Practice* 2011. 60 (6): 333-339.

Jones, J. Tamoxifen side effects may be attributable to other causes. *Journal of the National Cancer Institute* 2001. 93 (1): 11-12.

Jones, R. J. and Brown, J. Circulating biomarkers in cancer care: What possible use. *Practical Laboratory Medicine* 2017. 7: 45-48.

Jordan, V. C. An overview of considerations for the testing of tamoxifen as a preventive for breast cancer. *Ann. New York Acad. Sci.* 1995. 768, 141-147.

Kapil, K. S., Lawal, T. O., Locklear, T. D., and Mahady, G. B. Black cohosh for menopause: Safety and efficacy issues and future perspectives. *Drug Information Journal* 2011. 45 (1): 37-44.

Kauffmann, G. and Liauw, S. L. The use of Hormonal Therapy to Augment Radiation Therapy in Prostate Cancer: An Update. *Current urology reports* 2017. 18 (7): 50.

Kaweski, S. Anti-aging medicine: Part I. Hormone replacement therapy in women. *Plastic and Reconstructive Surgery* 2003. 111 (2): 935-938.

Kedar, A., Hakimian, A., and Gamus, D. Acupuncture for cancer patients. *Progress in Palliative Care* 2012. 20 (5): 284-294.

Kelly, C. M. and Buzdar, A. U. Aromatase inhibitors alone or in sequence with tamoxifen - Clinical Evaluation of the BIG 1-98 trial. *Expert opinion on pharmacotherapy* 2010. 11 (3): 489-492.

Kessel, B. and Kronenberg, F. The role of complementary and alternative medicine in management of menopausal symptoms. *Endocrinology and metabolism clinics of North America* 2004. 33 (4): 717-739.

Kim, S. H., Lee, M.-R., Lee, K.-C., Lee, J.-H., Kwon, H.-C., Kim, D.-C., Lee, K. W., and Cho, S.-H. Use of antidepressants in patients with breast cancer taking tamoxifen. *Journal of Breast Cancer* 2010. 13 (4): 325-336.

Kontos, M., Agbaje, O. F., Rymer, J., and Fentiman, I. S. What can be done about hot flushes after treatment for breast cancer? *Climacteric, the journal of the International Menopause Society* 2010. 13 (1): 4-21.

Lambertini, M. and Azim, Jr. Adjuvant hormonal therapy in young breast cancer patients. *Breast Cancer Management* 2014. 3 (1): 1-4.

Landa, Goni J., Lopes, Rauno P., Hernandez, Nunez J., and Nunez, Palomo S. Menopause. *Atencion Primaria* 2002. 30 (7): 458-462.

Langer, R. D. The evidence base for HRT: what can we believe. *Climacteric: the journal of the International Menopause Society* 2017. 20 (2): 91-96.

Lee, L., Schreiber, A., Seluzicki, C., Li, S., and Mao, J. Development of traditional chinese medicine diagnostic categories for breast cancer survivors with symptom distress. *Journal of Alternative and Complementary Medicine* 2013. 19 (7): A26-A27.

Lee, S. U. and Cho, K. H. Multimodal therapy for locally advanced prostate cancer: The roles of radiotherapy, androgen deprivation therapy, and their combination. *Radiation Oncology Journal* 2017. 35 (3): 189-197.

Lee, W., Hong, B., and Adler, H. Pins and needles: Acupuncture and its impact on urology. *Journal of Urology* 2014. 191 (4 SUPPL. 1): e628.

Lefkowitz, C. C. and Arnold, R. M. Hot flashes in palliative care, part 3 #263. *Journal of palliative medicine* 2013. 16 (2): 203-204. Letrozole - First-line indication: Too many unknowns. *Prescrire international* 2003. 12 (64): 58.

Levin, V. A., Jiang, X., and Kagan, R. Estrogen therapy for osteoporosis in the modern era. *Osteoporosis international: a journal established as result of cooperation between the European Foundation for Osteoporosis and the National Osteoporosis Foundation of the USA* 2018.

LoBuono, C. Clinical clips: summaries of new research Managing menopausal symptoms in breast cancer patients Ganz PA, Greendale GA, Petersen L, et al Managing menopausal symptoms in breast cancer survivors: results of a randomized controlled trial *J Natl Cancer Inst* 2000;92:1054-1064. *Patient care* 2000. 34 (18): 78.

Loprinzi, C. L., Pisansky, T. M., Fonseca, R., Sloan, J. A., Zahasky, K. M., Quella, S. K., Novotny, P. J., Rummans, T. A., Dumesic, D. A., and Perez, E. A. Pilot evaluation of venlafaxine hydrochloride for the therapy of hot flashes in cancer survivors. *J Clin Oncol* 1998. 16 (7): 2377-2381.

Lowry, F., Wachter, K., and Worcester, S. Citalopram reduces hot flashes in randomized phase III trial. *Oncology Report* 2008. (FALL): 104.

Lu, W., Zhou, I., and Rosenthal, D. S. Oncology acupuncture trials and trends from 1997 to 2010, search results from American society of clinical oncology (ASCO) database. *Journal of the Society for Integrative Oncology* 2010. 8 (4): 188-189.

Lupron Depot-4 Month 30 mg. Formulary 1997. 32 (9): 893.

MacInnis, M. Lifestyle strategies in the management of women's midlife health concerns. *Canadian Pharmacists Journal* 2010. 143 (SUPPL. 2): S21.

Magee, P. J. Is equal production beneficial to health? *Proceedings of the Nutrition Society* 2011. 70 (1): 10-18.

Mahady, Gail B., Fabricant, Daniel, Chadwick, Lucas R., and Dietz, Birgit. Black cohosh: an

alternative therapy for menopause? *Nutrition in clinical care*, an official publication of Tufts University 2002. 5 (6): 283-289.

Maki, P. M. New data on mindfulness-based stress reduction for hot flashes: How do alternative therapies compare with selective serotonin reuptake inhibitors? *Menopause (New York, N.Y.)* 2011. 18 (6): 596-598.

Management of menopausal symptoms. *Obstetrics and gynecology* 2014. 123 (1): 202-216.

Marko, K. I. and Simon, J. A. Clinical trials in menopause. *Menopause (New York, N.Y.)* 2018. 25 (2): 217-230.

Marsden, J. and Sacks, N. The national randomised trial of hormone replacement therapy in women with a history of early stage breast cancer: An update. *Journal of the British Menopause Society* 2002. 8 (4): 129.

Marsden, J., A'Hern, R., and Whitehead, M. More breast cancer findings from the Women's Health Initiative. *The journal of the British Menopause Society* 2003. 9 (3): 97-99.

Mathe, G., Vo Van, M. L., and Duchier, J. An oriented phase-II trial of D-Trp6-LH-RH in patients with prostatic carcinoma. *Medical Oncology and Tumor Pharmacotherapy* 1984. 1 (2): 119-122.

Maung, K. and Fisher, M. D. Highlights from: 37th Annual Meeting of the American Society of Clinical Oncology San Francisco, California May 12-15, 2001. *Clinical breast cancer* 2001. 2 (3): 180-185.

Medroxyprogesterone acetate better than venlafaxine at relieving hot flashes. *Oncology Report* 2005. (FALL): 127.

Medroxyprogesterone acetate better than venlafaxine at relieving hot flashes. *Journal of Supportive Oncology* 2005. 3 (4): 312.

Megestrol prevents hot flashes. *Hospital Practice* 1994. 29 (12): 22.

Merchant, S. and Stebbing, J. Black cohosh, hot flushes, and breast cancer. *The Lancet Oncology* 2015. 16 (2): 137-138.

Messina, Mark and Hughes, Claude. Efficacy of soyfoods and soybean isoflavone supplements for alleviating menopausal symptoms is positively related to initial hot flush frequency. *Journal of medicinal food* 2003. 6 (1): 1-11.

Messina, Mark, Kucuk, Omer, and Lampe, Johanna W. An overview of the health effects of isoflavones with an emphasis on prostate cancer risk and prostate-specific antigen levels. *Journal of AOAC International* 2006. 89 (4): 1121-1134.

Miller, R. G. and Ashar, B. H. Managing menopause: Current therapeutic options for vasomotor symptoms. *Advanced Studies in Medicine* 2004. 4 (9): 484.

Moraska, A. R., Moraska, J. M., Sideras, K., and Loprinzi, C. L. Management of hot flashes in breast cancer patients. *European journal of Clinical and Medical Oncology* 2012. 4 (1): 1-9.

Morgan, A., Fenlon, D., Coles, C., Armstrong, A., Randle, K., Thompson, A., and Dunn, J. Is it me or is it hot in here? Hot flushes (or flashes): An unmet need. UK NCRI breast clinical studies group working party on symptom management (vasomotor). *Cancer Research* 2013. 73 (24 SUPPL. 1)

Moyad, Mark A. Complementary/alternative therapies for reducing hot flashes in prostate cancer patients: reevaluating the existing indirect data from studies of breast cancer and postmenopausal women. *Urology* 2002. 59 (4 Suppl 1): 20-33.

Murthy, V. and Chamberlain, R. S. Menopausal symptoms in young survivors of breast cancer: A growing problem without an ideal solution. *Cancer control, journal of the Moffitt Cancer Center* 2012. 19 (4): 317-329.

Nash, Michael R., Perez, Nicole, Tasso, Anthony, and Levy, Jacob J. Clinical research on the utility of hypnosis in the prevention, diagnosis, and treatment of medical and psychiatric disorders. *The International journal of clinical and experimental hypnosis* 2009. 57 (4): 443-450.

Ndefo, U. A., Eaton, A., and Green, M. R. Polycystic ovary syndrome: A review of treatment options with a focus on pharmacological approaches. *P and T* 2013. 38 (6): 336-355.

Nguyen, M.-L. The use of pregabalin in the treatment of hot flashes. *Canadian Pharmacists Journal* 2013. 146 (4): 193-196.

Ning, Y.-M. Treatment choice between GnRH receptor agonists and antagonists for advanced prostate cancer. *Community Oncology* 2009. 6 (5): 200-201.

No authorship indicated. Abstracts. *Psycho-oncology* 2005. 14 (12): 1083-1091.

Nourmoussavi, Melica, Pansegrau, Gary, Popesku, Jason, Hammond, Geoffrey L., Kwon, Janice S., and Carey, Mark S. Ovarian ablation for premenopausal breast cancer: A review of treatment considerations and the impact of premature menopause. *Cancer treatment reviews* 2017. 55: 26-35.

OHSU Knight Cancer Institute. Daptomycin in Treating Neutropenia and Fever in Patients With Cancer. <https://clinicaltrials.gov/ct2/show/NCT00335478> 2011.

Orleans, R. J., Li, L., Kim, M.-J., Guo, J., Sobhan, M., Soule, L., and Joffe, H. V. FDA approval of paroxetine for menopausal hot flashes. *Obstetrical and Gynecological Survey* 2015. 69 (10):

590-591.

Orleans, R. J., Li, L., Kim, M.-J., Guo, J., Sobhan, M., Soule, L., and Joffe, H. V. FDA approval of paroxetine for menopausal hot flashes. *New England Journal of Medicine* 2014. 370 (19): 1777-1779.

Otte, J. L., Skaar, T., Wu, J., Wu, M., Ryker, K., Burns, D., and Carpenter, J. Medication use in breast cancer survivors. *Clinical and Translational Science* 2012. 5 (2): 171.

Payton, S. Prostate cancer: Enzalutamide impresses in European studies. *Nature Reviews Urology* 2014. 11 (5): 243.

Payton, S. Prostate cancer: Intermediate-risk patients on radiotherapy benefit from addition of short-term ADT. *Nature Reviews Urology* 2011. 8 (9): 469.

Philippou, Y., Hadjipavlou, M., Khan, S., and Rane, A. Complementary and alternative medicine (CAM) in prostate and bladder cancer. *BJU international* 2013. 112 (8): 1073-1079.

Phytoestrogens and endometrial hyperplasia. *Prescrire international* 2006. 15 (82): 62-63.

Pinkerton, J. V. Does addition of gabapentin to antidepressant therapy improve control of hot flashes? *Nature Clinical Practice Endocrinology and Metabolism* 2007. 3 (8): 566-567.

Pinkerton, J. V. and Santen, R. Use of alternatives to estrogen for treatment of menopause. *Minerva endocrinologica* 2002. 27 (1): 21-41.

Pinto, Ana Catarina and de Azambuja, Evandro. Improving quality of life after breast cancer: dealing with symptoms. *Maturitas* 2011. 70 (4): 343-348.

Pitkin, Joan. Alternative and complementary therapies for the menopause. *Menopause international* 2012. 18 (1): 20-27.

Ponholzer, A. and Madersbacher, S. Re: Intermittent androgen suppression for rising PSA level after radiotherapy. *European Urology* 2013. 64 (2): 338.

Powles, T. Isoflavones and women's health. *Breast Cancer Research* 2004. 6 (3): 140-142.

Prasad, V. and Diener-West, M. Primary chemoprevention of breast cancer: Are the adverse effects too burdensome. *CMAJ: Canadian Medical Association journal = journal de l'Association medicale canadienne* 2015. 187 (9): E276-E278.

Price, D. L. and Allen, Jr. Common acronyms used by health professionals who prescribe or prepare hormone replacement therapy. *International Journal of Pharmaceutical Compounding* 2007. 11 (4): 288-291.

Pritchard, K. I. Hormone replacement in women with a history of breast cancer. *The oncologist* 2001. 6 (4): 353-362.

Purohit, D. R., Navlakha, P. L., Modi, R. S., and Eshpumiyan, R. The role antidepressants in hospitalised cancer patients. (A pilot study). *J Assoc Physicians India* 1978. 26 (4): 245-248.

Rada, G., Capurro, D., Pantoja, T., Corbalan, J., Moreno, G., Letelier, L. M., and Vera, C. Non-hormonal interventions for hot flushes in women with a history of breast cancer. *Sao Paulo Medical Journal* 2013. 131 (2): 141.

Ranganathan, A., Moore, Z., and O'Shaughnessy, J. A. Phase III trial comparing fulvestrant with exemestane in patients with advanced breast cancer in whom previous nonsteroidal aromatase inhibitor therapy has failed. *Clinical breast cancer* 2007. 7 (6): 446-447.

Ranganathan, A., Muneer, S., Cunningham, S., Shivakumar, L., and Tripathy, D. Meeting Highlights from the 24th Annual Miami Breast Cancer Conference Miami, FL March 14-17, 2007. *Supportive cancer therapy* 2007. 4 (3): 137-144.

Reddy, G. K., Tyagi, P., Jain, V. K., and O'Shaughnessy, J. A. Highlights from: 26th annual San Antonio breast cancer symposium. San Antonio, Texas December 2003. *Clinical breast cancer* 2004. 5 (1): 22-28.

Rees, M. Alternatives to HRT. *Medicine* 2006. 34 (1): 43-44.

Rich, T., Porter, G. W., Ricks-Santi, L., Milshstein, T., and Corbin, T. Intermittent 96-Hour Auricular Electroacupuncture for Hot Flashes in Patients with Prostate Cancer: A Pilot Study. *Medical Acupuncture* 2017. 29 (5): 313-321.

Robertson, F. R., Osborne, C. K., Howell, A., Jones, S. E., Mauriac, L., Ellis, M., Kleeberg, U. R., Come, S. E., Vergote, I., Gertler, S., Buzdar, A., Webster, A., Morris, C., and Chew, H. K. Fulvestrant versus anastrozole for the treatment of advanced breast carcinoma in postmenopausal women: A prospective combined analysis of two multicenter trials. *Women's Oncology Review* 2004. 4 (2): 137-138.

Rohayem, J. and Kliesch, S. [Androgen deprivation therapy in prostate cancer. Indication and systemic consequences]. *Der Urologe.Ausg.A* 2012. 51 (4): 557-6.

Rosenthal, D. and Ades, T. Complementary & alternative methods update. *Ca-A Cancer Journal for Clinicians* 2001. 51 (5): 316-320.

Rostock, M. Complementary treatments for menopausal symptoms in breast cancer patients - An updated review of clinical trials. *Onkologie* 2012. 35, 90.

Rostock, M. Complementary medicine for treatment of menopausal symptoms in breast cancer patients - A review of clinical trials. *Onkologie* 2010. 33 (6): 87-88.

Rostom, A. Y. The management of menopausal sequelae in patients with breast cancer. *Clinical oncology (Royal College of Radiologists (Great Britain))* 2001. 13 (3): 174-180.

Roth, A. J. and Scher, H. I. Sertraline relieves hot flashes secondary to medical castration as treatment of advanced prostate cancer. *Psychooncology* 1998. 7 (2): 129-132.

Sacks, Frank M., Lichtenstein, Alice, Van Horn, Linda, Harris, William, Kris-Etherton, Penny, Winston, Mary, and American Heart Association Nutrition Committee. Soy protein, isoflavones, and cardiovascular health: an American Heart Association Science Advisory for professionals from the Nutrition Committee. *Circulation* 2006. 113 (7): 1034-1044.

Sagar, S. M. Acupuncture as an evidence-based option for symptom control in cancer patients. *Current Treatment Options in Oncology* 2008. 9 (2-3): 117-126.

Sagar, S. M. Is there a role for acupuncture for the treatment of hot flushes in breast cancer patients?: Commentary. *Focus on Alternative and Complementary Therapies* 2008. 13 (2): 112-113.

Sanchez-Barcelo, E. J., Mediavilla, M. D., Alonso-Gonzalez, C., and Reiter, R. J. Melatonin uses in oncology: Breast cancer prevention and reduction of the side effects of chemotherapy and radiation. *Expert opinion on investigational drugs* 2012. 21 (6): 819-831.

Santen, Richard J., Stuenkel, Cynthia A., Davis, Susan R., Pinkerton, Joann V., Gompel, Anne, and Lumsden, Mary Ann. Managing Menopausal Symptoms and Associated Clinical Issues in Breast Cancer Survivors. *The Journal of clinical endocrinology and metabolism* 2017. 102 (10): 3647-3661.

Sarkissian, Angela, Neher, Jon O., Singh, Ravipal, and St Anna, Leilani. Clinical Inquiry: Do venlafaxine and gabapentin control hot flashes in women with a history of breast cancer? *The Journal of family practice* 2012. 61 (12): 759-772.

