Efficacy of vitamin B-6 in the treatment of premenstrual syndrome: systematic review

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Abstract

Objective To evaluate the efficacy of vitamin B-6 in the treatment of premenstrual syndrome.

Design Systematic review of published and unpublished randomised placebo controlled trials of the effectiveness of vitamin B-6 in the management of premenstrual syndrome.

Subjects Nine published trials representing 940 patients with premenstrual syndrome.

Main outcome measures Proportion of women whose overall premenstrual symptoms showed an improvement over placebo. A secondary analysis was performed on the proportion of women whose premenstrual depressive symptoms showed an improvement over placebo.

Results Odds ratio relative to placebo for an improvement in overall premenstrual symptoms was 2.32 (95% confidence interval 1.95 to 2.54). Odds ratio relative to placebo for an improvement in depressive symptoms was 1.69 (1.39 to 2.06) from four trials representing 541 patients.

Conclusion Conclusions are limited by the low quality of most of the trials included. Results suggest that doses of vitamin B-6 up to 100 mg/day are likely to be of benefit in treating premenstrual symptoms and premenstrual depression.

Introduction

The UK Department of Health and the Medical Control Agency have recently published recommendations to restrict the dose of vitamin B-6 available generally to 10 mg and to limit the dose sold by a pharmacist to less than 50 mg. Vitamin B-6 is often used to treat premenstrual syndrome without clear evidence of its efficacy, hence it is timely to re-evaluate vitamin B-6 in the treatment of premenstrual syndrome.

Premenstrual syndrome exists when women complain of regularly recurring psychological or somatic symptoms, or both, which occur specifically during the luteal phase of the menstrual cycle and which are relieved by the onset of, or during, menstruation. Symptoms can be severe enough to disrupt every day life. Mild physiological symptoms occur in approximately 95% of all women of reproductive age. Approximately 5% of symptomatic women complain of such severe symptoms that their lives are completely disrupted.

Somatic symptoms of premenstrual syndrome include bloating, weight gain, mastalgia, abdominal discomfort and pain, lack of energy, headache, and exacerbations of chronic illnesses such as asthma, allergies, epilepsy, or migraine. Commonly reported affective changes are dysphoria, irritability, anxiety, tension, aggression, feelings of being unable to cope, and a sense of loss of control.

Since the original description of the syndrome in 1931 numerous hypotheses have been advanced to explain premenstrual syndrome, but to date the pathogenesis remains unclear and speculative. This uncertainty reflects the many treatments available; one reviewer suggested that there were as many as 32 different treatments for premenstrual syndrome. Most interventions, however, have been on the basis of informal observations, retrospective data collection, or inadequately controlled trials.

The recommended dietary allowance for vitamin B-6 is around 2.0 mg/day, depending on age and protein intake, and deficiency of vitamin B-6 is rare. Excessive ingestion (2000-6000 mg) of vitamin B-6 causes peripheral neuropathy, and doses of 200 mg/day may cause similar, although probably reversible, effects.

Because the efficacy of vitamin B-6 has not yet been proved, and in light of recent government recommendations, we undertook a systematic review of published and unpublished randomised controlled trials where efficacy of vitamin B-6 was compared with placebo in women with premenstrual syndrome.

Methods

Trials

We found reports of published and unpublished clinical trials by searching medical databases for trials of vitamin B-6 (pyridoxine) in the management of premenstrual syndrome (MeSH terms used were premenstrual syndrome and pyridoxine, together with title and abstract searches for keywords vitamin and pyridoxine, premenstrual syndrome, PMT, LLPDD, and PMDD). We also contacted relevant pharmaceutical companies manufacturing vitamin B-6 preparations. The trials were identified by searching Embase (1988 to 1996), Medline (1966 to 1998), Psychlit (1974 to 1997), Cinahl (1982 to 1997), and the database of...
the Cochrane Controlled Trials Register. We searched references cited in all included and excluded trials to
detect any missing studies. All languages were
included. Trials investigating the effect of vitamin B-6
on premenstrual symptoms were included if they were
randomised, placebo controlled, double blind, parallel,
or crossover studies (where the first treatment period
could be treated as a parallel trial) for which data could
be acquired. We also included studies investigating the
effect of multivitamin supplements on premenstrual
symptoms, when the vitamin preparation contained 50
mg or more of vitamin B-6.