Sarri, G., Davies, M., and Lumsden, M. A. Diagnosis and management of menopause: Summary of NICE guidance. *BMJ (Online)* 2015. 351: no.

Savard, M.-H. and Savard, J. Cognitive-Behavioral Therapy for Insomnia in Cancer Patients: An Update of Efficacy Evidence and Areas for Future Research. *Current Sleep Medicine Reports* 2017. 3 (2): 66-75.

Schellhammer, P. F. Combined androgen blockade for the treatment of metastatic cancer of the prostate. *Urology* 1996. 47 (5): 622-628.

Schuyler, D. Hem/Onc news. *Clinical Advances in Hematology and Oncology* 2014. 12 (2): 139.

Seruga, B. and Tannock, I. F. Up-front use of aromatase inhibitors as adjuvant therapy for breast cancer: The emperor has no clothes. *Journal of Clinical Oncology* 2009. 27 (6): 840-842.

Seruga, B. and Tannock, I. F. The changing face of hormonal therapy for prostate cancer. *Annals of Oncology* 2008. 19 (SUPPL. 7): vii79-vii85.

Shanafelt, T. D., Barton, D. L., Adjei, A. A., and Loprinzi, C. L. Pathophysiology and treatment of hot flashes. *Mayo Clinic proceedings* 2002. 77 (11): 1207-1218.

Simpson, B. Hot flash pharmacotherapy in breast cancer survivors: A literature review. *Canadian Pharmaceutical Journal* 2004. 137 (3): 36-45.

Soares, H. P., Kumar, A., and Djulbegovic, B. Evidence profiles for breast cancer: Benefit/harms data based on the totality of randomized evidence. *Cancer treatment reviews* 2007. 33 (1): 87-89.

Sousa, M. S., Peate, M., Jarvis, S., Hickey, M., and Friedlander, M. A clinical guide to the management of genitourinary symptoms in breast cancer survivors on endocrine therapy. *Therapeutic Advances in Medical Oncology* 2017. 9 (4): 269-285.

Spetz, A. C., Zetterlund, E. L., Varenhorst, E., and Hammar, M. Incidence and management of hot flashes in prostate cancer. *The journal of supportive oncology* 2003. 1 (4): 263-272.

Stearns, V., Isaacs, C., Rowland, J., Crawford, J., Ellis, M. J., Kramer, R., Lawrence, W., Hanfelt, J. J., and Hayes, D. F. A pilot trial assessing the efficacy of paroxetine hydrochloride (Paxil) in controlling hot flashes in breast cancer survivors. *Annals of oncology, official journal of the European Society for Medical Oncology / ESMO* 2000. 11 (1): 17-22.

Stearns, Vered. Management of hot flashes in breast cancer survivors and men with prostate cancer. *Current oncology reports* 2004. 6 (4): 285-290.

Stearns, Vered and Hayes, Daniel F. Approach to menopausal symptoms in women with breast cancer. *Current Treatment Options in Oncology* 2002. 3 (2): 179-190.

Stearns, Vered and Loprinzi, Charles L. New therapeutic approaches for hot flashes in women. *The journal of supportive oncology* 2003. 1 (1): 11-21.

Stiefel, L. Hormone therapy for menopausal symptoms--update for the clinical nurse specialist. *Clinical nurse specialist CNS* 2004. 18 (1): 14-15.

Stow, W. and Wilde, M. I. The 42nd Annual Meeting of the American Society of Clinical Oncology (ASCO): 2-6 June 2006, Atlanta, Georgia, USA. *American Journal of Cancer* 2006. 5 (4): 273-284.

Stramba-Badiale, Marco. Postmenopausal hormone therapy and the risk of cardiovascular disease. *Journal of cardiovascular medicine (Hagerstown, Md.)* 2009. 10 (4): 303-309.

Stuart, K. E. and Boyages, J. Adjuvant endocrine therapy for post-menopausal women with ductal carcinoma in situ-is the pain worth the gain? A commentary on the NSABP-B35 trial. *Translational Cancer Research* 2016. 5: S113-S116.

Stubbs, Chris, Mattingly, Lisa, Crawford, Steven A., Wickersham, Elizabeth A., Brockhaus, Jessica L., and McCarthy, Laine H. Do SSRIs and SNRIs reduce the frequency and/or severity of hot flashes in menopausal women. *The Journal of the Oklahoma State Medical Association* 2017. 110 (5): 272-274.

Suvarna, K. Hormone replacement therapy: An update. *Journal of Obstetrics and Gynecology of India* 2012. 62 (3): 261-265.

Taille, A., Martinez-Pineiro, L., Cabri, P., Houchard, A., and Schalken, J. Factors predicting progression to castrate-resistant prostate cancer in patients with advanced prostate cancer receiving long-term androgen-deprivation therapy. *BJU international* 2017. 119 (1): 74-81.

Taneja, S. S. Re: Intermittent androgen suppression for rising PSA level after radiotherapy. *Journal of Urology* 2013. 190 (3): 879.

Tanna, N. What can be done to treat menopausal symptoms in breast cancer patients? *Pharmaceutical Journal* 2012. 289 (7727): 403-404.

Tchen, N., Juffs, H. G., Yi, Q. L., Chemerynsky, I., Downie, F. P., Sabate, K., and Tannock, I. F. Cognitive function, fatigue and menopausal symptoms in women following adjuvant chemotherapy for breast cancer: One and two year follow-up of a prospective controlled study [abstract]. *Annual Meeting Proceedings of the American Society of Clinical Oncology* 2004. 726.

Thanarajasingam, Gita, Atherton, Pamela J., Novotny, Paul J., Loprinzi, Charles L., Sloan, Jeff A., and Grothey, Axel. Longitudinal adverse event assessment in oncology clinical trials: the Toxicity over Time (ToxT) analysis of Alliance trials NCCTG N9741 and 979254. *The Lancet.Oncology* 2016. 17 (5): 663-670.

Thomay, A. A. Nonsurgical Adjunctive Treatment and Its Effects on the Axilla. *Current Problems in Cancer* 2012. 36 (5): 305-324.

Thompson, Elizabeth A. Homeopathy and the menopause. *The journal of the British Menopause Society* 2002. 8 (4): 151-154.

Towlerton, G., Filshie, J., O'Brien, M., and Duncan, A. Acupuncture in the control of vasomotor symptoms caused by tamoxifen. *Palliat.Med* 1999. 13 (5): 445.

Treatment of menopausal vasomotor symptoms. *The Medical letter on drugs and therapeutics* 2004. 47 (1197-1198): 98-99.

Trifunovic, J. and Pesic, J. Novelties in the treatment of breast cancer: Report from 35th San Antonio Breast Cancer Symposium 2012. *Archive of Oncology* 2013. 21 (1): 50-51.

Triptorelin pamoate (Trelstar). *Medical Letter on Drugs and Therapeutics* 2002. 44 (1132): 51-52.

Tucker, P. E. and Cohen, P. A. Sexuality and risk-reducing salpingo-oophorectomy. *International Journal of Gynecological Cancer* 2017. 27 (4): 847-852.

Twombly, R. Critics question price of success in halted clinical trial of aromatase inhibitor letrozole. *Journal of the National Cancer Institute* 2003. 95 (23): 1738-1739.

Twombly, R. Task force urges doctors to discuss breast cancer prevention. *Journal of the National Cancer Institute* 2002. 94 (15): 1121-1122.

United States. National Institute on Aging. Estrogen use and postmenopausal women. NIH consensus development conference summary 1979. 2 (8): 1-5.

Valois, B., Young, T., Robinson, N., McCourt, C., and Maher, E. J. Using acupuncture to manage hot flashes and night sweats in women with early breast cancer [abstract number PI-4]. *J Alt & Comp Med* 2007. 13 (8): 863-864.

Vastag, B. Raloxifene prevails in STAR trial, may face easier road to acceptance than previous drugs. *Journal of the National Cancer Institute* 2006. 98 (11): 733-735.

Venlafaxine for hot flushes? *Pharmaceutical Journal* 2000. 265 (7128): 907.

Venlafaxine offers nonhormonal option for hot flashes in breast cancer patients. *Formulary* 2000. 35 (8): 644.

Villaseca, P. Non-estrogen conventional and phytochemical treatments for vasomotor symptoms: what needs to be known for practice. *Climacteric, the journal of the International Menopause Society* 2012. 15 (2): 115-124.

Virginia Commonwealth University. Magnesium Oxide in Treating Hot Flashes in Menopausal Women With Cancer. <https://clinicaltrials.gov/ct2/show/NCT01008904> 2013.

Wesa, K. and Cassileth, B. Acupuncture for decreasing hot flashes in peri- and postmenopausal women and in women with breast cancer receiving oestrogen-antagonist therapy: Commentary. *Focus on Alternative and Complementary Therapies* 2009. 14 (2): 107-110.

Wickramasekera, Ian II. Review of Randomized trial of a hypnosis intervention for treatment of hot flashes among breast cancer survivors. *American Journal of Clinical Hypnosis* 2009. 51 (3): 307.

Yeo, B., Turner, N. C., and Jones, A. An update on the medical management of breast cancer. *BMJ (Online)* 2014. 348.

Woo, H. H., Murphy, D. G., Testa, G. M., Grummet, J. P., Chong, M., and Stork, A. P. Effect of triptorelin on lower urinary tract symptoms in Australian prostate cancer patients. *Research and Reports in Urology* 2017. 9: 27-35.

Woyka, J. and Tanna, N. Consensus statement for non-estrogen-based treatments for menopausal symptoms. *Post Reproductive Health* 2014. 20 (2): 76-79.

Zaheer, K. and Humayoun, Akhtar M. An updated review of dietary isoflavones: Nutrition, processing, bioavailability and impacts on human health. *Critical reviews in food science and nutrition* 2017. 57 (6): 1280-1293.

Zeps, N. Nhmrc homeopathy working party. *Asia-Pacific Journal of Clinical Oncology* 2014. 10, 113-114.

27th European Society of Medical Oncology Congress. *Clinical breast cancer* 2002. 3 (5): 302-307.

Reports on patients without cancer/history of cancer [or less than two-thirds of subjects with current/history of cancer] (n = 41)

Al-Akoum, Mahera, Maunsell, Elizabeth, Verreault, Rene, Provencher, Louise, Otis, Helene, and Dodin, Sylvie. Effects of *Hypericum perforatum* (St. John's wort) on hot flashes and quality of life in perimenopausal women: a randomized pilot trial. *Menopause (New York, N.Y.)* 2009. 16 (2): 307-314.

Albertazzi, P., Pansini, F., Bonaccorsi, G., Zanotti, L., Forini, E., and De, Aloysio D. The effect of dietary soy supplementation on hot flashes. *Obstet Gynecol* 1998. 91 (1): 6-11.

Atkinson, Charlotte, Warren, Ruth M. L., Sala, Evis, Dowsett, Mitch, Dunning, Alison M., Healey, Catherine S., Runswick, Shirley, Day, Nicholas E., and Bingham, Sheila A. Red-clover-derived isoflavones and mammographic breast density: a double-blind, randomized, placebo-controlled trial [ISRCTN42940165]. *Breast cancer research, BCR* 2004. 6 (3): R170-R179.

Ayers, B., Smith, M., Hellier, J., Mann, E., and Hunter, M. S. Effectiveness of group and self-help cognitive behavior therapy in reducing problematic menopausal hot flashes and night sweats (MENOS 2): a randomized controlled trial. *Menopause (New York, N.Y.)* 2012. 19 (7): 749-759.

Barton, D. L., LaVasseur, B. I., Sloan, J. A., Stawis, A. N., Flynn, K. A., Dyar, M., Johnson, D. B., Atherton, P. J., Diekmann, B., and Loprinzi, C. L. Phase III, placebo-controlled trial of three doses of citalopram for the treatment of hot flashes: NCCTG trial N05C9. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 10-7-2010. 28 (20): 3278-3283.

Barton, D. L., Schroeder, K. C. F., Banerjee, T., Wolf, S., Keith, T. Z., and Elkins, G. Efficacy of a biobehavioral intervention for hot flashes: A randomized controlled pilot study. *Menopause (New York, N.Y.)* 2017. 24 (7): 774-782.

Carmody, J. F., Crawford, S., Salmoirago-Blotcher, E., Leung, K., Churchill, L., and Olendzki, N. Mindfulness training for coping with hot flashes: results of a randomized trial. *Menopause* (New York, N.Y.) 2011. 18 (6): 611-620.

Carpenter, Janet S., Burns, Debra S., Wu, Jingwei, Otte, Julie L., Schneider, Bryan, Ryker, Kristin, Tallman, Eileen, and Yu, Menggang. Paced respiration for vasomotor and other menopausal symptoms: a randomized, controlled trial. *Journal of general internal medicine* 2013. 28 (2): 193-200.

Cowles, Verne E., Gordi, Toufigh, and Hou, Sui Yuen Eddie. Steady-state pharmacokinetics of gabapentin after administration of a novel gastroretentive extended-release formulation in postmenopausal women with vasomotor symptoms. *Clinical drug investigation* 2012. 32 (9): 593-601.

Delmanto, Armando, Nahas-Neto, Jorge, Traiman, Paulo, Uemura, Gilberto, Pessoa, Eduardo Carvalho, and Nahas, Eliana Aguiar Petri. Effects of soy isoflavones on mammographic density and breast parenchyma in postmenopausal women: a randomized, double-blind, placebo-controlled clinical trial. *Menopause* (New York, N.Y.) 2013. 20 (10): 1049-1054.

Ee, Carolyn, Xue, Charlie, Chondros, Patty, Myers, Stephen P., French, Simon D., Teede, Helena, and Pirotta, Marie. Acupuncture for Menopausal Hot Flashes: A Randomized Trial. *Annals of internal medicine* 2016. 164 (3): 146-154.

Evans, M. L., Pritts, E., Vittinghoff, E., McClish, K., Morgan, K. S., and Jaffe, R. B. Management of postmenopausal hot flushes with venlafaxine hydrochloride: a randomized, controlled trial. *Obstet Gynecol* 2005. 105 (1): 161-166.

Faure, E. D., Chantre, P., and Mares, P. Effects of a standardized soy extract on hot flashes: a multicenter, double-blind, randomized, placebo-controlled study. *Menopause* 2002. 9 (5): 329-334.

Freedman, Robert R., Woodward, Suzanne, Brown, Barbara, Javaid, Javaid I., and Pandey, Ghanshayam N. Biochemical and thermoregulatory effects of behavioral treatment for menopausal hot flashes. *Menopause* 1995. 2 (4): 211-218.

Gordon, P. R., Kerwin, J. P., Boesen, K. G., and Senf, J. Sertraline to treat hot flashes: a randomized controlled, double-blind, crossover trial in a general population. *Menopause* 2006. 13 (4): 568-575.

Grady, D., Cohen, B., Tice, J., Kristof, M., Olyae, A., and Sawaya, G. F. Ineffectiveness of sertraline for treatment of menopausal hot flashes: a randomized controlled trial. *Obstet Gynecol* 2007. 109 (4): 823-830.

Guttuso, T., Jr., Kurlan, R., McDermott, M. P., and Kieburtz, K. Gabapentin's effects on hot flashes in postmenopausal women: a randomized controlled trial. *Obstet Gynecol* 2003. 101 (2): 337-345.

Hunter, Myra S. and Liao, K. Evaluation of a fourG. *British Journal of Health Psychology* 1996. 1 (2): 113-125.

Kaari, C., Haidar, M. A., Junior, J. M. S., Nunes, M. G., Quadros, L. G. D. A., Kemp, C., Stavale, J. N., and Baracat, E. C. Randomized clinical trial comparing conjugated equine estrogens and isoflavones in postmenopausal women: A pilot study. *Maturitas* 2006. 53 (1): 49-58.

Loprinzi, C. L., Levitt, R., Barton, D., Sloan, J. A., Dakhil, S. R., Nikcevich, D. A., Bearden III, J. D., Mailliard, J. A., Tschetter, L. K., Fitch, T. R., and Kugler, J. W. Phase III comparison of depomedroxyprogesterone acetate to venlafaxine for managing hot flashes: North Central Cancer Treatment Group Trial N99C7. *Journal of Clinical Oncology* 2006. 24 (9): 1409-1414.

Loprinzi, C. L., Qin, R., Balcueva, E. P., Flynn, K. A., Rowland, K. M., Jr., Graham, D. L., Erwin, N. K., Dakhil, S. R., Jurgens, D. J., and Burger, K. N. Phase III, randomized, double-blind, placebo-controlled evaluation of pregabalin for alleviating hot flashes, N07C1. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 1-2-2010. 28 (4): 641-647.

Maclaughlan David, Shannon, Salzillo, Sandra, Bowe, Patrick, Scuncio, Sandra, Malit, Bridget, Raker, Christina, Gass, Jennifer S., Granai, C. O., and Dizon, Don S. Randomised controlled trial comparing hypnotherapy versus gabapentin for the treatment of hot flashes in breast cancer survivors: a pilot study. *BMJ open* 2013. 3 (9): e003138.

Maskarinec, G., Franke, A. A., Williams, A. E., and Stanczyk, F. C. The effects of an isoflavone intervention on the urinary excretion of hormone metabolites in premenopausal women. *IARC.Sci Publ.* 2002. 156, 375-377.

Passamonti, F., Griesshammer, M., Palandri, F., Egyed, M., Benevolo, G., Devos, T., Callum, J., Vannucchi, A. M., Sivgin, S., Bensasson, C., Khan, M., Mounedji, N., and Saydam, G. Ruxolitinib for the treatment of inadequately controlled polycythaemia vera without splenomegaly (RESPONSE-2): a randomised, open-label, phase 3b study. *The Lancet.Oncology* 2017. 18 (1): 88-99.

Pockaj, Barbara A., Gallagher, James G., Loprinzi, Charles L., Stella, Philip J., Barton, Debra L., Sloan, Jeff A., Lavoisier, Beth I., Rao, Radha M., Fitch, Tom R., Rowland, Kendrith M., Novotny, Paul J., Flynn, Patrick J., Richelson, Elliott, and Fauq, Abdul H. Phase III double-blind, randomized, placebo-controlled crossover trial of black cohosh in the management of hot flashes: NCCTG Trial N01CC1. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 2006. 24 (18): 2836-2841.

Pruthi, Sandhya, Qin, Rui, Terstreip, Shelby A., Liu, Heshan, Loprinzi, Charles L., Shah, Tushar R. C., Tucker, Kenneth F., Dakhil, Shaker R., Bury, Martin J., Carolla, Robert L., Steen, Preston D., Vuky, Jacqueline, and Barton, Debra L. A phase III, randomized, placebo-controlled, double-blind trial of flaxseed for the treatment of hot flashes: North Central Cancer Treatment Group N08C7. *Menopause (New York, N.Y.)* 2012. 19 (1): 48-53.

Reddy, S. Y., Warner, H., Guttuso, T., Jr., Messing, S., DiGrazio, W., Thornburg, L., and Guzick, D. S. Gabapentin, estrogen, and placebo for treating hot flushes: a randomized controlled trial. *Obstet Gynecol* 2006. 108 (1): 41-48.

Secreto, G., Chiechi, L. M., Amadori, A., Miceli, R., Venturelli, E., Valerio, T., and Marubini, E. Soy isoflavones and melatonin for the relief of climacteric symptoms: A multicenter, double-blind, randomized study. *Maturitas* 2004. 47 (1): 11-20.

Sekhavat, L. and Firouzabadi, R. D. Effect of soya protein on symptoms of hot flash in menopausal women in Yazd, Iran. *Iranian Journal of Obstetrics, Gynecology and Infertility* 2012. 15 (6): 10-15.

Sood, Richa, Sood, Amit, Wolf, Sherry L., Linquist, Breanna M., Liu, Heshan, Sloan, Jeff A., Satele, Daniel V., Loprinzi, Charles L., and Barton, Debra L. Paced breathing compared with usual breathing for hot flashes. *Menopause (New York, N.Y.)* 2013. 20 (2): 179-184.

Speroff, L., Gass, M., Constantine, G., and Olivier, S. Efficacy and tolerability of desvenlafaxine succinate treatment for menopausal vasomotor symptoms: a randomized controlled trial. *Obstet Gynecol* 2008. 111 (1): 77-87.

St, Germain A., Peterson, C. T., Robinson, J. G., and Alekel, D. L. Isoflavone-rich or isoflavone-poor soy protein does not reduce menopausal symptoms during 24 weeks of treatment. *Menopause* 2001. 8 (1): 17-26.

St.Germain, A., Peterson, C. T., Robinson, J. G., and Alekel, D. L. Isoflavone-rich or isoflavone-poor soy protein does not reduce menopausal symptoms during 24 weeks of treatment. *Menopause (New York, N.Y.)* 2001. 8 (1): 17-26.

Stearns, V., Beebe, K. L., Iyengar, M., and Dube, E. Paroxetine controlled release in the treatment of menopausal hot flashes: a randomized controlled trial. *JAMA* 4-6-2003. 289 (21): 2827-2834.

Stockler, M. R., O'Connell, R., Nowak, A. K., Goldstein, D., Turner, J., Wilcken, N. R., Wyld, D., Abdi, E. A., Glasgow, A., Beale, P. J., Jefford, M., Dhillon, H., Heritier, S., Carter, C., Hickie, I. B., and Simes, R. J. Effect of sertraline on symptoms and survival in patients with advanced cancer, but without major depression: a placebo-controlled double-blind randomised trial. *Lancet Oncol* 2007. 8 (7): 603-612.

Suvanto-Luukkonen, E., Koivunen, R., Sundstrom, H., Bloigu, R., Karjalainen, E., Haiva-Mallinen, L., and Tapanainen, J. S. Citalopram and fluoxetine in the treatment of postmenopausal symptoms: a prospective, randomized, 9-month, placebo-controlled, double-blind study. *Menopause* 2005. 12 (1): 18-26.

Tice, Jeffrey A., Ettinger, Bruce, Ensrud, Kris, Wallace, Robert, Blackwell, Terri, and Cummings, Steven R. Phytoestrogen supplements for the treatment of hot flashes: the Isoflavone Clover Extract (ICE) Study: a randomized controlled trial. *JAMA* 2003. 290 (2): 207-214.

Venzke, L., Calvert, J. F., Jr., and Gilbertson, B. A randomized trial of acupuncture for vasomotor symptoms in post-menopausal women. *Complement Ther Med* 2010. 18 (2): 59-66.

Walton, S. M. and Batra, H. K. The use of medroxyprogesterone acetate 50 mg in the treatment of painful pelvic conditions: Preliminary results from a multicentre trial. *Journal of Obstetrics and Gynaecology* 1992. 12 (SUPPL. 2): S50-S53.

Webster, A. D., Finstad, D. A., Kurzer, M. S., and Torkelson, C. J. Quality of life among postmenopausal women enrolled in the Minnesota Green Tea Trial. *Maturitas* 2018. 108: 1-6.

Wyon, Yvonne, Lindgren, R., Lundeberg, T., and Hammar, Mats. Effects of acupuncture on climacteric vasomotor symptoms, quality of life, and urinary excretion of neuropeptides among postmenopausal women. *Menopause* 1995. 2 (1): 3-12.

Ineligible intervention or comparator (n = 32)

Ahimahalle, T. Z., Ahmadi, A. S., Arabi, M., and Rahmani, L. Clinical comparison of the effects of gabapentin and Megestrol acetate on hot flashes in patients with breast cancer. *International Journal of Hematology-Oncology and Stem Cell Research* 2012. 6 (1): 6-10.

Al-Bareeq, Reem J., Ray, A. Andrew, Nott, Linda, Pautler, Stephen E., and Razvi, Hassan. Dong Quai (*angelica sinensis*) in the treatment of hot flashes for men on androgen deprivation therapy: results of a randomized double-blind placebo controlled trial. *Canadian Urological Association journal = Journal de l'Association des urologues du Canada* 2010. 4 (1): 49-53.

Andersen, S. R., Wurtzen, H., Steding-Jessen, M., Christensen, J., Andersen, K. K., Flyger, H., Mitchelmore, C., Johansen, C., and Dalton, S. O. Effect of mindfulness-based stress reduction on sleep quality: Results of a randomized trial among Danish breast cancer patients. *Acta Oncologica* 2013. 52 (2): 336-344.

Berger, Ann M., Treat Marunda, Heather A., and Agrawal, Sangeeta. Influence of menopausal status on sleep and hot flashes throughout breast cancer adjuvant chemotherapy. *Journal of obstetric, gynecologic, and neonatal nursing, JOGNN / NAACOG* 2009. 38 (3): 353-366.

Boer, R. D. A randomised trial of buserelin and tamoxifen in metastatic breast cancer. *Breast Cancer Research* 2000. 2 (1): no.

Buchanan, R. B., Blamey, R. W., and Durrant, K. R. A randomized comparison of tamoxifen with surgical oophorectomy in premenopausal patients with advanced breast cancer. *Journal of Clinical Oncology* 1986. 4 (9): 1326-1330.

Carpenter, Janet S., Wells, Nancy, Lambert, Beth, Watson, Peggy, Slayton, Tami, Chak, Bapsi, Hepworth, Joseph T., and Worthington, W. Bradley. A pilot study of magnetic therapy for hot flashes after breast cancer. *Cancer nursing* 2002. 25 (2): 104-109.

Carpenter, Janet S., Yu, Menggang, Wu, Jingwei, Von Ah, Diane, Milata, Jennifer, Otte, Julie L., Johns, Shelley, Schneider, Bryan, Storniolo, Anna Maria, Salomon, Ronald, Desta, Zeuresenay, Cao, Donghua, Jin, Yan, Philips, Santosh, and Skaar, Todd C. Evaluating the role of serotonin in hot flashes after breast cancer using acute tryptophan depletion. *Menopause (New York, N.Y.)* 2009. 16 (4): 644-652.

Chang, Jose, Couture, Felix A., Young, Scott D., Lau, Catherine Y., and Lee McWatters, Kara. Weekly administration of epoetin alfa improves cognition and quality of life in patients with breast cancer receiving chemotherapy. *Supportive cancer therapy* 2004. 2 (1): 52-58.

Dyer, Jeannie, Ashley, Sue, and Shaw, Clare. A study to look at the effects of a hydrolat spray on hot flushes in women being treated for breast cancer. *Complementary therapies in clinical practice* 2008. 14 (4): 273-279.

Fisher, M. D., O'Shaughnessy, J., and Sparano, J. A. Anastrozole may be superior to Tamoxifen as adjuvant treatment for postmenopausal patients with breast cancer. *Clinical breast cancer* 2002. 2 (4): 269-271.

Frisk, Jessica, Kallstrom, Ann Christine, Wall, Najme, Fredrikson, Mats, and Hammar, Mats. Acupuncture improves health-related quality-of-life (HRQoL) and sleep in women with breast cancer and hot flushes. *Supportive care in cancer, official journal of the Multinational Association of Supportive Care in Cancer* 2012. 20 (4): 715-724.

Ganz, P. A., Greendale, G. A., Petersen, L., Zibecchi, L., Kahn, B., and Belin, T. R. Managing menopausal symptoms in breast cancer survivors: results of a randomized controlled trial. *Journal of the National Cancer Institute* 2000. 92 (13): 1054-1064.

Irani, Jacques, Salomon, Laurent, Oba, Rostand, Bouchard, Philippe, and Mottet, Nicolas. Efficacy of venlafaxine, medroxyprogesterone acetate, and cyproterone acetate for the treatment of vasomotor hot flushes in men taking gonadotropin-releasing hormone analogues for prostate cancer: a double-blind, randomised trial. *The Lancet.Oncology* 2010. 11 (2): 147-154.

Jacobs, Jennifer, Herman, Patricia, Heron, Krista, Olsen, Steven, and Vaughters, Lucy. Homeopathy for menopausal symptoms in breast cancer survivors: a preliminary randomized controlled trial. *Journal of alternative and complementary medicine (New York, N.Y.)* 2005. 11 (1): 21-27.

Joffe, Hadine, Partridge, Ann, Giobbie-Hurder, Anita, Li, Xiaochun, Habin, Karleen, Goss, Paul, Winer, Eric, and Garber, Judy. Augmentation of venlafaxine and selective serotonin reuptake inhibitors with zolpidem improves sleep and quality of life in breast cancer patients with hot flashes: a randomized, double-blind, placebo-controlled trial. *Menopause (New York, N.Y.)* 2010. 17 (5): 908-916.

Marshall-McKenna, R., Morrison, A., Stirling, L., Hutchison, C., Rice, A. M., Hewitt, C., Paul, L., Rodger, M., Macpherson, I. R., and McCartney, E. A randomised trial of the cool pad pillow topper versus standard care for sleep disturbance and hot flushes in women on endocrine therapy for breast cancer. *Supportive care in cancer: official journal of the Multinational Association of*

Supportive Care in Cancer 2016. 24 (4): 1821-1829.

Maung, K. Randomized phase II trial comparing exemestane to tamoxifen for first-line hormonal therapy of postmenopausal patients with metastatic breast cancer. *Clinical breast cancer* 2001. 2 (2): 110-112.

McLeod, D. G., Iversen, P., See, W. A., Morris, T., Armstrong, J., and Wirth, M. P. Bicalutamide 150 mg plus standard care vs standard care alone for early prostate cancer. *BJU international* 2006. 97 (2): 247-254.

Montgomery, B., Tretiakova, M. S., Joshua, A. M., Gleave, M. E., Fleshner, N., Bubley, G. J., Mostaghel, E. A., Chi, K. N., Lin, D. W., Sanda, M., Novotny, W., Wu, K., Kantoff, P. W., Marck, B. T., Plymate, S., Balk, S. P., Nelson, P. S., Matsumoto, A. M., Lis, R. T., Kibel, A., Haas, G. P., Krivoshik, A., Hannah, A., and Taplin, M.-E. Neoadjuvant enzalutamide prior to prostatectomy. *Clinical Cancer Research* 2017. 23 (9): 2169-2176.

Munstedt, K., Voss, B., Kullmer, U., Schneider, U., and Hubner, J. Bee pollen and honey for the alleviation of hot flushes and other menopausal symptoms in breast cancer patients. *Molecular and Clinical Oncology* 2015. 3 (4): 869-874.

Nunez, Geila Ribeiro, Pinczowski, Helio, Zanellato, Rebecca, Tateyama, Livia, Schindler, Fernanda, Fonseca, Fernando, and Del Giglio, Auro. Bupropion for control of hot flashes in breast cancer survivors: a prospective, double-blind, randomized, crossover, pilot phase II trial. *Journal of pain and symptom management* 2013. 45 (6): 969-979.

Othman, Ahmed H. and Zaky, Amen H. Management of hot flushes in breast cancer survivors: comparison between stellate ganglion block and pregabalin. *Pain medicine (Malden, Mass.)* 2014. 15 (3): 410-417.

Recent studies with anastrozole versus tamoxifen in the management of breast cancer. *Clinical breast cancer* 2002. 3 (5): 309-311.

Reddy, G. K., Jain, V. K., and Sartor, O. Abarelix (Plenaxis™): A Gonadotropin-Releasing Hormone Antagonist for Medical Castration in Patients with Advanced Prostate Cancer. *Clinical Prostate Cancer* 2004. 2 (4): 209-211.

Rose, C., Kamby, C., and Mouridsen, H. T. Combined endocrine treatment of postmenopausal patients with advanced breast cancer. A randomized trial of tamoxifen vs. tamoxifen plus aminoglutethimide and hydrocortisone. *Breast cancer research and treatment* 1986. 7 (SUPPL.): 45-50.

Schover, Leslie R., Jenkins, Rosell, Sui, Dawen, Adams, Jennifer Harned, Marion, Michelle S., and Jackson, Karen Eubanks. Randomized trial of peer counseling on reproductive health in African American breast cancer survivors. *Journal of clinical oncology, official journal of the American Society of Clinical Oncology* 2006. 24 (10): 1620-1626.

Schover, Leslie R., Rhodes, Michelle M., Baum, George, Adams, Jennifer Harned, Jenkins, Rosell, Lewis, Pamela, and Jackson, Karen Eubanks. Sisters Peer Counseling in Reproductive Issues After

Treatment (SPIRIT): a peer counseling program to improve reproductive health among African American breast cancer survivors. *Cancer* 2011. 117 (21): 4983-4992.

Semiglazov, V. F., Semiglazov, V. V., and Dashyan, G. A. Primary endocrine therapy vs chemotherapy: A phase II randomized trial in postmenopausal patients with estrogen receptor-positive breast cancer. *American Journal of Hematology/ Oncology* 2007. 6 (11): 617-624.

Thompson, E. A., Montgomery, A., Douglas, D., and Reilly, D. A pilot, randomized, double-blinded, placebo-controlled trial of individualized homeopathy for symptoms of estrogen withdrawal in breast-cancer survivors. *J Altern Complement Med* 2005. 11 (1): 13-20.

UZER, Y., SHNIDER, B. I., and GOLD, G. L. A double blind study with iproniazid in patients with far-advanced cancer. *Antibiotic.Med Clin Ther (New York)* 1960. 7, 777-781.

Walker, Lauren M. A psycho-education intervention to help men with prostate cancer adapt to androgen deprivation therapy. *Dissertation Abstracts International: Section B: The Sciences and Engineering* 2014. 75 (4-B(E)): No-Specified.

No outcomes of interest (n=15)

Anderson, Debra J., Seib, Charlotte, McCarthy, Alexandra L., Yates, Patsy, Porter-Steele, Janine, McGuire, Amanda, and Young, Leonie. Facilitating lifestyle changes to manage menopausal symptoms in women with breast cancer: a randomized controlled pilot trial of The Pink Women's Wellness Program. *Menopause (New York, N.Y.)* 2015. 22 (9): 937-945.

Bower, Julianne E., Crosswell, Alexandra D., Stanton, Annette L., Crespi, Catherine M., Winston, Diana, Arevalo, Jesusa, Ma, Jeffrey, Cole, Steve W., and Ganz, Patricia A. Mindfulness meditation for younger breast cancer survivors: a randomized controlled trial. *Cancer* 2015. 121 (8): 1231-1240.

Courneya, K. S., McKenzie, D. C., Mackey, J. R., Gelmon, K., Friedenreich, C. M., Yasui, Y., Reid, R. D., Cook, D., Jespersen, D., Proulx, C., Dolan, L. B., Forbes, C. C., Wooding, E., Trinh, L., and Segal, R. J. Effects of exercise dose and type during breast cancer chemotherapy: multicenter randomized trial. *Journal of the National Cancer Institute* 4-12-2013. 105 (23): 1821-1832.

Hayes, Sandra C., Rye, Sheree, Disipio, Tracey, Yates, Patsy, Bashford, John, Pyke, Chris, Saunders, Christobel, Battistutta, Diana, and Eakin, Elizabeth. Exercise for health: a randomized, controlled trial evaluating the impact of a pragmatic, translational exercise intervention on the quality of life, function and treatment-related side effects following breast cancer. *Breast cancer research and treatment* 2013. 137 (1): 175-186.

Hoffman, C. J., Ersser, S. J., Hopkinson, J. B., Nicholls, P. G., Harrington, J. E., and Thomas, P. W. Effectiveness of mindfulness-based stress reduction in mood, breast- and endocrine-related quality of life, and well-being in stage 0 to III breast cancer: a randomized, controlled trial. *Journal*

of clinical oncology: official journal of the American Society of Clinical Oncology 4-20-2012. 30 (12): 1335-1342.

Koch, A. K., Rabsilber, S., Lauche, R., Kummel, S., Dobos, G., Langhorst, J., and Cramer, H. The role of yoga and self-esteem for menopausal symptoms and quality of life in breast cancer survivors-a mediation analysis. *BMC complementary and alternative medicine* 2017. 17 (Supplement 1).

Koch, Anna K., Rabsilber, Sybille, Lauche, Romy, Kummel, Sherko, Dobos, Gustav, Langhorst, Jost, and Cramer, Holger. The effects of yoga and self-esteem on menopausal symptoms and quality of life in breast cancer survivors-A secondary analysis of a randomized controlled trial. *Maturitas* 2017. 105: 95-99.

Maly, Rose C., Liang, Li Jung, Liu, Yihang, Griggs, Jennifer J., and Ganz, Patricia A. Randomized Controlled Trial of Survivorship Care Plans Among Low-Income, Predominantly Latina Breast Cancer Survivors. *Journal of clinical oncology: official journal of the American Society of Clinical Oncology* 2017. 35 (16): 1814-1821.