Data extraction and outcome measures
We extracted the data from each trial that met the
inclusion criteria. When there were insufficient data
presented for inclusion, we contacted authors for
further details. Data on the dosage and preparation of
vitamin B-6 were collected. The main outcome
measure was an improvement in overall premenstrual
symptoms. Combined or overall symptoms was chosen
in an attempt to overcome the clinical heterogeneity
concerned with the measurement and scoring of
premenstrual symptoms. As a secondary outcome we
recorded the improvement in depressive premenstrual
symptoms when suitable information was presented.
Where possible we also recorded the number of
women withdrawing from treatment and those
complaining of side effects.

Quality assessment
We assessed the quality of each trial with two different
methods. Firstly, we assessed the methodology of each
trial with a scale developed by Jadad and colleagues. This
scale assesses the randomisation and double
blinding and reports of dropouts and withdrawals.
Secondly, we developed a second quality score to assess
the trials for study design, reproducibility, and statistical
analysis. The eight point scale measured: preliminary
diagnosis of premenstrual syndrome for all partici-
pants in the trial; confirmation that no other vitamin
supplements or oral contraceptives were being concur-
rently taken; the randomisation procedure described
detail; a power calculation to justify participant
numbers, or >65 participants in each arm of the
study; a single clearly stated dose of vitamin B-6 only;
reproducible measurement of premenstrual symptoms
such as use of visual analogue scales or Moos’
menstrual distress questionnaire; clear presentation of
results; and a description of the number and reason for
trial withdrawals. One point was awarded for each cat-
egory. Each trial was independently scored by KMW
and PWD, and any areas of disagreement arbitrated by
PMWO. A predetermined criterion for the recognition
of the highest quality trials was established. A score of
3 or more was required in the Jadad score (as
recommended by Jadad and colleagues’)
and a score of
6 or more was required in our eight item quality
assessment.

Statistical analysis
Where dichotomous data were presented, odds ratios
with 95% confidence intervals were generated for the
primary and, where possible, secondary outcome in
each trial. We calculated odds ratios by categorising
patients with a subjective improvement as “better,” and
those with no change or worse symptoms as “not
better.” Odds ratios of >1 indicated that an event was
more likely to occur in the group receiving vitamin B-6
than in the group receiving placebo. We calculated an
overall odds ratio with fixed and random effects
models. Homogeneity was tested for with a $\chi^2$ test,
with $P<0.05$ indicating significant heterogeneity. For
trials using continuous measures of premenstrual
symptomology, we calculated a standardised mean dif-
fERENCE (OR effect size), and converted to an odds ratio
using a relation given by Hasselblad and Hedges.

To detect bias (such as publication and location)
within the analysed trials, we constructed a funnel
plot. To assess quantitatively the asymmetry of the
funnel plot we used the method of Egger and
colleagues. Briefly, a linear regression of the standard
normal deviate defined as the odds ratio is divided by
its SE against precision (inverse of the standard error).
A regression line which passes through the origin of
the plot (within error limits) indicates symmetry and
hence the absence of bias.

Results
We identified 25 published trials. Of these, four
were excluded because they did not include a placebo
group, 14 15 16 17 two were retrospective studies 18 19 and
nine presented quantitative data that could not be
analysed, 14 15 16 17 19 20 21 22 leaving 10 placebo controlled
trials, 19 20 22 23 24 25 26 27 28 30 31 32 33 34 35 36 37 38 39 40 41 42 43
Two of the trials had two separate dosing
regimens and were effectively treated as four studies.
Only one trial contained details of the method of
randomisation.

Quality assessment of the trials
Three of the included trials met the Jadad scale cut off
points of a score of 3 25 26 31. However, only one of
the trials included in the meta-analysis scored 6 on our
eight point criteria for classification as a high quality
trial. Unfortunately this trial had too few subjects to
achieve sufficient power and had a low Jadad score. The
overall methodology of the trials was poor, with none
of the included trials justifying patient numbers with a
power calculation. Three of the 10 studies reported the
number of withdrawals from a trial, together with
reasons, and side effects when taking either vitamin B-6
or placebo.

Of the nine trials included in the meta-analysis
(one trial was excluded owing to statistical hetero-
genesis), a statement regarding whether women taking
oral contraceptives were excluded from the trial was
reported in three trials, 25 26 31 three other trials do not
mention this as an exclusion criterion, 22 28 30 and one
trial excluded women on medication. Two trials 31 32
included women who were taking the contraceptive
pill, but they both flagged those women who did and
analysed them separately and found no statistically sig-
ificant difference between those taking oral contra-
ceptives and those not taking oral contraceptives.