Musselman, D. L., Somerset, W. I., Guo, Y., Manatunga, A. K., Porter, M., Penna, S., Lewison, B., Goodkin, R., Lawson, K., Lawson, D., Evans, D. L., and Nemeroff, C. B. A double-blind, multicenter, parallel-group study of paroxetine, desipramine, or placebo in breast cancer patients (stages I, II, III, and IV) with major depression. *J Clin Psychiatry* 2006. 67 (2): 288-296.

Peng, N., Yu, M., Yang, G., Fu, Q., Xu, Y., Yu, J., Liu, Q., Li, C., Xu, W., Zhang, Y., Ma, C., Yang, L., Yu, R., and Wang, X. Effects of the Chinese medicine Yi Shen Jian Gu granules on aromatase inhibitor-associated musculoskeletal symptoms: A randomized, controlled clinical trial. *Breast (Edinburgh, Scotland)* 2018. 37: 18-27.

Pickett, M., Mock, V., Ropka, M. E., Cameron, L., Coleman, M., and Podewils, L. Adherence to moderate-severity exercise during breast cancer therapy. *Cancer Practice* 2002. 10 (6): 284-292.

Roscoe, J. A., Morrow, G. R., Hickok, J. T., Mustian, K. M., Griggs, J. J., Matteson, S. E., Bushunow, P., Qazi, R., and Smith, B. Effect of paroxetine hydrochloride (Paxil) on fatigue and depression in breast cancer patients receiving chemotherapy. *Breast Cancer Res Treat* 2005. 89 (3): 243-249.

Shapiro, A. C., Adlis, S. A., Robien, K., Kirstein, M. N., Liang, S., Richter, S. A., and Lerner, R. E. Randomized, blinded trial of vitamin D3 for treating aromatase inhibitor-associated musculoskeletal symptoms (AIMSS). *Breast cancer research and treatment* 2016. 155 (3): 501-512.

Sharma, Preetika, Wisniewski, Amy, Braga-Basaria, Milena, Xu, Xiaoqiang, Yep, Mary, Denmeade, Samuel, Dobs, Adrian S., DeWeese, Theodore, Carducci, Michael, and Basaria, Shehzad. Lack of an effect of high dose isoflavones in men with prostate cancer undergoing androgen deprivation therapy. *The Journal of urology* 2009. 182 (5): 2265-2272.

Spahn, G., Choi, K. E., Kennemann, C., Ludtke, R., Franken, U., Langhorst, J., Paul, A., and Dobos, G. J. Can a multimodal mind-body program enhance the treatment effects of physical activity in breast cancer survivors with chronic tumor-associated fatigue? A randomized controlled trial. *Integr Cancer Ther* 2013. 12 (4): 291-300.

Cross-over study not reporting outcomes for each study period (n=3)

Buijs, Ciska, Mom, Constantijne H., Willemse, Pax H. B., Marike Boezen, H., Maurer, J. Marina, Wymenga, A. N. M., de Jong, Robert S., Nieboer, Peter, de Vries, Elisabeth G. E., and Mourits, Marian J. E. Venlafaxine versus clonidine for the treatment of hot flashes in breast cancer patients: a double-blind, randomized cross-over study. *Breast cancer research and treatment* 2009. 115 (3): 573-580.

Carpenter, Janet S., Storniolo, Anna Maria, Johns, Shelley, Monahan, Patrick O., Azzouz, Faouzi, Elam, Julie L., Johnson, Cynthia S., and Shelton, Richard C. Randomized, double-blind, placebo-controlled crossover trials of venlafaxine for hot flashes after breast cancer. *The oncologist* 2007. 12 (1): 124-135.

Nikander, Eini, Kilkkinen, Annamari, Metsa-Heikkila, Merja, Adlercreutz, Herman, Pietinen, Pirjo, Tiitinen, Aila, and Ylikorkala, Olavi. A randomized placebo-controlled crossover trial with phytoestrogens in treatment of menopause in breast cancer patients. *Obstetrics and gynecology* 2003. 101 (6): 1213-1220.

Other – does not examine the effect of the intervention on hot flashes (n=1)

Schmidt, Martina E., Wiskemann, Joachim, Schneeweiss, Andreas, Potthoff, Karin, Ulrich, Cornelia M., and Steindorf, Karen. Determinants of physical, affective, and cognitive fatigue during breast cancer therapy and 12 months follow-up. *International Journal of Cancer* 2018. 142 (6): 1148-1157.

Appendix 6: Reporting of Outcomes by Study

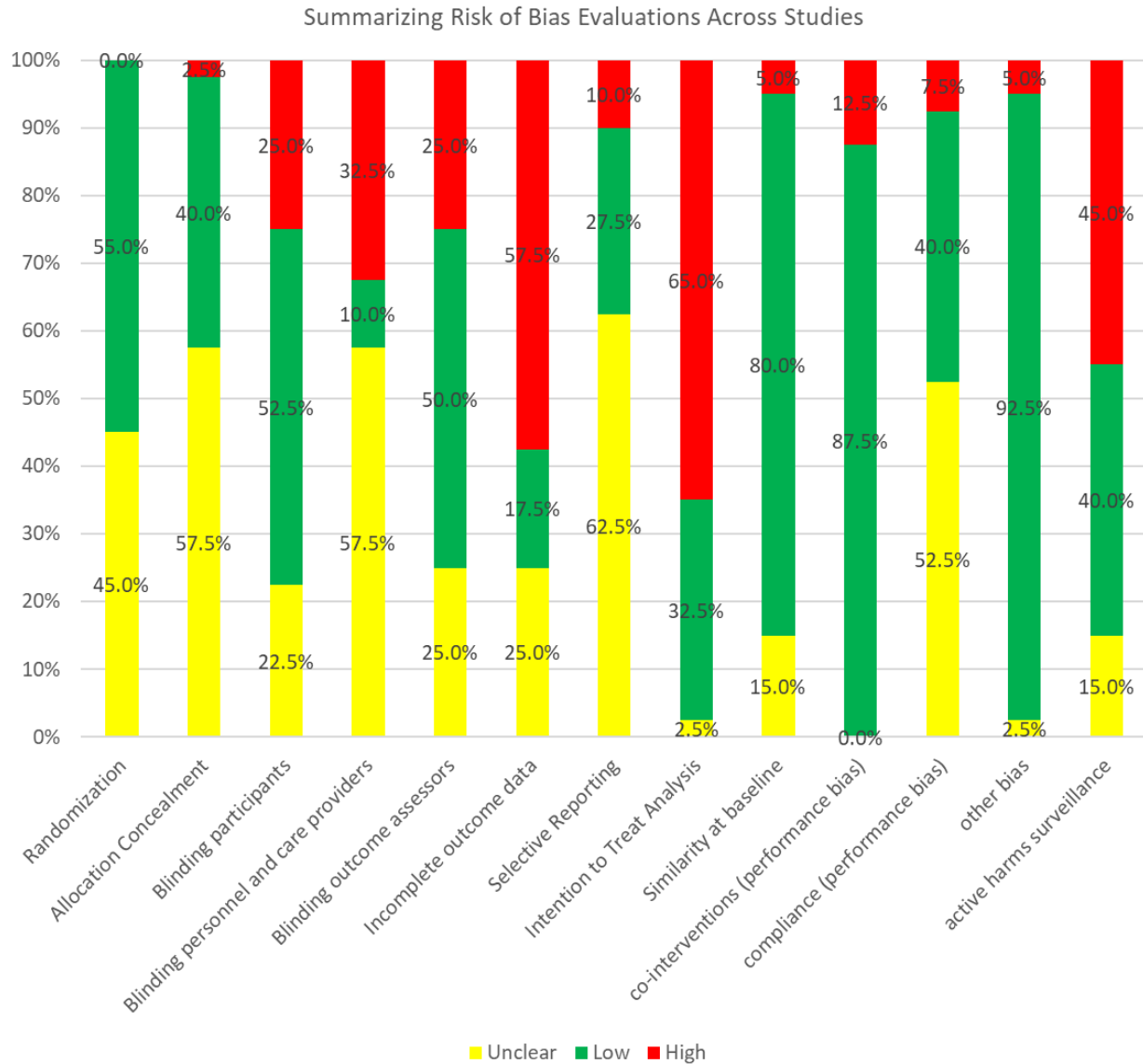
Entries of 'X' are shown to reflect where studies have reported the outcome noted within the header row of each column.

Study	Year	Changes in Patients' Hot Flash Experience			Quality of Life Measures			
		Severity?	Frequency?	Composite (S x F)?	General HR QoL?	Sleep-related?	Depression-related	Sexual function related?
Biglia	2016		X	X			X	
Lesi	2016			X				
Stefanopoulou	2015		X		X		X	
Mao	2015		X	X				
Cramer	2015				X		X	
Chen	2014	X	X	X		X	X	
Bao	2014			X	X	X	X	
Vitolins	2013	X	X	X	X			
Bokmand	2013							
Liljegren	2012		X					
Mann	2012		X			X	X	
Duijts	2012		X		X		X	X
Boekhout	2011			X		X	X	X
Bordeleau	2010	X	X	X	X			
Walker	2010	X	X		X		X	
Loprinzi	2009		X	X	X		X	
Biglia	2009		X	X	X	X		
Wu	2009		X	X	X			
Carson	2009	X	X	X		X		
Frisk	2009		X	X				
Hervik	2009		X					
Elkins	2008		X	X		X	X	
Fenlon	2008	X	X		X			
Loibl	2007	X	X	X				

Study	Year	Changes in Patients' Hot Flash Experience			Quality of Life Measures			
		Severity?	Frequency?	Composite (S x F)?	General HR QoL?	Sleep-related?	Depression-related	Sexual function related?
Deng	2007		X					
Loprinzi	2007		X	X	X			
Kimmick	2006		X	X	X		X	
Nedstrand	2005		X		X			
Stearns	2005		X	X	X	X	X	X
Pandya	2005		X	X				
MacGregor	2005				X			
Hernández Munoz	2003	X						
Van Patten	2002		X	X				
Loprinzi	2002		X	X	X		X	X
Jacobson	2001	X		X	X			
Pandya	2000	X	X	X	X			
Loprinzi	2000		X	X	X		X	X
Quella	2000		X	X				
Fenlon	1999		X					
Barton	1998	X	X	X				

Appendix 7: Findings from Risk of Bias Assessment

An overview of the study risk of bias of the included trials is provided below, followed by a table providing a detailed account of the assessment for each included study. All assessments are based upon the Cochrane Risk of Bias Tool for RCTs (Higgins et al., 2011).



Study	Randomization	Allocation Concealment	Blinding participants	Blinding personnel and care providers	Blinding outcome assessors	Incomplete outcome data	Selective Reporting	Intention to Treat Analysis	Similarity at baseline	co-int (performance bias)	compliance (perf bias)	other bias	active harms surveillance	Overall judgment for efficacy and harms endpoints
Loprinzi (2009)	Green	Green	Green	Green	Red	Yellow	Yellow	Green	Green	Green	Green	Green	Green	Yellow
Bordeleau (2010)	Yellow	Green	Red	Red	Green	Green	Green	Red	Green	Green	Green	Green	Green	Red
Vitolins (2013)	Yellow	Yellow	Green	Yellow	Red	Red	Green	Red	Green	Green	Green	Green	Red	Red
Biglia (2009)	Green	Yellow	Red	Red	Green	Red	Yellow	Red	Green	Green	Yellow	Green	Red	Red
Boekhout (2011)	Yellow	Green	Green	Yellow	Green	Red	Yellow	Red	Green	Green	Yellow	Green	Green	Red
Chen (2014)	Yellow	Green	Green	Yellow	Green	Red	Green	Red	Green	Green	Green	Green	Red	Red
Wu (2009)	Yellow	Yellow	Green	Yellow	Yellow	Yellow	Yellow	Red	Green	Green	Yellow	Green	Green	Red
Carson (2009)	Green	Yellow	Yellow	Green	Green	Green	Yellow	Green	Green	Green	Green	Red	Red	Yellow
Bao (2014)	Green	Red	Green	Green	Red	Red	Green	Red	Green	Green	Yellow	Green	Red	Red
Bokmand (2013)	Yellow	Yellow	Red	Red	Yellow	Green	Green	Green	Green	Red	Yellow	Green	Red	Red
Walker (2010)	Yellow	Yellow	Yellow	Yellow	Green	Red	Yellow	Red	Red	Green	Yellow	Green	Yellow	Red
Frisk (2009)	Yellow	Yellow	Green	Red	Green	Green	Yellow	Red	Yellow	Green	Yellow	Green	Red	Red
Liljegren (2012)	Yellow	Green	Green	Red	Green	Green	Yellow	Red	Green	Green	Green	Green	Red	Red
Loibl (2007)	Green	Green	Green	Yellow	Red	Red	Yellow	Red	Green	Green	Yellow	Green	Green	Red

Study	Randomization	Allocation Concealment	Blinding participants	Blinding personnel and care providers	Blinding outcome assessors	Incomplete outcome data	Selective Reporting	Intention to Treat Analysis	Similarity at baseline	co-int (performance bias)	compliance (perf bias)	other bias	active harms surveillance	Overall judgment for efficacy and harms endpoints
Stefanopoulou (2015)	Green	Yellow	Red	Red	Yellow	Red	Red	Red	Green	Green	Green	Green	Red	Red
Elkins (2008)	Green	Yellow	Yellow	Yellow	Green	Red	Green	Red	Green	Green	Yellow	Green	Red	Red
Deng (2007)	Yellow	Green	Green	Yellow	Yellow	Green	Green	Red	Yellow	Red	Green	Green	Yellow	Red
Fenlon (1999)	Yellow	Green	Yellow	Yellow	Red	Red	Yellow	Red	Yellow	Red	Green	Green	Red	Red
Mao (2015)	Green	Green	Red	Red	Yellow	Red	Green	Green	Green	Green	Green	Green	Green	Red
Fenlon (2008)	Green	Green	Yellow	Yellow	Yellow	Red	Yellow	Red	Green	Red	Red	Green	Red	Red
Mann (2012)	Green	Yellow	Red	Red	Green	Red	Green	Red	Green	Green	Green	Green	Red	Red
Kimmick (2006)	Yellow	Yellow	Green	Yellow	Green	Red	Yellow	Red	Green	Green	Yellow	Green	Green	Red
Hervik (2009)	Yellow	Yellow	Green	Red	Green	Red	Yellow	Red	Green	Green	Yellow	Green	Red	Red
Nedstrand (2005)	Green	Yellow	Green	Yellow	Yellow	Red	Yellow	Red	Green	Green	Yellow	Green	Green	Red
Stearns (2005)	Yellow	Green	Yellow	Yellow	Green	Red	Yellow	Red	Yellow	Green	Red	Green	Red	Red
Pandya (2005)	Green	Yellow	Green	Yellow	Green	Red	Yellow	Red	Green	Green	Yellow	Green	Green	Red
MacGregor (2005)	Green	Yellow	Green	Yellow	Green	Red	Yellow	Red	Red	Red	Yellow	Red	Yellow	Red
Jacobson (2001)	Green	Yellow	Green	Yellow	Yellow	Red	Yellow	Green	Green	Green	Green	Green	Red	Red

Study	Randomization	Allocation Concealment	Blinding participants	Blinding personnel and care providers	Blinding outcome assessors	Incomplete outcome data	Selective Reporting	Intention to Treat Analysis	Similarity at baseline	co-int (performance bias)	compliance (perf bias)	other bias	active harms surveillance	Overall judgment for efficacy and harms endpoints
Barton (1998)	Yellow	Yellow	Yellow	Yellow	Green	Yellow	Yellow	Red	Green	Green	Yellow	Green	Green	Yellow
Van Patten (2002)	Yellow	Yellow	Green	Yellow	Green	Red	Yellow	Red	Green	Green	Green	Green	Yellow	Red
Pandya (2000)	Green	Green	Green	Yellow	Green	Red	Red	Green	Green	Green	Yellow	Green	Green	Red
Loprinzi C (2000)	Green	Green	Green	Green	Red	Yellow	Yellow	Green	Yellow	Green	Yellow	Green	Green	Yellow
Loprinzi C (2007)	Green	Green	Red	Red	Green	Yellow	Yellow	Green	Green	Green	Yellow	Green	Green	Red
Quella (2000)	Green	Yellow	Green	Yellow	Green	Yellow	Yellow	Green	Green	Green	Green	Green	Green	Yellow
Loprinzi C (2002)	Green	Yellow	Green	Green	Red	Yellow	Yellow	Green	Green	Green	Yellow	Green	Green	Yellow
Hernandez Munoz (2003)	Yellow	Yellow	Red	Red	Yellow	Yellow	Yellow	Red	Yellow	Green	Yellow	Green	Yellow	Red
Duijts (2012)	Green	Yellow	Yellow	Yellow	Red	Yellow	Red	Green	Green	Green	Red	Green	Red	Red
Cramer (2015)	Green	Green	Red	Red	Yellow	Green	Green	Green	Green	Green	Green	Green	Red	Red
Biglia (2016)	Yellow	Yellow	Yellow	Yellow	Red	Yellow	Green	Yellow	Green	Green	Green	Yellow	Green	Red
Lesi (2016)	Green	Green	Red	Red	Red	Red	Red	Green	Green	Green	Yellow	Green	Yellow	Red

Appendix 8: Model Fit Statistics from Network Meta-Analyses

Model fit statistics for network meta-analyses related to reductions in hot flash score and hot flash frequency are presented below. As contrast-based models were used to allow for the incorporation of both the absolute measures and the percentages in the estimation of ratios of means, the number of unconstrained data points is equal to the total number of study arms minus the number of comparator arms.

Model	# unconstrained data points	Total residual deviance	Between-study SD (95% CrI)	DIC
Reduction in hot flash score (12 studies)				
RE consistency	20 intervention arms in contrast with 12 comparator arms	20.30	0.20 (0.01 to 0.49)	22.40
RE unrelated means		20.19	0.19 (0.01 to 0.50)	22.58
Reduction in hot flash frequency (11 studies)				
RE consistency	17 intervention arms in contrast with 11 comparator arms	17.76	0.29 (0.04 to 0.66)	20.78
RE unrelated means		17.52	0.34 (0.07 to 0.77)	21.33

Appendix 9: Checking the Consistency Assumption for NMAs

After fitting the RE consistency model and unrelated means model with the same treatment coding assigned to different doses of a regimen, we plotted the posterior mean residual deviance of every contrast (instead of plotting the posterior mean deviance contributions of every arm from an arm-based model) and of every study. In addition to review of model fit statistics (DIC) to assess support for the consistency assumption, plots of deviance residuals were also assessed. These are provided below.

Hot flash score: Loprinzi et al 2000 had three contrasts of different doses of venlafaxine against placebo: venlafaxine 37.5mg/d vs. placebo had smaller residual deviance from the RE consistency model than from the RE unrelated means model, while venlafaxine 75mg/d vs. placebo and venlafaxine 150mg/d vs. placebo had larger residual deviance from the RE consistency model than from the RE unrelated means model (Figure A1). When we plotted posterior mean residual deviance of every study, however, the residual deviance measures of Loprinzi et al 2000 from both models were close. This may relate to the diverse effect sizes reported for different doses of venlafaxine in Loprinzi et al 2000, but not for venlafaxine as a whole. We exercised caution and preferred not to exclude this study.

Hot flash score: As displayed in Figure A2, no severe violation of the consistency assumption had been detected.

Figure A1: posterior mean residual deviance for hot flash score

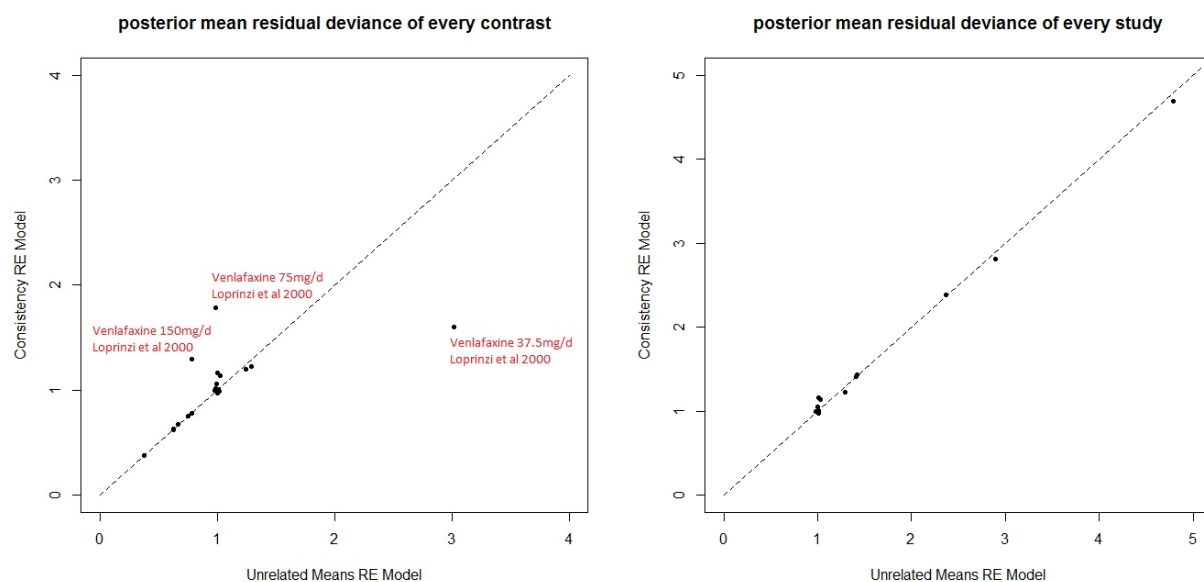
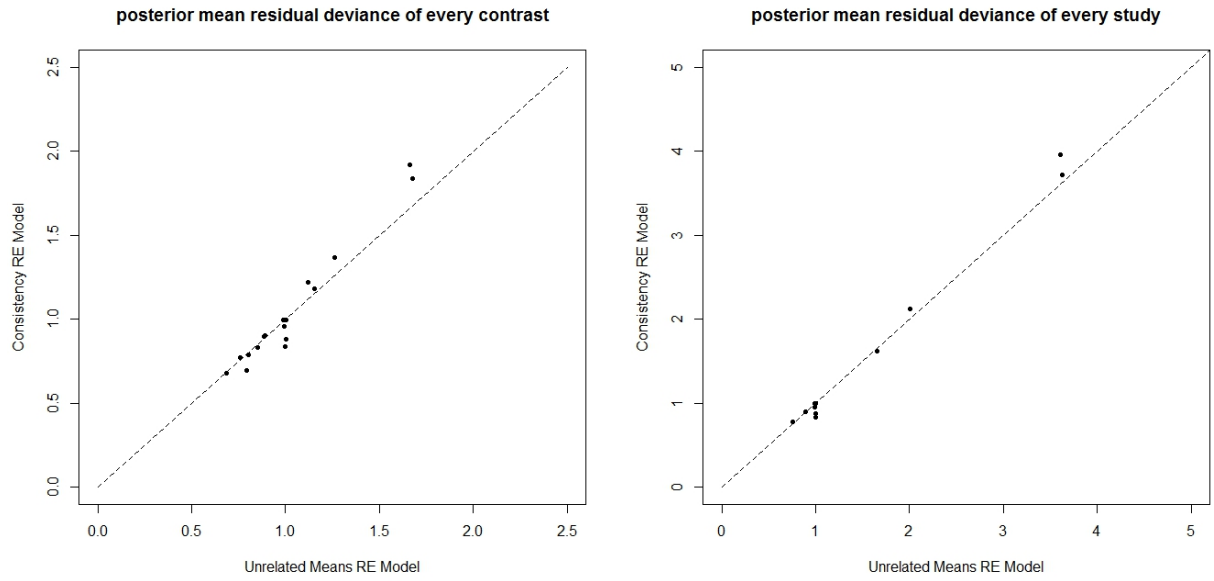


Figure A2: posterior mean residual deviance for hot flash frequency



Appendix 10: Secondary Effect Measures from Network Meta-Analyses

For reductions in hot flash frequency and composite hot flash score, where NMAs were performed, findings from pairwise comparisons were summarized in this review in terms of ratios of means with 95% credible intervals. As is common in applications of NMA, secondary measures of effect were also estimated. The tables below provide numeric details from the random effects model analyses with regard to Surface Under the Cumulative Ranking curve (SUCRA), the probability of each treatment being ranked the best, as well as the mean treatment ranking. For all three parameters, values nearest 1 are indicative of more preferable interventions.

Hot Flash Frequency

Intervention	RE model		
	Mean SUCRA	Mean Pr(best)	Mean Rank
Paroxetine	0.873	0.515	2.02 (1 to 6)
Venlafaxine	0.801	0.188	2.59 (1 to 6)
Gabapentin + AD	0.592	0.086	4.27 (1 to 8)
Sertraline	0.548	0.062	4.61 (1 to 8)
Gabapentin	0.525	0.007	4.80 (2 to 7)
Clonidine	0.518	0.011	4.86 (2 to 8)
Melatonin	0.387	0.13	5.90 (1 to 9)
Placebo	0.224	0	7.21 (5 to 8)
Vitamin E	0.033	0	8.74 (7 to 9)

Composite Hot Flash Score

Intervention	RE model		
	Mean SUCRA	Mean Pr(best)	Mean Rank
Paroxetine	0.872	0.484	2.28 (1 to 7)
Clonidine	0.760	0.110	3.40 (1 to 8)
Electro Acupuncture	0.733	0.138	3.67 (1 to 8)
Venlafaxine	0.589	0.013	5.11 (2 to 9)
Sham Acupuncture	0.569	0.031	5.31 (1 to 9)
Sertraline	0.539	0.052	5.61 (1 to 10)
Gabapentin	0.451	0.001	6.49 (3 to 9)
Gabapentin + AD	0.424	0.021	6.76 (2 to 10)
Melatonin	0.336	0.150	7.64 (1 to 11)
Placebo	0.212	0	8.88 (7 to 10)
Vitamin E	0.016	0	10.84 (10 to 11)

Appendix 11: Summary of Findings, Narrative Summary of A Priori Outcomes and Tolerability

For studies that could not be included in meta-analyses or network meta-analyses, a detailed account of their findings was compiled. These summaries are provided below, with one summary table per outcome for each of the following endpoints: hot flash frequency, hot flash severity, hot flash score, generic quality of life, sleep related quality of life, depression related quality of life, sexual dysfunction related quality of life, and harms. These details have been provided in this supplement to maximize completeness and transparency of this systematic review while maintaining readability of the main text. Green cell coloring has been used to denote studies where effective interventions and/or significant differences between treatments were found, while red cell coloring has been used to denote studies where no such difference was identified.

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		
Biglia 2016	Escitalopram (n=30) vs duloxetine (n=28)	In this study, HFF and HFS were self-reported at baseline and following 4 and 12 weeks of treatment. At 12 weeks, the total number of HFs per week decreased 49.8% in the duloxetine group (p=0.003) and in the escitalopram group they decreased 53% (P=0.001). The conclusion stated by the authors was that both escitalopram and duloxetine had similar efficacy for the relief of HFs in survivors of breast cancer.
Mao 2015	Gabapentin (n=28) vs electroacupuncture (n=30) vs sham acupuncture (n=32) vs placebo (n=30)	The study was for 8 weeks with additional evaluation at week 24 for durability of treatment effects. The mean (SD) daily frequency at baseline for electroacupuncture was 8.3 (5.6), and 6.3 (2.8) for the related sham group; the mean (SD) for the placebo gabapentin arm was 8.1 (5.4), while the related value for the gabapentin group was 6.8 (3.3). The authors concluded that acupuncture produced larger placebo and smaller nocebo effects than did pills for the treatment of hot flashes, however detailed data with regard to frequency were not reported. It was noted that electroacupuncture may be more effective than gabapentin with fewer adverse effects for HF management.
Vitolins 2013	Placebo pill + milk protein powder (n=30) Venlafaxine + milk protein powder (n=30) vs placebo pill + soy (n=30) vs	This study was for 12 weeks. Hot flashes were less frequent in the venlafaxine group in the initial 2 weeks of the study, but this early difference was not sustained at 12 weeks. No difference was noted between the soy and placebo groups throughout the study. The conclusion stated in by the authors was that neither soy nor venlafaxine effectively treated hot flashes over the 12-week study period. They noted the need for additional research for treatment of hot flashes in men with prostate cancer.

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
	venlafaxine + soy (n=30)	
Bordeleau 2010	Gabapentin vs venlafaxine; n=66 overall; crossover study	This was a cross-over trial with 2-4 weeks in between study periods. The authors reported that with regard to hot flash frequency, the ratio of venlafaxine compared to gabapentin was 0.94 (95% CI not reported, but the p-value was reported to be >0.61). The authors also reported that 38 of 56 patients completing the study preferred venlafaxine over gabapentin; amongst them, 84.2% felt the frequency of hot flashes was reduced with venlafaxine. The authors concluded that breast cancer survivors prefer venlafaxine over gabapentin for treating hot flashes.
Loprinzi 2002	Fluoxetine vs placebo; n=81 overall; crossover study	The first study period was 5 weeks followed by a second (cross-over) 4-week period. Findings include a decrease in hot flash frequency for patients in the fluoxetine group (3.4 HF per day, 42% decrease) and in the placebo group (2.5 HF per day, 31% decrease) (P=0.54). The conclusion stated by the authors was that the dose of fluoxetine studied resulted in a modest improvement in hot flashes. The authors concluded that this dose of fluoxetine resulted in a modest improvement in hot flashes.
Comparisons Involving Non-Pharmacologics		
Stefanopoulou 2015	CBT (n=33) vs usual care (n=35) (prostate cancer study)	The CBT intervention included a booklet, CD plus telephone contact during a 4-week period. Validated self-report questionnaires were completed at baseline, 6 weeks and 32 weeks after randomisation. There was a significant difference between groups in incidence of weekly HFNS (hot flashes with night sweats) at 6 weeks, with greater reductions from baseline observed in the CBT group compared to the usual care group (adjusted mean difference -12.12, 95% CI -22.39 to -1.84; p =0.02); the corresponding value at 32 weeks was -12.43 (95% CI -28.38 to +3.52). For HF (without night sweats), the adjusted mean differences did not reach statistical significance at either 6 (-4.97, 95% CI -13.09 to 3.14) or 32 weeks (-12.80, 95% CI -25.21 to -3.86). The authors concluded that guided self-help CBT appears to be a safe and effective brief treatment for men who have problematic HFNS following prostate cancer treatments.
Duijts 2012	CBT+exercise (n=106) vs CBT	Self-report questionnaires were completed by patients at baseline, 12 weeks, and 6 months. Findings from intention to treat analyses based on overall model effects

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
	(n=109) vs exercise (n=104) vs waitlist (n=103)	indicated statistically significant differences between groups in improvement over time for endocrine symptoms and perceived burden of HFs and night sweats, but not for frequency ratings of HFNS (hot flashes with night sweats).
Liljegren 2012	Acupuncture (n=42) vs sham acupuncture (n=42)	Patients received treatment twice weekly for a duration of 5 weeks. The reductions in frequencies of HFs reached statistical significance at week 6 in both the acupuncture (from baseline mean (SD) 8.4 (5.5) to 5.7 (4.1) at 6 weeks) and sham acupuncture (from baseline 7.1 (4.4) to 4.5 (3.7) at 6 weeks) groups; however, the difference between groups was not statistically significant (mean difference 1.2, 95% CI -0.7 to 3.0; p=0.21).
Mann 2012	CBT (n=47) vs usual care (n=49)	The CBT intervention included a 90-minute group CBT session every week for 6 weeks. Assessments were done at baseline, 9 weeks, and 26 weeks after randomisation. HFNS (hot flashes with night sweats) frequency was measured with the HFNS frequency subscale (total number of HFNS reported in the past week) of the Hot Flush Rating Scale. No statistically significant differences in HFNS frequency, HF frequency and NS frequency subscales were identified at 9 weeks or 26 weeks. Compared with baseline, both groups reported non-significantly fewer HFNS at 9 weeks (21% reduction in the CBT group and 24% reduction in the usual care group) and 26 weeks (38% reduction in both groups). There was little change in 24hr rate of HFNS at 9 weeks. The authors concluded that CBT and usual care resulted in a 38% reduction in HFNS frequency compared with baseline values.
Carson 2009	Yoga (n=17) vs waitlist (n=20)	Study participants were enrolled in an 8-week yoga program or to wait-list control. Daily reports of hot flashes at baseline, post treatment, and 3 months after treatment were captured via an interactive telephone system. Patients' average daily frequency of hot flashes at baseline were 4.40 in the yoga group (range 1.56 to 8.64) and 4.27 (range 1.21 to 8.71) in the control group. Analyses conducted both after completion of treatment (Yoga from daily mean HF frequency 4.44 to 3.73 versus waitlist from 4.29 to 4.40) as well as 3 months later (Yoga from daily mean HF frequency 4.46 to 3.19 versus waitlist from 4.34 to 4.42) identified statistically significant reductions in HF frequency with yoga compared to control.

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Frisk 2009	Acupuncture (n=16) vs electroacupuncture (n=15)	There was no significant difference between the acupuncture and electroacupuncture groups over time ($p=0.25$; ANOVA), however, hot flushes did decrease significantly in both groups and remained decreased at all time points, except for 12 months. The differences in hot flushes per 24 hours decreased from a median of 7.6 at baseline to 4.1 at 12 weeks in the electroacupuncture group and from a median of 5.7 to 3.4 at 12 weeks in the acupuncture group ($p=0.001$). The authors concluded that both electroacupuncture and acupuncture lowered number of HFs.
Hervik 2009	Acupuncture (n=30) vs sham acupuncture (n=29)	Patients were provided with twice weekly acupuncture or sham acupuncture for the first 5 weeks, and subsequently once per week for the next 5 weeks. Daytime HFs were significantly reduced in the acupuncture group (from baseline mean (SD) 9.5 (4.9) to 4.7 (3.7) at 10 weeks, which further reduced to 3.2 (2.2) over the next 12 weeks), while no significant change was seen within the sham acupuncture group (from baseline mean (SD) 12.3 (7.3) to 11.7 (8.5) at 10 weeks, which increased back to 12.1 (8.3) over the next 12 weeks). Similar patterns were reported for nighttime HFs. The difference in acupuncture versus sham acupuncture was statistically significant for both daytime and nighttime HFs.
Elkins 2008	Hypnosis (n=30) vs waitlist (n=30)	There were 5 weeks of sessions, with follow-up focused on HF frequency at baseline and post-test. ANCOVAs (using pre-test HF frequency as a covariate) identified a statistically significant improvement for the hypnosis group compared with the control group (detailed data not reported). The authors concluded that hypnosis appears to reduce perceived hot flashes in breast cancer survivors and may have additional benefits such as reduced anxiety and depression, and improved sleep.
Fenlon 2008	Relaxation (n=74) vs no treatment (n=76)	At baseline, there were median (IQR) numbers of flashes per week of 31.5 (20-45) in the relaxation group and 37 (IQR 20-81) in the control group. After the one-month study period, there was a median improvement of seven flashes per week compared to an improvement of 1 in the control group (median difference in improvement 7, 95% CI 4 to 11; $p<0.001$). After three months, the corresponding improvements were 11 and 4, respectively (median difference in improvement 5, 95% CI 0-10; $p=0.06$). The authors concluded the study showed a small but significant reduction in the incidence of HF with relaxation.