As none of the trials met both our and the Jadad
quality criteria, we did not take the quality score into
account when considering trials for inclusion. Tables 1
and 2 present the quality scores for included and
excluded trials.

We calculated the odds ratios with both fixed and
random effects models. Minimal difference was found
with the inclusion of this trial. Table 1 lists the nine
remained significantly in favour of vitamin B-6 even
should be noted, however, that the overall odds ratio
which resulted in an odds ratio in favour of placebo. It
may be due to an unexpectedly high placebo effect,
vitamin B-6 was 2.32 (1.95 to 2.54). This heterogeneity
P = 0.187). The recalculated odds ratio in favour of
trial resulted in homogeneity (homogeneity test,
Table 1 Characteristics of studies included in meta-analysis of vitamin B-6 in premenstrual syndrome

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcome measures</th>
<th>Reported results</th>
<th>Withdrawals and side effects*</th>
<th>Jadad (authors’) quality score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colin 1982⁶⁴</td>
<td>32 with diagnosed</td>
<td>500 mg/day for</td>
<td>Mastalgia symptoms worse or better</td>
<td>58% better taking vitamin B-6, 59%</td>
<td>None reported</td>
<td>1 (3)</td>
<td>Only studied mastalgia Exclusion of women on oral contraceptives not mentioned</td>
</tr>
<tr>
<td>Barr 1984⁶⁴</td>
<td>48, crossover study design</td>
<td>100 mg/day for 3 after cycle for 2 months</td>
<td>Depression, irritability, tiredness, headache, stomach ache, and swollen breasts, abdomen, fingers, or ankles</td>
<td>Vitamin B-6 significantly better than placebo</td>
<td>None reported</td>
<td>3 (4)</td>
<td>“Most” women were not on oral contraceptives</td>
</tr>
<tr>
<td>Williams et al 1985⁷⁵</td>
<td>434 with diagnosed</td>
<td>100 mg/day (55%), 200 mg/day (39%) 50 mg/day (3%)</td>
<td>Depression, irritability, tension, violence, coordination, breast tenderness, bloating, headache, acne rated on a 4 point scale</td>
<td>Significant improvement of global symptoms only for vitamin B-6 over placebo</td>
<td>Owing to side effects 11 women withdrew on vitamin B-6 and B-8 withdrew on placebo</td>
<td>3 (4)</td>
<td>Patients included were allowed drugs; 74 psychotropics; 60 analgesics; 33 diuretics; 150 oral contraceptives Only analgesia significantly affected analysis</td>
</tr>
<tr>
<td>Chakmakjian et al 1985⁴⁵</td>
<td>31 with diagnosed</td>
<td>Multivitamin containing 300 mg vitamin B-6/day for 2 × 3 cycles</td>
<td>19 symptoms in 4 subgroups: PMT-A, PMT-C, PMT-D, and PMT-H</td>
<td>Significant effect for symptom groups PMT-A and PMT-D but not for PMT-H and PMT-D</td>
<td>None reported</td>
<td>2 (3)</td>
<td>Women on oral contraceptives excluded</td>
</tr>
<tr>
<td>Smallwood et al 1988⁴⁵</td>
<td>42 hospital patients with severe cyclical mastalgia; crossover study design</td>
<td>200 mg/day for 2 × 2 cycles</td>
<td>Breast pain and tenderness rated on chart and visual analogue scale</td>
<td>No significant effect</td>
<td>None reported</td>
<td>2 (4)</td>
<td>Only studied mastalgia Exclusion of women on oral contraceptives not mentioned</td>
</tr>
<tr>
<td>Stewart 1987⁶⁶</td>
<td>222 with premenstrual syndrome symptomology; 49 given vitamin B-6, 70 given placebo 46 given 100 mg vitamin B-6, 58 given placebo</td>
<td>Multivitamin containing 100 mg vitamin B-6 day 1 to day 14 then 200 mg for 4 cycles Multivitamin containing 50 mg vitamin B-6 day 1 to day 14 then 100 mg</td>
<td>19 symptoms in 4 subgroups: PMT-A, PMT-C, PMT-D, and PMT-H rated worse, no better, slightly better, substantially better, or cured</td>
<td>100 mg and 200 mg significantly better than placebo, 50 mg and 100 mg not significantly better than placebo</td>
<td>30 withdrew on placebo, 26 withdrew on vitamin B-6, 5 had side effects on vitamin B-6 and 1 on placebo, 17 withdrew on vitamin B-6, 5 had side effects on vitamin B-6 and 2 on placebo</td>
<td>1 (4)</td>
<td>Women on oral contraceptives not mentioned Study blinded to patient only</td>
</tr>
<tr>
<td>Kendall and Schnurr 1987⁷⁵</td>
<td>55 (financially reimbursed) with moderate to severe premenstrual mood changes recruited from general population; 29 given vitamin B-6, 26 given placebo</td>
<td>150 mg/day for 2 cycles</td>
<td>Pain, water retention, negative effect, positive effect, control, impaired concentration, behaviour change, autonomic reactions</td>
<td>No significant effect</td>
<td>None reported</td>
<td>1 (6)</td>
<td>Women on oral contraceptives excluded</td>
</tr>
<tr>
<td>Dall et al 1989⁶⁹</td>
<td>32 with moderate to severe premenstrual symptoms in previous year recruited from general practitioners; crossover study design</td>
<td>50 mg/day for 3 cycles with one washout cycle between</td>
<td>3 symptom groups: emotional, somatic, and menstrual</td>
<td>Significant effect on emotional symptoms</td>
<td>None reported</td>
<td>2 (5)</td>
<td>Included women on oral contraceptives but data flagged</td>
</tr>
<tr>
<td>London et al 1991⁷ⁱ</td>
<td>44 with self perceived premenstrual syndrome recruited form the general population; 28 given vitamin B-6, 16 given placebo</td>
<td>2 parallel arms Multivitamin containing 300 mg vitamin B-6 or 600 mg vitamin B-6/day for 3 cycles</td>
<td>19 symptoms in 4 subgroups: PMT-A, PMT-C, PMT-D, and PMT-H with London variation</td>
<td>Significant effect observed</td>
<td>Withdrawals: 1 taking placebo, 1 taking 300 mg vitamin B-6, 2 taking 600 mg vitamin B-6, 1 noted “tingling in fingers” at the end of the 600 mg study</td>
<td>3 (5)</td>
<td>Exclusion of women on oral contraceptives not mentioned Women on “medication” excluded</td>
</tr>
</tbody>
</table>