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Deng 2007	Acupuncture (n=42) vs sham acupuncture (n=30)	The protocol included twice weekly treatments for 4 weeks with evaluations at baseline, 6 weeks and 6 months. Patients in the sham group were crossed over to acupuncture at week 7. At week 6 no difference was noted between groups (95% CI, -0.7 to 2.4; p=0.3). At week 12 HFF reduced from 7.3 to 5.4 and treatment improvements were sustained at 6 months. Although HFF was reduced following acupuncture the reduction was not statistically significant.
Nedstrand 2005	Relaxation (n=19) vs electroacupuncture (n=19)	This was a 12-week study comparing relaxation therapy with electroacupuncture. The number of daily HFs was registered in a logbook before and during treatment and after 3 and 6 months of follow-up. For the outcome of HFF, after an initial, statistically significant improvement was seen at 4 weeks, no long-term decreases were seen at 6 months. The conclusion of the authors was that additional research is needed on relaxation and electroacupuncture for treatment of hot flashes.
Van Patten 2002	Soy (n=59) vs placebo (n=64)	This study included a 4-week lead-in phase and 12-week treatment phase involving assignment to a soy or placebo beverage. There were no statistically significant differences between the soy and placebo groups in the mean reductions of daytime (-1.2 soy vs -1.8 placebo), night time (-0.5 soy vs -0.7 placebo) or 24-hr (-1.8 soy vs -2.5 placebo) HFs; however, presumably because of a strong placebo effect, both groups had significant reductions in hot flashes. The authors concluded that the soy beverage did not alleviate HFs any more than placebo.
Quella 2000	Soy (n=88) vs Placebo (n=88) (crossover trial)	This study compared soy tablets to placebo. Following a 1-week lead-in patients received 4 weeks of soy followed by 4 weeks of placebo or the opposite schedule. The study was double blinded and patients self-reported HFF, hot flash intensity and side effects. Among patients receiving placebo, 36% reported that HF frequency was halved, compared with only 24% of patients receiving soy (P =0.01). The authors concluded that the soy product did not alleviate HFs in breast cancer survivors.
Fenlon 1999	Relaxation (n=8) vs no trt (n=8)	The study was for one month and the median was 1-year post treatment with a range of 3 months to 5 years. When comparing the change in hot flushes between the two groups, there appeared to be a trend to reduce both the frequency of hot flushes and associated distress, but none of these differences were shown to be significant. There was an apparent increase in the amount of hot flushes and distress factor in the control

Hot Flash Frequency: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		group. This was not statistically significant. The authors concluded that a trend was seen for HF's and night sweats to be reduced, but the results did not achieve significance.
Barton 1998	Vitamin E (n=54) vs placebo (n=50) (crossover trial)	This study compared vitamin E 800 IU to placebo. Following a 1-week lead-in, patients received 4 weeks of vitamin E followed by 4 weeks of placebo or the opposite schedule. At the first check at 4 weeks, no difference was found between interventions (decrease of 25% with vitamin E compared with 22% decrease with placebo, p=.90). Incorporating the second study period, a small but statistically significant advantage favouring Vitamin E was noted (suggesting approximately 1 less HF per day). The authors noted that while a significant reduction in HF frequency was seen with vitamin E, clinical relevance was small.

Hot Flash Score: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		
Biglia 2016	Escitalopram (n=30) vs duloxetine (n=28)	HF score was assessed at both 4 and 12 weeks of treatment. At the end of the study period, the decrease in weekly HF score was 53.6% in the duloxetine group (P=0.003) and 60.4% in the escitalopram group (P=0.001). While both groups demonstrated a significant reduction from baseline, the difference between interventions was not statistically significant. The authors concluded that their data showed that a 12-week treatment both with escitalopram and duloxetine is effective for HF management.
Boekhout 2011	Venlafaxine (n=41) vs clonidine (n=41) vs placebo (n=20)	Daily HF score was calculated as the sum of HF severity values experienced in a given day. At 12 weeks, venlafaxine and clonidine were both associated with lower median HF scores compared to placebo; the median (IQR) scores for the 3 groups were as follows: Placebo - median 10.9, IQR 7.4-15.8; Clonidine: median 7.5, IQR 2.0-10.8; Venlafaxine: median 7.6, IQR 4.0-110.4. It was also noted that when considering the entire 12-week study period, HF score reduction was greater overall with venlafaxine than clonidine due to an earlier start of benefits during the 12-week

Hot Flash Score: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		period. The study authors concluded that venlafaxine and clonidine are effective treatments in the management of HFs.
Bordeleau 2010	Gabapentin vs venlafaxine (n=66 overall; crossover trial)	Daily HF score was assessed as average HF severity that day x frequency of HFs that day. Treatment periods lasted 4 weeks, with 2-4 weeks washout in between. Findings performed to compare the intervention groups using a mixed modeling approach identified a venlafaxine to gabapentin ratio of 0.96 (near 1), suggesting little difference between intervention groups (p value >0.61); both groups were noted to have important reductions from baseline (from week 2 mean (SD) 18.7 (23.2) to 5.7 (4.6) for venlafaxine in the first study period; from 18.6 (15.4) to 6.5 (8.3) in the gabapentin group). Analyses were also performed to compare groups as based upon patients' preferred treatment; those that preferred venlafaxine (n=38) were reported to experience scores 41% lower, while those that preferred gabapentin (n=18) were reported to experience scores 47% lower.
Frisk 2009	Acupuncture (n=13) vs electroacupuncture (n=11) (prostate cancer trial)	Daily HF distress calculated by summing individual HF distress (scored from 0-10). After 52 weeks of treatment, mean daily HF distress changed from baseline median 7.6 (IQR 4.7-8.3) to median 4.3 (IQR) 1.3 – 7.7 in the acupuncture group and from baseline median 8.2 (IQR 6.5-10.7) to median 5.5 (IQR 3.8-6.9) in the electroacupuncture group (p=0.65 between groups).
Loprinzi 2002	Fluoxetine vs placebo (n=81 total; crossover trial)	In the first study period, HF scores decreased by a median of 4.7 units per day (36%) for those on placebo and by 6.4 units per day (50%) in those receiving fluoxetine, and the difference was not statistically significant between groups (P = 0.35). Subsequent cross-over analyses identified a significantly greater reduction with fluoxetine. The authors concluded that fluoxetine was associated with a modest improvement in HF score.
Comparisons Involving Non-Pharmacologies		
Lesi 2016	Acupuncture + enhanced self-care (n=85) vs enhanced self-care (n=105)	The HF score was calculated by multiplying the mean number of daily hot flashes that occurred during the week before assessment by the mean daily severity (1, mild; 2, moderate; 3, severe). After having comparable mean HF scores at baseline, the HF score at week 12 was higher in the enhanced self group (mean (SD) 22.70 (19.40)) than in the acupuncture + enhanced self-care group (11.34 (14.75); p<0.001 for the

Hot Flash Score: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		between-group difference of -11.36, 95% CI -16.39 to -6.33). Similar mean differences favoring the acupuncture + enhanced self-care group were seen at both 3-month (-7.86, 95% CI -12.99 to -2.73) and 6-month follow-up (-8.82, 95% CI -14.04 to -3.61). The authors concluded that acupuncture in association with enhanced self-care is an effective integrative intervention for managing HFs.
Bao 2014	Acupuncture (n=25) vs sham acupuncture (n=26)	HF score was determined using a 100-point visual analog scale (VAS) ≥ 20 . The study presents comparison of median (IQR) scores between groups after 8 weeks of treatment. The change in the sham acupuncture group wasn't statistically significant (from median (IQR) 20.5 (54.75) to 10 (47.25)), while the change in the acupuncture group was significant (from median (IQR) 31 (67) to 14 (32.5)); the comparison of change between groups was not statistically significant (p=0.56). The authors reported no important differences between interventions.
Vitolins 2013	Venlafaxine+soy protein (n=30) vs venlafaxine+milk protein (n=30) vs soy protein (n=30) vs milk protein (n=30) (prostate cancer trial)	The study reported that there were no statistically significant differences between the soy and placebo arms at any time, and although participants in the venlafaxine arm tended to have fewer hot flashes during the initial 2 weeks, this early difference had disappeared by 12 weeks; mean (SD) 12-week HF score values were as follows: venlafaxine + soy protein – 11.2 (10.9); venlafaxine + milk protein – 9.2 (7.2); placebo + soy protein – 13.6 (15.3); placebo + milk protein – 9.3 (8.5). The authors concluded that in androgen-deprived men, neither venlafaxine nor soy proved effective in reducing HFs.
Carson 2009	Yoga (n=17) vs waitlist control (n=17)	Statistically significant improvements in the yoga group both post-treatment (yoga group: from mean score change 20.92 to 14.46 vs control group: mean score change from 23.01 to 25.81) and at 3-month follow-up. This pilot study provides promising support for the beneficial effects of a comprehensive yoga program for management of HFs and other menopausal symptoms.
Elkins 2008	Hypnosis (n=30) vs waitlist control (n=30)	The authors used the Hot Flash Related Daily Interference Scale, based upon HF frequency and severity. Patients in the hypnosis group demonstrated statistically significantly better improvement in HF score (from baseline mean (SD) 15.05 (13.75) to 4.84 (5.02)) compared to those in the control group (from baseline mean (SD) 17.17

Hot Flash Score: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		(10.37) to 15.60 (10.71); $p < .001$). The authors concluded that hypnosis appears to reduce HFs in breast cancer survivors.
Van Patten 2002	Soy (n=78) vs placebo (n=79)	HF score was assessed according to: [hot flash frequency x severity for day] + [hot flash frequency x severity for night] for 24 hours. The study reported there were no differences in hot flash related outcomes between groups: during the final 4 weeks of treatment, comparable changes from baseline in the soy group (mean (SD) change from baseline 18.0 (13.9) to final value 12.6 (13.4)) and placebo groups (mean (SD) change from baseline 18.9 (18.9) to final value 11.4 (11.3)) were observed.
Jacobson 2001	Black cohosh (n=42) vs placebo (n=43)	The HF score used was unclear in the study report. After 9 weeks, the HF score changed from baseline median 53.2 (IQR 25.3-71.3) to 31.0 (IQR 18.3-77.0) in the black cohosh group and from median 52.5 (IQR 28.9-93.0) to median 24.6 (IQR 16.4-64) in the placebo group; the difference was noted as not statistically significant, but no other data were provided.
Quella 2000	Soy (n=87) vs placebo (n=88)	Patients averaged approximately seven HFs per day during the baseline study week (SD 54.5), with an average HF score of 13 points (SD 59.0). The totals of patients reporting reductions in HF score of <25%, 25-50% and >50% were 44%, 21% and 35% in the soy group and 40%, 22% and 38% in the placebo group, respectively. The authors concluded that the available data strongly suggest that soy phytoestrogens do not substantially reduce HFs when compared with placebo
Barton 1998	Vitamin E vs placebo (n=104 total; crossover trial)	HF score was calculated as the product of frequency x severity. After the first 4 weeks of therapy, the HF score decreased by 28% with vitamin E and 20% with placebo ($P = 0.68$). During the second treatment period, the mean hot-flash scores decreased by 0.03% and 25% in the placebo group and vitamin E group ($P=0.24$), respectively. A subsequent analysis encompassing the full crossover design suggested the presence of a small but statistically significant advantage of vitamin E over placebo.

Hot Flash Severity: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		

Hot Flash Severity: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Bordeleau 2010	Gabapentin vs venlafaxine (n=66 overall; crossover trial)	HF severity was assessed as 1=mild, 2=moderate, 3=severe, 4=severe, and were averaged per day. Study treatment periods lasted 4 weeks, with 2-4 weeks washout in between. Findings performed to compare the intervention groups using a mixed modeling approach identified a venlafaxine to gabapentin ratio of 1.02 (near 1), suggesting little difference between intervention groups (p value >0.61). Analyses were also performed to compare groups as based upon patients' preferred treatment; amongst those that preferred venlafaxine (n=38), 94.7% reported decreased HF severity, while amongst those that preferred gabapentin (n=18), 94.4% reported decreased HF severity.
Walker 2010	Venlafaxine (n=25) vs acupuncture (n=25)	Treatments were provided for 12 weeks, with outcomes measured up to 1 year post-treatment. The study reported that ANOVA analysis of patient data over time found no important differences between intervention groups with regard to changes in HF severity (p>0.05; detailed numeric data are not reported). Both groups experienced some improvement, with a subsequent return toward baseline values after the end of treatment. The authors suggested acupuncture may offer similar benefits as venlafaxine, with better tolerability.
Loibl 2007	Clonidine (n=40) vs venlafaxine (n=40)	The duration of this study was 4 weeks of treatment. HF severity was scored as 1=mild, 2=moderate, 3=severe, 4=very severe. The mean HF severity at baseline week was 2.1 for clonidine and 1.9 for venlafaxine with a P-value of 0.78. Findings for this outcome are not clearly reported in the study report. Author conclusions appear to suggest benefits of venlafaxine over clonidine for reduction of HF frequency, but not HF severity.
Pandya 2000	Clonidine (n=99) vs placebo (n=99)	The study included a 1-week baseline period and follow-up at 4, 8 and 12 weeks; HFs were scored as 1=mild, 2=moderate, 3=severe, 4=very severe). Mean (SE) severity grades at baseline were 2.2 (0.1) and 2.1 (0.1) in the clonidine and placebo groups, respectively. The study reported % changes from these baseline values; median reductions of -11.7%, -17.3% and -9.3% were reported at 4, 8 and 12 weeks in the clonidine group while corresponding values of -8.5%, -10.5% and -8.3% were observed with placebo. None of the differences reached statistical significance.
Non-Pharmacologic Interventions		

Hot Flash Severity: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Chen 2014	Melatonin (n=48) vs placebo (n=47)	The study duration was 4 months, and HF severity was scored as 1=mild, 2=moderate, 3=severe, 4=very severe. The study denotes that there were no statistically significant differences between the groups with regard to changes in the numbers of mild, moderate and severe HFs experienced.
Vitolins 2013	Placebo pill + milk protein powder (n=30) Venlafaxine + milk protein powder (n=30) vs placebo pill + soy (n=30) vs venlafaxine + soy (n=30) (prostate cancer study)	The duration reported findings at 4, 8 and 12 weeks; HF severity was scored as 1=mild, 2=moderate and 3=severe. There were no significant differences in the comparison of soy and placebo at any time point. The venlafaxine arm tended to have lower HF severity values at weeks 1, 2, 3, and 4, though the difference was not significant at 12 weeks.
Carson 2009	Yoga (n=17) vs waitlist control (n=20)	The study lasted 8 weeks and included a 3-month follow-up; HF severity was scored on a scale from 0-9 (higher scores denoting higher severity). Findings identified significant improvements with yoga compared to the control group in daily HF severity (as well as frequency and score); in the yoga group, mean score improved from 4.16 to 3.21 post-treatment, while mean score in the control group shifted from 4.67 to 4.41 ($p < 0.01$ for the difference between groups). Similar values were also observed 3 months after treatment. The authors suggested the study provides promising support for the beneficial effects of a comprehensive yoga program for HFs and other menopausal symptoms.
Fenlon 2008	Relaxation (n=74) vs no trt (n=76)	The study occurred over one month. The severity of HFs, as recorded by diaries, significantly declined over one month in the relaxation group compared with the control group ($P < 0.01$). The authors concluded the study showed a small, but statistically significant reduction in the incidence and severity of HFs associated with relaxation therapy.
Hernandez Munoz 2003	Black cohosh (90) vs usual care (46)	Patients were compared in terms of the % free of hot flashes, % still having moderate hot flashes (a few episodes of heat with discrete sweating), and % still having severe hot flashes (>5 or more sudden episodes of heat are experienced during the day,

Hot Flash Severity: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		accompanied by sweating, sleep disturbances, feeling of irritation and anxiety) at study end. At the 52-week conclusion of the study, the proportions of patients who were free of hot flashes/still endured moderate hot flashes/still endured severe hot flashes were different between those receiving black cohosh (46.7%, 28.9%, and 24.4%) compared to usual care (0%, 26.1%, and 73.9%).
Jacobson 2001	Black cohosh (n=42) vs placebo (n=43)	Patients completed HF diaries at 30 and 60 days, with an additional questionnaire at final follow-up. HF severity was scores as 1=mild, 2=moderate, 3=severe. The study notes that both groups experienced a decline in HF severity during the first month of study preparation. The differences between groups in severity at the end of the study were described as not statistically significant, and no additional data were provided.
Barton 1998	Vitamin E vs placebo (n=104 overall; crossover trial)	Diaries were used to measure HF's (including mean daily HF severity) during the baseline week and the two subsequent 4-week treatment periods. The authors suggest there were few to no benefits of Vitamin E for HF severity.

Sleep Function: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		
Boekhout 2011	Venlafaxine (n=41) vs clonidine (n=41) vs placebo (n=20)	The Groningen Sleep Quality Scale (GSQ) was assessed. Sleep quality was not found to differ between the venlafaxine and clonidine intervention groups; no additional data or information was provided.
Biglia 2009	Gabapentin (n=60) vs vitamin E (n=55)	Based on findings from the PSQI, gabapentin demonstrated a statistically significant improvement in sleep quality from baseline; the gabapentin group incurred a mean global PSQI score reduction of 21.33% at twelve weeks and a mean absolute reduction of 1.67 (95% CI 0.90-2.43). The authors note that no significant change from baseline to twelve weeks was observed in women receiving Vitamin E. No numeric data for vitamin E is provided, nor is a statistical comparison between the gabapentin and vitamin E groups.
Stearns 2005	Paroxetine (2 dose levels; 10mg, 20mg)	The MOS Sleep Problems Index was assessed. All three intervention groups (placebo, paroxetine 10mg and paroxetine 20mg) were associated with improvements of at least

Sleep Function: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
	vs placebo (crossover trial, n=151 overall)	10 points in the MOS Sleep Problems Index from baseline, however Paroxetine 10mg was associated with significantly greater improvement compared to placebo.
Comparisons Involving Non-Pharmacologics		
Bao 2014	Acupuncture (n=23) vs sham acupuncture (n=24)	Assessed sleep quality and sleep disturbance using Pittsburgh Sleep Quality Index (PSQI), which has both an overall score and seven domain scores (sleep quality; sleep latency; sleep duration; habitual sleep efficiency; sleep disturbance; use of sleeping medications; daytime dysfunction) which were summed to form a total score out of 21. Comparison of median and IQR scores between groups at 4, 8 and 12 weeks found no differences between acupuncture and sham acupuncture.
Chen 2014	Melatonin (n=48) vs placebo (n=47)	The authors observed significantly improved sleep quality in those taking melatonin compared to placebo in terms of PSQI global score as well as the sleep quality, sleep duration and daytime dysfunction sub-domains.
Mann 2012	CBT (n=47) vs usual care (n=49)	The sleep subscale of the Women's Health Questionnaire (WHQ) was assessed, with values ranging from 0-1 (lower values indicate better sleep). Women receiving CBT were found to demonstrate significantly fewer sleep problems at both 9 weeks (mean difference favouring CBT of -0.26, 95% CI -0.39 to -0.12) and 26 weeks (mean difference favouring CBT of -0.16, 95% CI -0.29 to -0.02) of follow-up compared to the usual care group.
Carson 2009	Yoga (n=17) vs waitlist (n=20)	Measured sleep disturbance on a scale from 0-9 (higher values denoted larger amounts). The yoga group was noted to have incurred significant post-treatment improvement in sleep disturbance compared to the control group (reduction from pre-treatment mean of 3.82 to 3.29 in the yoga group compared to pre- and post-treatment means of 4.21 and 4.37 in the control group; p < 0.01, but no 95% CI reported).
Elkins 2008	Hypnosis (n=27) vs waitlist (n=24)	The Medical Outcomes Study (MOS) Sleep Problems Index was assessed. Hypnosis was associated with an improvement in sleep compared to the control group after five weeks treatment (F-test from an analysis of covariance reported; p < 0.001), as well as in comparison to baseline levels within the group (MOS Sleep Index mean (SD) of 24.26 (8.17) at baseline and 13.71 (4.35) at follow-up).

Depression: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		
Biglia 2016	Duloxetine (n=28) vs escitalopram (n=30)	Both the BDI and MADRS were evaluated. A significant reduction of depression from baseline was observed in both groups after both 4 and 12 weeks, with no important differences identified between treatments. In the duloxetine group, the mean MADRS score changed from 12.9 at baseline to 5.6 after 12 weeks (a 56.6% reduction), and BDI changed from 4.9 to 3.6 in the same time period (a 26.5% reduction). The corresponding changes in the escitalopram group were from 19.4 to 11.1 (a 42.8% reduction) for MADRS and from 8.3 to 6.6 (a 20.5% reduction) for BDI.
Boekhout 2011	Venlafaxine (n=41) vs clonidine (n=41) vs placebo (n=20)	The HADS tool was evaluated. After twelve weeks, depression scores were significantly higher in patients receiving venlafaxine than patients receiving clonidine (p=0.03), suggesting more depression. However, no additional numeric details are provided, and statistical comparisons with the placebo group are not detailed in the study report.
Walker 2010	Venlafaxine (n=25) vs acupuncture (n=25)	The Beck Depression Index Primary Care (BDI-PC) was evaluated. Both the venlafaxine group and the acupuncture group were associated with statistically significant reductions in depression after 12 months. The study report presents no detailed numeric data for changes within either group or the comparison of changes between groups; a figure within the report indicates overlapping confidence intervals at final follow-up, suggesting no statistically significant difference between groups was present. Digitized data from a study figure suggest reductions from 10.1 (SE 0.9) to 8.3 (SE 1.1) and from 12.1 (SE 0.8) to 9.6 (SE 1.1) in the venlafaxine group after twelve months.
Loprinzi 2009	Gabapentin (n=161 across 3 dose groups) vs placebo (n=54)	The POMS-B Scale was evaluated. At 4 weeks, no significant differences were identified between the gabapentin and placebo groups and its subdomains, which included depression/dejection. No additional numeric data are provided in the study report.
Kimmick 2006	Sertraline vs placebo (n=62 overall; crossover study)	The CES-D scale was evaluated. After 12 weeks, mean CES-D score increased in the sertraline group (from 11.2 (SD 9.2) to 12.8 (SD 11.7)) and decreased in the placebo group (from 11.5 (SD 7.9) to 7.9 (SD 6.8)). The study reports no important differences between groups with regard to effects on depression were identified.

Depression: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Stearns 2005	Paroxetine vs placebo (n=151 overall; crossover with 2 paroxetine groups)	The CES-D scale was evaluated. The study authors reported that after five weeks, there were no differences in the percentages of patients in the placebo and paroxetine groups who improved, worsened or stayed the same in terms of depressive symptoms.
Loprinzi 2000	Venlafaxine (n=165 across three dose groups) vs placebo (n=56)	The Beck Depression Inventory was evaluated (once per week for 5 weeks). The study authors reported that at the end of the study, totals of 16/48 (33% (evaluable patients in the placebo group, and corresponding totals of 11/40 (23%), 9/43 (21%) and 13/49 (27%) in the venlafaxine 37.5mg, 75mg and 150mg groups had depression scores consistent with the presence of at least mild depression.
Comparisons Involving Non-Pharmacologies		
Cramer 2015	Yoga (n=19) vs waitlist (n=21)	The HADS Scale was evaluated. No differences between the intervention groups for depression were observed at either 12 weeks (mean difference -0.70, 95% CI -1.7 to 0.3) or 24 weeks (mean difference 0.10, 95% CI -0.80 to 1.0). Changes from baseline were of small magnitude in both groups.
Stefanopoulou 2015	CBT (n=33) vs usual care (n=33)	The Hospital Anxiety and Depression Scale (HADS) was evaluated. No differences between the CBT and usual care groups were observed at either 6 weeks (adjusted mean difference -0.59, 95% CI -1.94 to 0.74) or 32 weeks (adjusted mean difference -0.52, 95% CI -1.15 to 2.20); point estimates favoured the CBT group.
Bao 2014	Acupuncture (n=23) vs sham acupuncture (n=24)	The Center for Epidemiologic Studies Depression (CES-D) Scale was evaluated. After eight weeks, reported median (IQR) changes in both the acupuncture group (reduction from median 16 (IQR of 9) at baseline to median 10 (IQR of 10.5)) and sham acupuncture group (reduction from median 10.5 (IQR of 10) at baseline to 6 (IQR of 11.25)) showed important changes within each group that reached statistical significance, while the difference between groups did not (p=0.44).
Chen 2014	Melatonin (n=48) vs placebo (n=47)	The CES-D Scale was evaluated. There was very little change in depression at four months from baseline in both the melatonin (mean change -0.2 (SD 4.6)) and placebo (mean change 0 (SD 5.4)) groups. No differences with respect to impact on depression were observed (p=0.66).

Depression: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Duijts 2012	CBT+exercise (n=106) vs exercise (n=104) vs CBT (n=109) vs control (n=103)	The HADS tool was evaluated. The authors note that after 6 months of treatment, no important differences in psychological distress/depression were observed between groups. The trial report provided no additional data to detail this summary.
Mann 2012	CBT (n=47) vs usual care (n=49)	The depression subscale of the Women's Health Questionnaire (WHQ) was evaluated. At 26 weeks of follow-up, the reduction in the CBT group (from mean 0.23 (SD 0.16) to mean 0.13 (SD 0.19)) was found to be significantly greater than the change in the usual care group (from mean 0.31 (SD 0.27) to 0.28 (SD 0.26)); mean difference - 0.13, 95% CI -0.22 to -0.05. A very similar difference was also present earlier on, at 9 weeks.
Elkins 2008	Hypnosis (n=27) vs waitlist (n=24)	The CES-D scale was evaluated. Data suggested an important mean reduction in the hypnosis group (from 29.48 (SD 7.72) to 24.58 (SD 6.45)) compared to the waitlist group (from 30.22 (SD 9.32) to 31.38 (SD 9.21)). The difference between groups was statistically significant in favour of the hypnosis group (p<0.01).
Jacobson 2001	Black cohosh (n=42) vs placebo (n=43)	The study reports evaluating changes in several menopausal symptoms, one of which was depression, though further details are not provided with regard to approach to measurement. The article denotes that while symptoms in general improved in both groups, there were no changes that were specifically impacted by treatment.

Sexual Function: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
Comparisons Involving Pharmacologics		
Boekhout 2011	Venlafaxine (n=41) vs clonidine (n=41) vs placebo (n=20)	Looked at changes in the overall Sexual Activity Questionnaire (SAQ). The authors report there were no important differences noted for sexual function between the intervention groups; no detailed numeric data are provided to give further insights.
Stearns 2005	Paroxetine vs placebo (n=151 overall)	Looked at the Medical Outcomes Study (MOS) Sexual Problems Index. The study authors report that the following numbers of patients improved / stayed the same /

Sexual Function: Study Findings		
Study First Author and Year	Treatment Comparison	Findings
		worsened: Placebo = 9 (25%) / 21 (58%) / 6 (17%); Paroxetine 10mg = 3 (20%) / 10 (67%) / 2 (13%); Paroxetine 20mg = 4 (25%) / 7 (44%) / 5 (31%). Thus, there were no important gains associated with paroxetine.
Loprinzi 2002	Fluoxetine vs placebo (n=81 overall)	Looked at libido change based on element 21 of the Beck Depression Index. The study report noted that after five weeks of treatment, totals of 11 patients in the fluoxetine group and 9 in the placebo group had improved libido compared to baseline, while totals of 1 patient in the fluoxetine group and 3 in the placebo group had reduced libido compared to baseline. Fluoxetine thus appeared to offer some gains, though no formal statistical comparisons were performed.
Loprinzi 2000	Venlafaxine (n=165 across three dose groups) vs placebo (n=56)	Looked at libido change based on element 21 of the Beck Depression Index. Improvements in libido were observed in the placebo group as well as patients receiving all doses of venlafaxine, however the authors do not report formal statistical comparisons to establish statistical significance nor clinical relevance of the between-group differences. Numeric values are also unreported, with only a line graph presented (one profile per group).
Comparisons Involving Non-Pharmacologics		
Duijts 2012	CBT+exercise (n=106) vs exercise (n=104) vs CBT (n=109) vs waitlist (n=103)	Looked at both the Habit and Pleasure subscales of the Sexual Activity Questionnaire (SAQ). Data analyses identified a statistically significant improvement in sexual function (SAQ-Habit) in the CBT + exercise group compared to the control group at long-term follow-up (effect size 0.65, p=0.002). Supplemental per protocol analyses also identified important gains in SAQ-Pleasure in the CBT and CBT+exercise groups.

Generic Quality of Life: Findings			
Study First Author and Year	Time of assessment	Treatments compared	Findings
Cramer 2015	24 wks	Waitlist vs yoga	FACT-B was significantly different at 24 weeks in regard to total score (group difference 12.6, 95% CI 4.2 to 21.1 in favour of yoga), as well as the physical

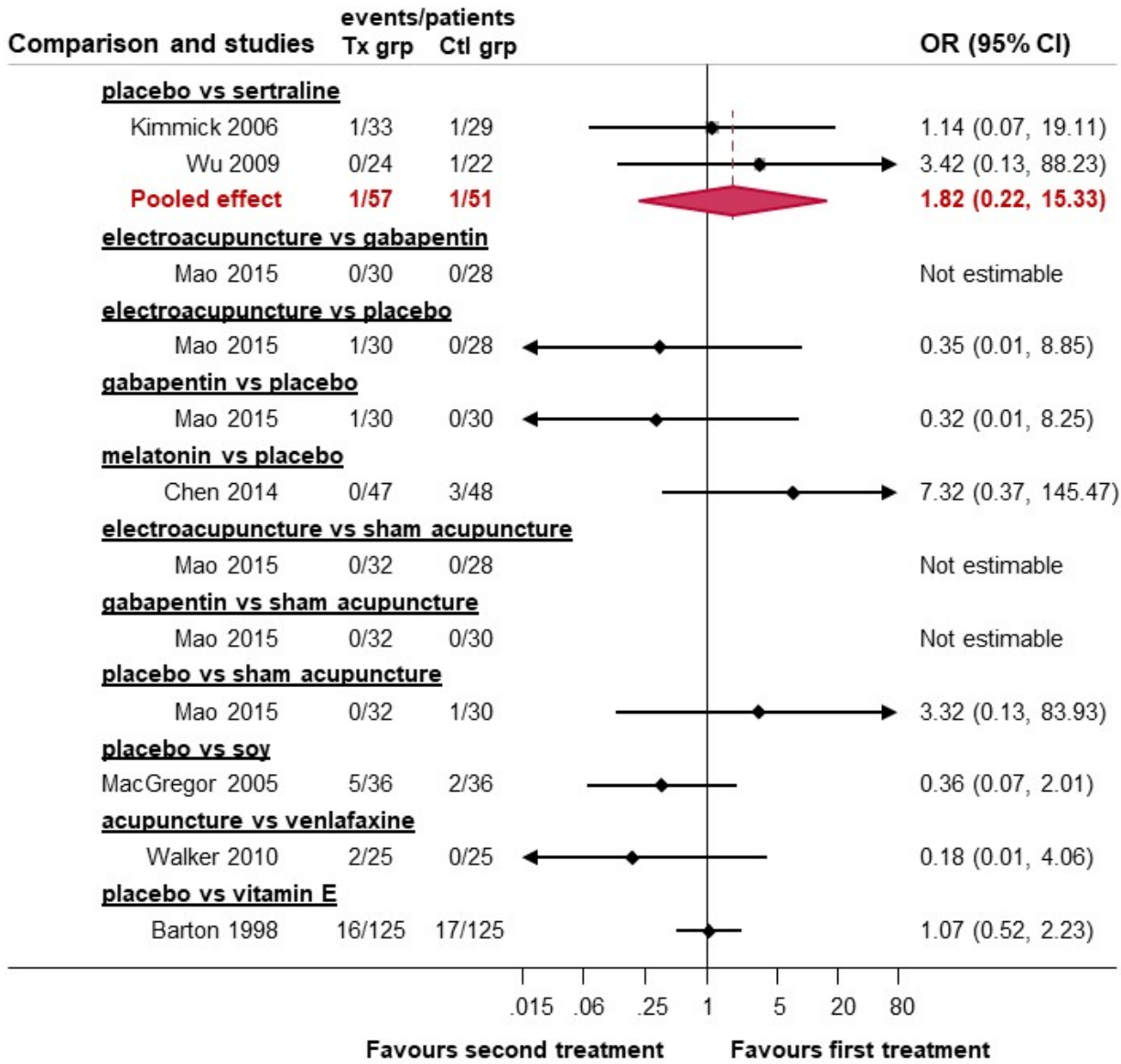
Generic Quality of Life: Findings			
Study First Author and Year	Time of assessment	Treatments compared	Findings
			(between group difference 3.6, 95% CI 0.9 to 6.3 in favour of yoga), social (between group difference 2.6, 95% CI 0.5 to 4.7) and emotional well being (between group difference, 95% CI 1.6, 95% CI 0.1 to 3.1) subscales.
Stefanopoulou 2015	32 wks	Usual care vs CBT	There was no difference in EORTC QLQ-C30 at either 6 weeks (3.61, 95% CI -5.41 to 12.63) or 32 weeks (95% CI -0.97, 95% CI -13.01 to 11.01).
Bao 2014	8 wks	Sham acupuncture vs acupuncture	At 12 weeks, median and IQR values of EuroQoL in both groups were equivalent (median 80, IQR 20).
Vitolins 2013	12 wks	Venlafaxine vs soy	The authors reported there were no significant effects of venlafaxine on FACT-P, FACT-G or subscales (social, emotional, physical, functional, prostate) after twelve weeks of follow-up in both unadjusted and adjusted analyses. In patients receiving soy (compared to those not receiving soy), there were important differences in FACT-G scores, FACT-P scores and in the related emotional and functional domains.
Bordeleau 2010	4 wks	Gabapentin vs venlafaxine	After four weeks, no differences between interventions were observed (detailed data not reported).
Walker 2010	64 wks	Acupuncture vs venlafaxine	There were no significant differences between intervention groups after 12 weeks (numeric details reported only in graphical format)
Biglia 2009	12 wks	Gabapentin vs vitamin E	Analysis of SD-36 data showed that mild improvements in health related quality of life with gabapentin: statistically significant changes were noted in both the mental health (absolute change -8.32, 95% CI -13.78 to -2.86) and physical health (absolute change -6.53, 95% CI -12.12 to -0.92) components. Changes did not reach significance in the Vitamin E group (data not reported).
Wu 2009	6 wks	Placebo vs sertraline	after 6 weeks, emotional well being was associated with a significantly greater improvement in emotional well being compared to placebo (p=0.041), however changes in physical, social/family and functional well being were not significant (all p>0.05). Only 39 of 46 randomized patients were included in the analyses.

Generic Quality of Life: Findings			
Study First Author and Year	Time of assessment	Treatments compared	Findings
Loprinzi 2009	4 wks	Placebo vs gabapentin	Changes in QoL (measured on a 10-point scale) after 4 weeks showed no significant difference between the placebo and gabapentin groups.
Fenlon 2008	13 wks	No trt vs relaxation	Comparison of median change in quality of life measured using the FACT-ES scale found no difference between the relaxation and no treatment groups (median difference 0.12, 95% CI -4.06 to 4.65).
Loprinzi 2007	4 wks	Gabapentin vs gabapentin+antidepressant	The study authors reported that there were no significant differences between groups in changes in linear analog self-assessment quality-of-life measures from baseline to week 4 for overall quality of life (P = .98) or for the related subdomains of mental well-being (P = .27), physical well-being (P = .23), emotional well-being (P = .45), social activity (P = .82), or spiritual well-being (P = .77).
Kimmick 2006	6 wks	Placebo vs sertraline	There were no important differences in changes in quality of life between groups from baseline levels (placebo: mean (SD) 122.1 (14.4) vs sertraline: 119.4 (18.7)) after either 6 weeks (placebo: 120.6 (12.3) vs sertraline: 126.4 (19.7); p=0.32) or 12 weeks (placebo: 124.2 (15.5) vs sertraline: 117.0 (18.5); p=0.88) of follow-up.
MacGregor 2005	12 wks	Placebo vs soy	Comparison of EORTC QLQ30 findings (range 0-100) between groups at 12 weeks found no difference (p=0.844).
Nedstrand 2005	38 wks	Relaxation vs electroacupuncture	There were improvements in psychological well being (as measured by the Symptom Checklist) in both the relaxation and electroacupuncture groups at 12 weeks; the differences between groups were not statistically significant. Statistically significant improvement in mood after 12 weeks was only observed in the electroacupuncture group.
Stearns 2005	4 wks	Placebo vs sertraline	Study authors reported that after 4 weeks, the proportions of patients maintaining and improving their quality of life status based on the EuroQoL linear rating scale were similar in all treatment groups.
Loprinzi 2002	4 wks	Placebo vs fluoxetine	There was insufficient evidence of an importance difference in patients' global rating of health and well being scores (range 0-100) to suggest the presence of an important difference between fluoxetine and placebo.