*Neurological side effects reported in 1 of 934 patients while taking 600 mg/day vitamin B-6 as part of multivitamin preparation.⁴⁵

between the two methods, and so the results from the more conservative random effects model were used. The overall odds ratio in favour of vitamin B-6 was 1.57 (95% confidence interval 1.40 to 1.77). One trial caused significant heterogeneity in the overall odds ratio (homogeneity test, P = 0.001), and removal of this trial resulted in homogeneity (homogeneity test, P = 0.187). The recalculated odds ratio in favour of vitamin B-6 was 2.32 (1.95 to 2.54). This heterogeneity may be due to an unexpectedly high placebo effect, which resulted in an odds ratio in favour of placebo. It should be noted, however, that the overall odds ratio remained significantly in favour of vitamin B-6 even with the inclusion of this trial. Table 1 lists the nine included trials, and table 2 lists the other 16 trials that were identified. Figure 1 shows the odds ratio and dosage for each of the nine included trials. We extracted data on the efficacy of vitamin B-6 in treating depressive premenstrual symptoms from five trials.⁶⁸ ⁷ⁱ-⁷⁵ Figure 2 shows the odds ratio for each trial and the term used by those trials to describe depression. The overall odds ratio in favour of vitamin B-6 was 2.12 (1.80 to 2.48; homogeneity test P < 0.001). This combined result showed significant heterogeneity with both fixed and random effects models. Exclusion of one trial¹¹ gave an overall odds ratio of 1.69 (1.59 to 2.06), which was homogeneous (homogeneity test, P = 0.079).
Of 1395 patients taking vitamin B-6, six reported neurological side effects: five patients taking 200 mg/day and one patient taking 100-200 mg/day.