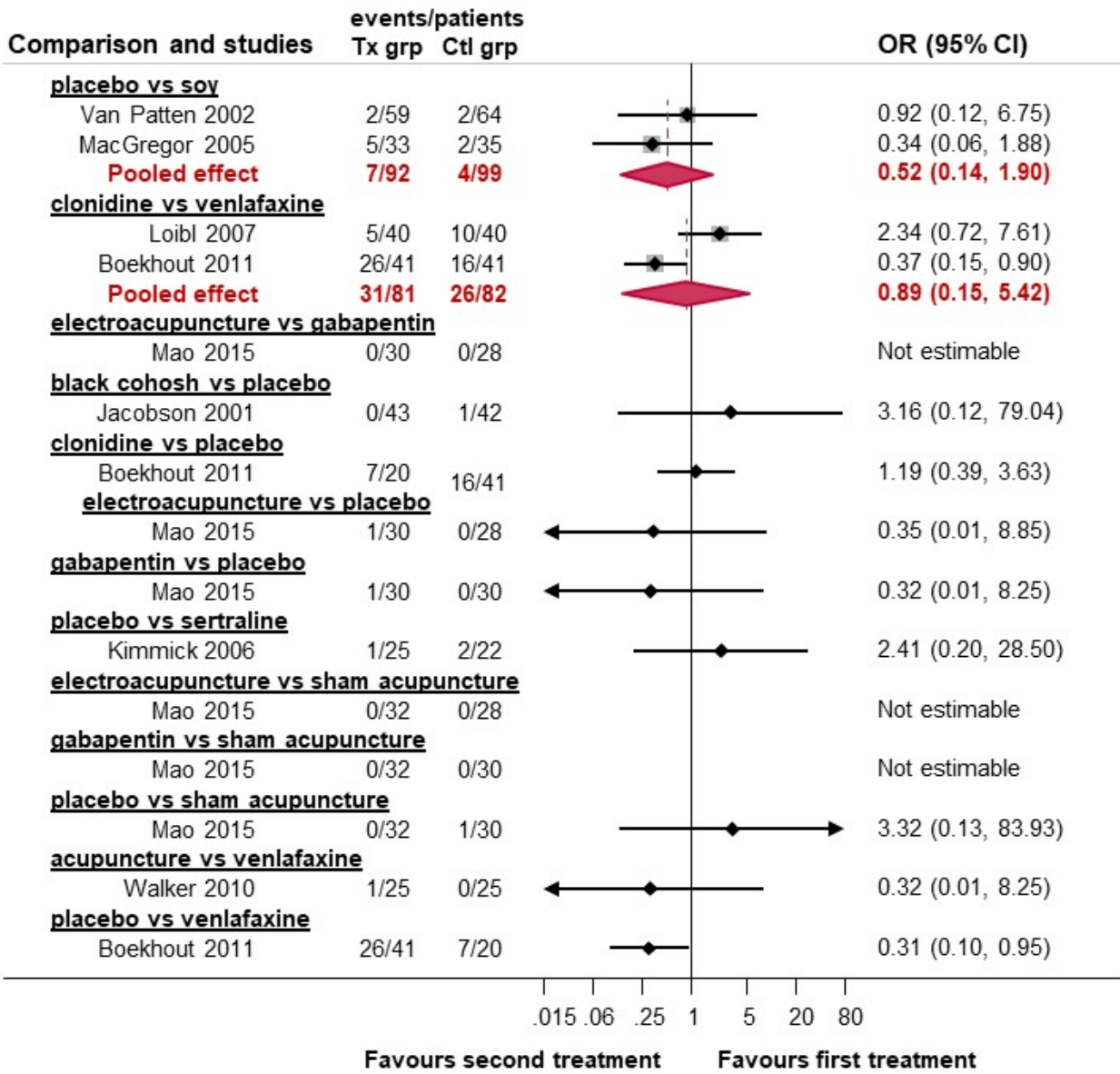
Generic Quality of Life: Findings			
Study First Author and Year	Time of assessment	Treatments compared	Findings
Jacobson 2001	9 wks	Placebo vs black cohosh	The authors reported that there were no important changes in the global rating of health and well being in either treatment group (additional data were not provided).
Loprinzi 2000	4 wks	Placebo vs venlafaxine	Based upon a single item quality of life question, after 4 weeks the study authors observed an average 3-point improvement in the venlafaxine groups and a 3-point reduction in the placebo group (p=0.02) based upon a single-item QoL tool.
Pandya 2000	12 wks	Placebo vs clonidine	Based on quality of life assessments rated on a scale from 1-10, differences after 4 and 8 weeks of follow-up showed a statistically significant difference between groups favoring clonidine over placebo. At 12 weeks, the difference was no longer statistically significant.

Tolerability Data: Constipation, Headache, Fatigue, Nausea

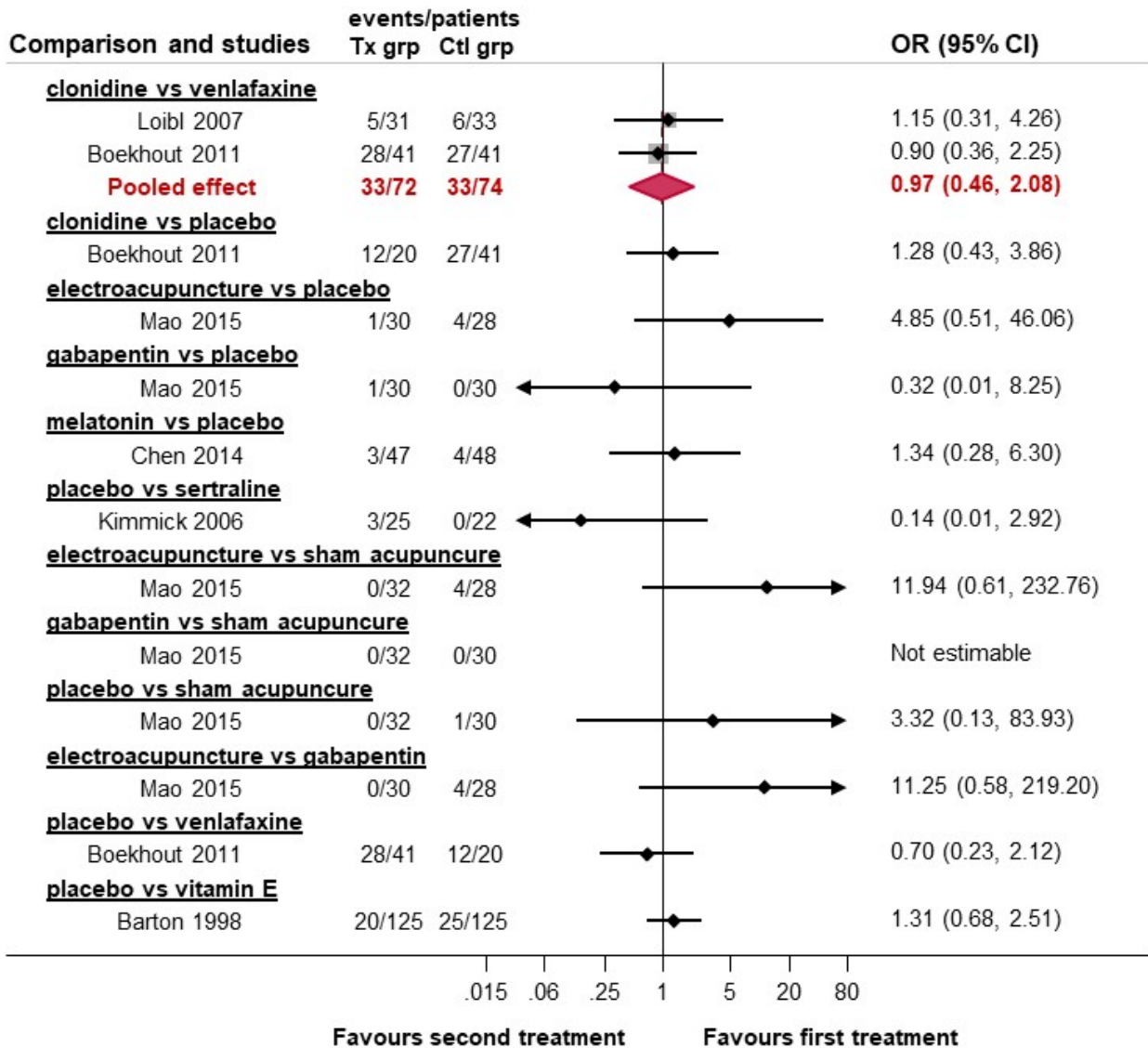
Headache:



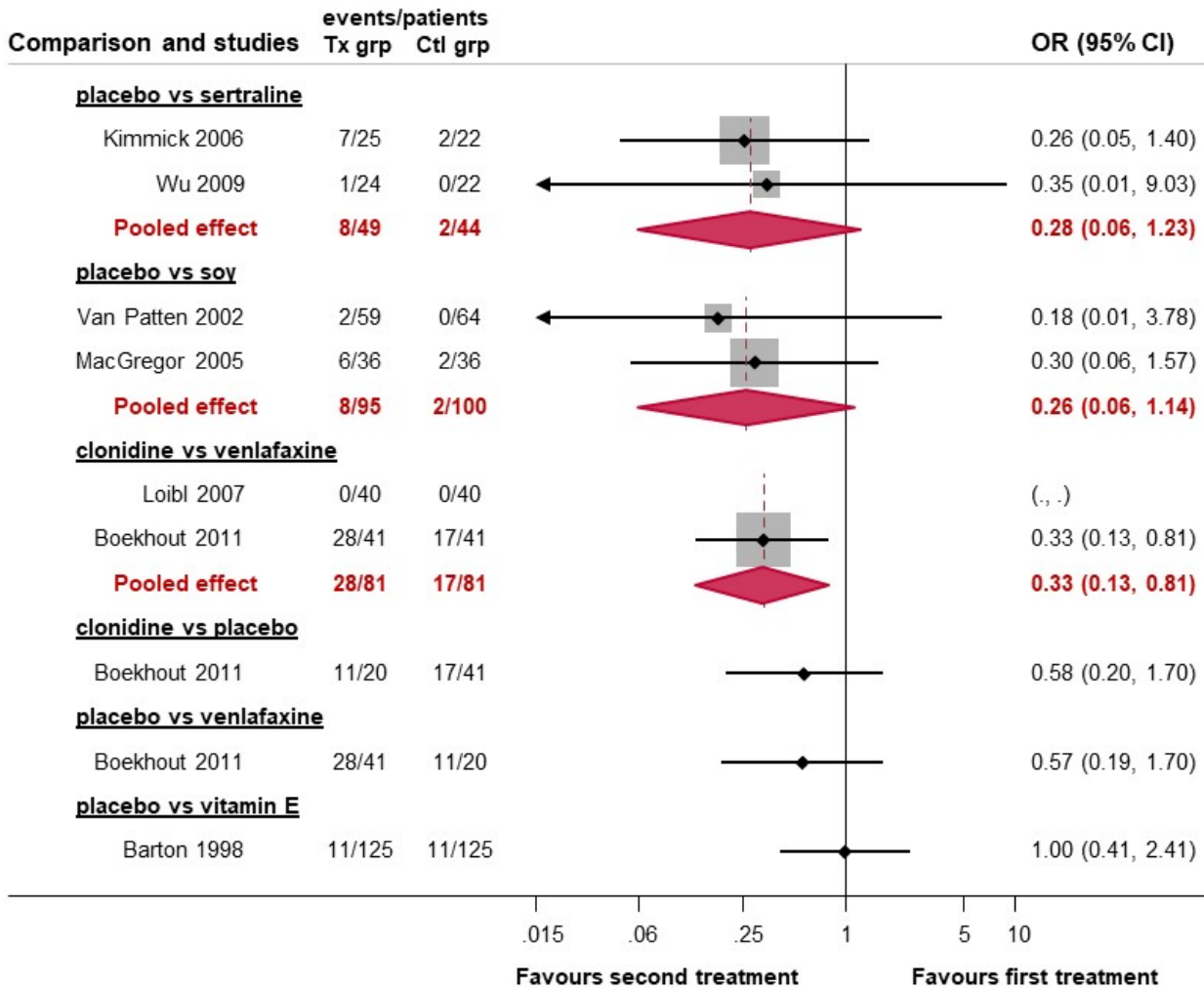
Constipation:



Fatigue:



Nausea:



Appendix 12: Overview of GRADE Certainty of Evidence

The following table presents the results of the graded network meta-analysis comparing each active intervention to placebo for the outcomes of hot flash composite score and hot flash frequency.

Primary Outcomes	CoE	Classification	Intervention	RoM (95% CI) vs PLC
Hot flash composite score	Low (Low to very low)	May be among the most effective	Venlafaxine	1.71 (1.05, 2.76)
			Paroxetine	2.83 (1.31, 6.09)
			Clonidine	2.13 (1.27, 3.54)
			Electroacupuncture	2.07 (1.01, 4.24)
		May be no more effective than placebo	Gabapentin	1.43 (0.95, 2.12)
			Gabapentin + Antidepressants	1.34 (0.59, 3.01)
			Sertraline	1.58 (0.70, 3.41)
			Sham acupuncture	1.65 (0.83, 3.31)
			Melatonin	0.70 (0.05, 11.19)
		May be among the least effective	Vitamin E	0.14 (0.03, 0.58)
Hot flash frequency	High (Moderate to High)	Among the most effective	Venlafaxine	2.48 (1.36, 4.32)
		No more effective than placebo	Gabapentin	1.62 (0.92, 2.73)
	Low (Low to very low)	May be among the most effective	Paroxetine	3.15 (1.29, 7.58)
		May be among the least effective	Clonidine	1.62 (0.86, 2.98)
			Gabapentin + Antidepressants	1.80 (0.65, 4.65)
			Sertraline	1.67 (0.69, 3.94)
			Melatonin	1.03 (0.11, 8.90)
Vitamin E	0.27 (0.06, 1.18)			

*CI: Confidence interval; CoE: Certainty of evidence; RoM: Ratio of Means (e.g. mean reduction of HF frequency in intervention / mean reduction of HF frequency in placebo)

Appendix 13: PRISMA NMA Checklist

PRISMA NMA Checklist of Items to Include When Reporting a Systematic Review Involving a Network Meta-analysis

Section/Topic	Item #	Checklist Item	Reported on Page #
TITLE			
Title	1	Identify the report as a systematic review <i>incorporating a network meta-analysis (or related form of meta-analysis)</i> .	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: Background: main objectives Methods: data sources; study eligibility criteria, participants, and interventions; study appraisal; and <i>synthesis methods, such as network meta-analysis</i> . Results: number of studies and participants identified; summary estimates with corresponding confidence/credible intervals; <i>treatment rankings may also be discussed</i> . <i>Authors may choose to summarize pairwise comparisons against a chosen treatment included in their analyses for brevity.</i> Discussion/Conclusions: limitations; conclusions and implications of findings. Other: primary source of funding; systematic review registration number with registry name.	1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known, <i>including mention of why a network meta-analysis has been conducted</i> .	1-2
Objectives	4	Provide an explicit statement of questions being addressed, with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	2
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists and if and where it can be accessed (e.g., Web address); and, if available, provide registration information, including registration number.	2
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale. <i>Clearly describe eligible treatments included in the treatment network, and note whether any have been clustered or merged into the same node (with justification)</i> .	2-3; Appendix 2
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	2

Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	Appendix 1
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	3
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	3
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	3
Geometry of the network	S1	Describe methods used to explore the geometry of the treatment network under study and potential biases related to it. This should include how the evidence base has been graphically summarized for presentation, and what characteristics were compiled and used to describe the evidence base to readers.	3-4
Risk of bias within individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	3
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means). <i>Also describe the use of additional summary measures assessed, such as treatment rankings and surface under the cumulative ranking curve (SUCRA) values, as well as modified approaches used to present summary findings from meta-analyses.</i>	3-4
Planned methods of analysis	14	Describe the methods of handling data and combining results of studies for each network meta-analysis. This should include, but not be limited to: <ul style="list-style-type: none"> • <i>Handling of multi-arm trials;</i> • <i>Selection of variance structure;</i> • <i>Selection of prior distributions in Bayesian analyses;</i> and • <i>Assessment of model fit.</i> 	3-4
Assessment of Inconsistency	S2	Describe the statistical methods used to evaluate the agreement of direct and indirect evidence in the treatment network(s) studied. Describe efforts taken to address its presence when found.	3-4
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	NA
Additional analyses	16	Describe methods of additional analyses if done, indicating which were pre-specified. This may include, but not be limited to, the following:	3-4

- Sensitivity or subgroup analyses;
- Meta-regression analyses;
- *Alternative formulations of the treatment network; and*
- *Use of alternative prior distributions for Bayesian analyses (if applicable).*

RESULTS†

Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	4; Appendix 2
Presentation of network structure	S3	Provide a network graph of the included studies to enable visualization of the geometry of the treatment network.	Figures 1, 2
Summary of network geometry	S4	Provide a brief overview of characteristics of the treatment network. This may include commentary on the abundance of trials and randomized patients for the different interventions and pairwise comparisons in the network, gaps of evidence in the treatment network, and potential biases reflected by the network structure.	7-8; Figures 1, 2
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	4-9; Table 1
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment.	Appendix 7
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: 1) simple summary data for each intervention group, and 2) effect estimates and confidence intervals. <i>Modified approaches may be needed to deal with information from larger networks.</i>	Data supplement file
Synthesis of results	21	Present results of each meta-analysis done, including confidence/credible intervals. <i>In larger networks, authors may focus on comparisons versus a particular comparator (e.g. placebo or standard care), with full findings presented in an appendix. League tables and forest plots may be considered to summarize pairwise comparisons.</i> If additional summary measures were explored (such as treatment rankings), these should also be presented.	9-15
Exploration for inconsistency	S5	Describe results from investigations of inconsistency. This may include such information as measures of model fit to compare consistency and inconsistency models, <i>P</i> values from statistical tests, or summary of inconsistency estimates from different parts of the treatment network.	Appendices 8, 9
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies for the evidence base being studied.	NA
Results of additional analyses	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression analyses, <i>alternative network geometries studied, alternative choice of prior distributions for Bayesian analyses, and so forth</i>).	Not feasible

DISCUSSION

Summary of evidence	24	Summarize the main findings, including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy-makers).	15-16
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias). <i>Comment on the validity of the assumptions, such as transitivity and consistency. Comment on any concerns regarding network geometry (e.g., avoidance of certain comparisons).</i>	16-17
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	17
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. This should also include information regarding whether funding has been received from manufacturers of treatments in the network and/or whether some of the authors are content experts with professional conflicts of interest that could affect use of treatments in the network.	17

PICOS = population, intervention, comparators, outcomes, study design.

* Text in italics indicates wording specific to reporting of network meta-analyses that has been added to guidance from the PRISMA statement.

† Authors may wish to plan for use of appendices to present all relevant information in full detail for items in this section.