Table 2 Characteristics of studies not included in meta-analysis of vitamin B-6 in premenstrual syndrome

<table>
<thead>
<tr>
<th>Study</th>
<th>No of participants</th>
<th>Intervention</th>
<th>Reason for exclusion</th>
<th>Reported results</th>
<th>Side effects*</th>
<th>Jadad (authors’) quality score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kerr 1977</td>
<td>70</td>
<td>40-100 mg</td>
<td>Not placebo controlled</td>
<td>Considerable benefit</td>
<td>None observed</td>
<td>0 (1)</td>
<td></td>
</tr>
<tr>
<td>Day 1979</td>
<td>57</td>
<td>100 mg</td>
<td>No detailed data</td>
<td>Improvement in 63% of patients on pyridoxine</td>
<td>No significant side effects observed</td>
<td>0 (3)</td>
<td></td>
</tr>
<tr>
<td>O’Brien 1987</td>
<td>53; crossover study</td>
<td>100 mg</td>
<td>Data not suitable for meta-analysis</td>
<td>No benefit of drug over placebo</td>
<td>None reported</td>
<td>1 (4) 24 patients preferred pyridoxine 14 taking placebo, but results not significant</td>
<td></td>
</tr>
<tr>
<td>Abraham and Hanegro 1980</td>
<td>25</td>
<td>500 mg</td>
<td>Data not suitable for meta-analysis</td>
<td>21 patients showed significant improvement over placebo</td>
<td>None reported</td>
<td>2 (5)</td>
<td></td>
</tr>
<tr>
<td>Mathes and Martin 1982</td>
<td>3</td>
<td>50 mg</td>
<td>Anecdotal study, no assessment of symptoms</td>
<td>Some beneficial effects</td>
<td>None reported</td>
<td>2 (1)</td>
<td></td>
</tr>
<tr>
<td>Goei and Abraham 1983</td>
<td>31</td>
<td>Multivitamin containing 150-600 mg vitamin B-6</td>
<td>Not placebo controlled</td>
<td>Significant decrease in symptoms in all patients</td>
<td>5 patients reported gastrointestinal side effects</td>
<td>1 (5) Multivitamin</td>
<td></td>
</tr>
<tr>
<td>Harrison et al 1984</td>
<td>30</td>
<td>50-150 mg</td>
<td>Sequential design, data not suitable for analysis</td>
<td>No benefit</td>
<td>&gt;100 mg/3 g tryptophan caused drowsiness, nausea, headache, overstimulation</td>
<td>1 (5) Cointervention each tablet: 50 mg vitamin B-6 + 1.5 g of tryptophan, up to 3 tablets per day</td>
<td></td>
</tr>
<tr>
<td>Hagen et al 1985</td>
<td>34</td>
<td>100 mg</td>
<td>Data not suitable for meta-analysis</td>
<td>No significant effect</td>
<td>6 reported nausea: 1 taking vitamin B-6 and 1 taking placebo</td>
<td>3 (5) Large phase effect: first treatment, whether placebo or vitamin B-6, gave same result Women on oral contraceptives excluded</td>
<td></td>
</tr>
<tr>
<td>Fuchs et al 1985</td>
<td>16</td>
<td>Multivitamin containing 390-600 mg vitamin B-6</td>
<td>Not placebo controlled</td>
<td>Beneficial effect</td>
<td>None reported</td>
<td>0 (2) Multivitamin study centred on analysis of liver enzymes</td>
<td></td>
</tr>
<tr>
<td>Malmgren et al 1987</td>
<td>19</td>
<td>300 mg</td>
<td>No data</td>
<td>No significant effect over placebo</td>
<td>None reported</td>
<td>1 (4) Study centred on uptake of platelet serotonin</td>
<td></td>
</tr>
<tr>
<td>Brush et al 1988</td>
<td>630</td>
<td>40-200 mg</td>
<td>Retrospective study, not placebo controlled</td>
<td>40% “good” response 65-88% partial response depending on dose</td>
<td>7 patients reported indigestion, 5 reported nausea, 3 reported breast soreness</td>
<td>0 (1) Other side effects were termed “coincidental” and included worse premenstrual symptoms and depression</td>
<td></td>
</tr>
<tr>
<td>Brush 1988</td>
<td>338</td>
<td>&lt;200 mg</td>
<td>Retrospective study, not placebo controlled</td>
<td>70% reported good or partial response</td>
<td>8 patients reported nausea, 5 dizziness, 6 mild tingling or numbness</td>
<td>0 (1) 5 of the patients reporting tingling or numbness were on the highest dose (200 mg)</td>
<td></td>
</tr>
<tr>
<td>Van den Berg et al 1989</td>
<td>19</td>
<td>120 mg</td>
<td>Data not suitable for meta-analysis</td>
<td>No beneficial effect</td>
<td>None reported</td>
<td>1 (4)</td>
<td></td>
</tr>
<tr>
<td>Berman et al 1990</td>
<td>28</td>
<td>250 mg</td>
<td>Not placebo controlled</td>
<td>Some favourable trends in improvement of symptoms</td>
<td>None reported</td>
<td>0 (5)</td>
<td></td>
</tr>
<tr>
<td>De Souza et al 1990</td>
<td>44; crossover study</td>
<td>50 mg every day for 2 × 1 cycle</td>
<td>Statistically heterogeneous</td>
<td>No significant effect</td>
<td>None reported</td>
<td>2 (4) 4 crossovers for magnesium, vitamin B-6, magnesium + vitamin B-6, placebo</td>
<td></td>
</tr>
</tbody>
</table>

*Of 1395 patients taking vitamin B-6, six reported neurological side effects: five patients taking 200 mg/day and one patient taking 100-200 mg/day.

Figure 3 shows a dose response plot of vitamin B-6 dosage against the odds ratio for each of the nine trials. There was no correlation between the amount of vitamin B-6 given and its efficacy.

Figure 4 details a funnel plot of the included trials. Regression analysis of this plot indicated no significant asymmetry (intercept -0.25 (90% confidence interval -0.88 to 0.38) P = 0.49), and thus no evidence of bias.

Discussion

The conclusions that can be drawn from our systematic review are limited. Although the results from the available data suggest that vitamin B-6 is more effective than placebo, there is insufficient evidence of high enough quality to give a confident recommendation for using vitamin B-6 in the treatment of premenstrual syndrome. For example, the evidence from the overall analysis would be more compelling if there were large scale rigorous trials with sufficient power to detect a clinically significant effect. To detect a medium effect size (0.5) at a significance level of 0.05 and 80% power, approximately 65 subjects would be required in each arm, using a two tailed test. Only one of the nine studies included a sufficient number of patients, and all the other trials had low statistical power (< 70%). The methodologies of each trial varied considerably using differing dosage regimens and different outcome measures, which makes intercomparisons difficult. In addition, the possible inclusion of women taking oral contraceptives complicates the overall analysis of the effect of vitamin B-6 on premenstrual syndrome as the vitamin may be treating pill induced premenstrual symptoms or depression.

An overall odds ratio was calculated from the nine included trials. Of these trials, two19 20 only studied the effect of vitamin B-6 on mastalgia and three20 21 22 used the multivitamin preparation Optivite (Optimox, Torrance, CA, USA). We believed it was appropriate to
include the trials of mastalgia, as breast pain and breast swelling are frequent premenstrual symptoms. As many as 60% of women with premenstrual syndrome report cyclical breast pain as a primary component.46

The odds ratios in the four included trials that used only vitamin B-6 and studied premenstrual symptomology25 26 31 32 were found to be heterogeneous. The combined odds ratio for the four trials (representing 541 patients) that presented data for depressive symptoms was 1.69 (1.39 to 2.06), and this was homogeneous. This indicates that vitamin B-6 is better than placebo in treating premenstrual depression. It is unlikely, however, that this is the central mode of action of vitamin B-6 in treating premenstrual syndrome, as the odds ratio for overall symptomatology is more favourable than when considering premenstrual depression alone.

Depression

One of the rationales behind vitamin B-6 being recommended as a treatment for premenstrual syndrome was the observation that it could ease induced depression in several conditions47–49 particularly that associated with contraceptive pills high in oestrogen and progesterone.50 51 The combined odds ratio of the four trials (representing 541 patients) that presented data for depressive symptoms was 1.69 (1.39 to 2.06), and this was homogeneous. This indicates that vitamin B-6 is better than placebo in treating premenstrual depression. It is unlikely, however, that this is the central mode of action of vitamin B-6 in treating premenstrual syndrome, as the odds ratio for overall symptomatology is more favourable than when considering premenstrual depression alone.

Dose response

The lack of a dose response (fig 3) indicates that the amount of vitamin B-6 given has no impact on the efficacy of its use as treatment for premenstrual syndrome, for either vitamin B-6 alone or when given in a multivitamin preparation. This result adds to the misgivings surrounding the use of vitamin B-6 as a treatment. The toxic effects of vitamin B-6 at doses higher than 200 mg/day are well characterised. As the recommended daily allowance of vitamin B-6 is around 2 mg, any
The effect of vitamin B-6 on premenstrual symptomatology would be pharmacological. However, there does remain some controversy as to the precise vitamin B-6 requirement in disease states, highlighted by the successful use of vitamin B-6 doses of around 100 mg/day in the management of carpal tunnel syndrome.13

**Multivitamins**

The rationale for including multivitamin treatments in a review on vitamin B-6 is the very large amount of vitamin B-6 in the tablets used; 50 mg per tablet (600 mg/day), which represents over 25 times the recommended daily allowance.14 Figure 1 shows the results of the published trials on use of multivitamins in the treatment of premenstrual syndrome, with an overall odds ratio of 2.08 (1.55 to 2.78; homogeneity test, P = 0.61). The lack of a dose response makes the daily consumption of more than 100 mg of vitamin B-6 inadvisable, and doses in excess of 200 mg/day cannot be recommended in the light of the proved toxic side effects of vitamin B-6, even in a multivitamin preparation.

**Side effects**

Only one patient of the 940 participating in these trials indicated the presence of any side effects that could be attributed to the neuropathy associated with pyridoxine toxicity.15,16 This may be due to the comparatively low doses used and the short duration of the trials. The symptoms, however, may have been missed owing to the lack of assessment by a suitably qualified neurologist. Detailed animal studies on pyridoxine indicate that nerve damage can occur before manifestation of the gross symptoms such as ataxia and neuropathy.17,18

**Conclusions**

Conclusions from this meta-analysis are limited by the quality of the trials. No conclusive evidence of vitamin B-6 toxicity was reported, and there seems to be no dose related response to treatment. We conclude, therefore, that there is no rationale for giving daily doses of vitamin B-6 in excess of 100 mg. Such doses, and possibly doses of 50 mg/day, are likely to be of benefit in relieving premenstrual symptoms.

We believe that this systematic review does highlight the need for a randomised placebo controlled trial, which should be conducted with sufficient subjects and should have the power to detect any significant clinical difference between vitamin B-6 and placebo.

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**Contributors:** PMSO’B originated the idea for the study and coauthored the paper. He also provided the clinical input to the text and resolved any areas of disagreement in the scoring and data extraction from the trials. KMW was the lead author of the paper and extracted and assessed the trial data. She also assisted in the literature searches, reference collation, data entry, and statistical analysis. PWD undertook the literature searches and located the references and assisted KMW in the data extraction and scoring of the trials. He coordinated the data analysis and statistical calculations in collaboration with KMW and under the guidance of the statistical adviser, PWJ. PWJ gave statistical input on the data extraction, validity of statistical tests, conversion of statistical measures, and assessment of the heterogeneity of the collated data. He also performed the power calculations and heterogeneity tests and advised on the statistical methods used in the meta-analysis. PWD and KMW will act as guarantors for the paper.

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Influence of hospital and clinician workload on survival from colorectal cancer: cohort study

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Abstract

Objective To determine whether clinician or hospital caseload affects mortality from colorectal cancer.

Design Cohort study of cases ascertained between 1990 and 1994 by a region-wide colorectal cancer register.

Outcome measures Mortality within a median follow up period of 54 months after diagnosis.

Results Of the 3217 new patients registered over the period, 1512 (48%) died before 31 December 1996. Strong predictors of survival both in a logistic regression (fixed follow up) and in a Cox’s proportional hazards model (variable follow up) were Duke’s stage, the degree of tumour differentiation, whether the liver was deemed clear of cancer by the surgeon at operation, and the type of intervention (elective or emergency and curative or palliative intent). In a multilevel model, surgeon’s caseload had no significant effect on mortality at 2 years. Hospital workload, however, had a significant impact on survival. The odds ratio for death within 2 years for cases managed in a hospital with a caseload of between 33 and 46 cases per year, 47 and 54 cases per year, and ≥55 cases per year (compared to one with ≤23 cases per year) were respectively 1.48 (95% confidence interval 1.03 to 2.13), 1.52 (1.08 to 2.13), and 1.18 (0.83 to 1.68).

Conclusions There was no detectable caseload effect for surgeons managing colorectal cancer, but survival of patients treated in hospitals with caseloads above 33 cases per year was slightly worse than for those treated in hospitals with fewer caseloads. Imprecise measurement of clinician specific “events rates” and the lack of routinely collected case mix data present major challenges for clinical audit and governance in the years ahead.

Introduction

In 1995, the then chief medical officer, Sir Kenneth Calman, made recommendations for improving...