Some Observations Regarding Management Of "The Menopause Transition" In An Urban Setting

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Summary: With increasing longevity, menopause and related sequelae are gaining greater significance in every woman's life. A study and analysis of 40 women who attended a 'menopause clinic' from Aug' 96 to Aug' 97 in a private set up was done. It was found that awareness about menopause and its management is very low, a lot of myths prevail and compliance is very difficult. Out of 40 women, 34 were chosen for treatment with HRT. Out of these HRT could be safely started in 24 women. Follow up attendance at 3 months was 91.17%; at 6 months it was 55.88% and at 1 year it was only 29.41%. Estrogen deficiency was assessed on the basis of symptom score. 58.06% women had symptom score between 5-15 at 3 months, 52.63% had symptom score <5 at 6 months and 40% had symptom score '0' and 40% <5 at 1 year.

Thus, proper management of menopause benefitted all symptomatic women irrespective of the mode of treatment.

Introduction

'The Menopause transition' is defined as the permanent cessation of menstruation resulting from the loss of ovarian follicular activity. Termination of ovarian function and menses is not an acute physiologic event, rather the physiologic antecedent associated with the transition from premenopausal to postmenopausal follicular function occurs in the perimenopause. The median age at menopause is 51 years. With increasing longevity nearly 85% of women are spending more than one third of their lives in the postmenopausal period and bear the consequences of this endocrine deficiency state.

Ovarian steroidogenesis starts declining once the ovaries have exhausted all follicular activity. The decreased level of estrogen and inhibin lead to a compensatory increase in FSH and LH levels. The increased FSH level and erratic hormonal pattern can cause various symptoms especially the vasomotor symptoms characteristic of the perimenopause.

Menopause related problems and its management are being widely studied in all parts of the world. In order to study this problem in the Indian perspective, some observations were made on women attending the menopause clinic in a private set up.

Material and Methods

An analysis of 40 women who attended the 'menopause clinic' from Aug' 96 to Aug' 97 was undertaken.

Analysis of cases was done on the basis of age group, socio-economic status, education, employment, awareness about menopause and/ or HRT, type of menopause and symptoms. Out of these 40 women 34 were found to be needing HRT on the basis of clinical assessment based on the symptoms of oestrogen deficiency or perception of the need for HRT to prevent long term sequelae.

Group a) Significant estrogen deficiency symptoms
Estrogen deficiency was assessed according to an 'estrogen level assessment chart'. Each symptom in the chart was ascribed a score 0, 1, 2 or 3 depending upon the severity. A total score of more than 15 was considered significant

Group b) High risk of long term complications like osteoporosis and / or heart disease These were assessed on the basis of questionaires. 6 women had problems unrelated to menopause.

Group c) These 34 women needing HRT were now screened and investigated for their eligibility for HRT. If they were found eligible, informed consent

was sought. HRT could be safely started in 24 women. Out of the remaining 10, 7 did not consent and 3 suffered from acute condition not warranting immediate hormone replacement. This 10 women were offered alternative forms of treatment like alphacalcidol, bisphosphonates etc.

Group d) All 34 women treated for menopause related problems were followed up for 1 year at regular intervals i.e. 3 months, 6 months and 1 year. Symptom score was assessed at every follow up and improvement in score noted down. Various side effects of HRT were also noted.

An inference and conclusion was drawn from all the above observations.

Results

On analysing the findings it was found that most women attending the clinic belonged to the 35-55 years age group and middle socio-economic status, 87.5% women were educated at least upto primary level, 80% were unemployed. However, only 7.5% women rightly aware about menopause and/ or HRT. The rest were either partially aware / unaware. 50% of the women under study belong to the surgical postmenopausal group, 30% to spontaneous postmenopausal group and 20% to the perimenopausal group. Symptom wise distribution showed that maximum (55-65%) women presented with vasomotor or genitourinary symptoms or muscle, bone and joint pains. These were followed by psychological and sexual symptoms. Follow up of the treated women showed that attendance at follow up after 3 months was 91.17%, at 6 months it dropped to 55.88% and after one year it was only 29.41%. The symptoms score at follow up showed that maximum number of women (i.e. 58.06%) presented with score of 5-15 at 3 months, 52.63% presented with score of <5 at 6 months and 1 year 40% presented with score of 0 and 40% with score of <5. No major side effect was seen with one year of treatment. Maximum number of women had breast tenderness (83.33%) nausea (62.50%) followed by breakthrough bleeding (41.66%), weight gain (41.66%) headache and moodiness (41.66% each).

Table No I
Distribution On The Basis Of Age And Socioeconomic Status.

Age (Yrs.)	No.	%	SE Status	No.	%
35-45	18	45	Low	2	5
45-55	16	40	Middle	30	75
55-65	6	15	High	8	20

Table No. II
Distribution on the Basis of Education and Employment

Education at least Primary Level	No.	%	Employment Status	No.	%
Educated	35	87.5	Employed	8	20
Uneducated	5	12.5	Unemployed	32	80

Table III
Symptom Wise Distribution

Symptoms	No.	%
Vasomotor	26	65
Genitourinary	22	55
Psychological	10	25
Sexual	4	10
Others (Bones, Joints, Skin etc.)	22	55

Table No. IV
Follow up

Follow Up (out of 34)	No.	%
After 3 months	31	91.17
After 6 months	19	55.88
After 1 year	10	29.41

Discussion

The above results indicate the following-

a) Women between 35-55 years of age availed the facility of the 'menopause clinic' more often. This may be attributed to the following 2 reasons: -

(i) As symptoms begin to appear in these women, they find it difficult to cope with them. With advancing age many women adapt themselves to these changes. Also acute symptoms subside or become milder.

Table No. V

Assessment of Symptom Score at Follow Up

Symptom score	At 3 months (out of 31)		At 6 month (out of 19)		At 1 year (out of 10)	
	No.	%	No.	%	No.	%
15 or more	5	16.12	2	10.52	-	-
5-15	18	58.061	7	36.84	2	20
<5	7	22.58	10	52.63	4	40
0			-	-	4	40

Table No VI

Side Effects of HRT

Minor (Mostly in the first few months)	No. (out of 24)	%
Nausea	15	62.50
Weight Gain	10	41.66
Headache	5	20.83
Moodiness	5	20.83
Breast Tenderness	20	83.33
Break Through Bleeding	10	41.66

(ii) Pan-Hysterectomies are mostly performed in this age group, leading to abrupt menopause.

b) Women from the middle socio-economic status were maximum probably because they face a more stressful life. Though the lower income group women also have problems they suffer more from social and monetary constraints. The higher income group women lead more comfortable lives and have the money and the means to mould their lives for the better.

c) 87.5% women attending the clinic were educated and 80% were unemployed. Unemployed women have more self centered life and less distractions. Some American studies have also found that working women suffer less from symptoms of menopause than housewives. Also the symptoms were more severe in housewives.

d) Only 7.5% women were rightly aware about menopause and/ or HRT. A number of myths prevailed among the ignorant group, like

(i) Menopause is a natural process and should never be interfered with.

(ii) Consummated married life should stop at menopause.

(iii) Conceptions cannot occur around menopause etc.

e) 50% of women who presented at the clinic belonged to the surgical post menopausal group and probably because they had an abrupt menopause and hence severe symptoms.

f) In the present study most commonly presented were vasomotor symptoms (65%) followed by genitourinary problems and symptoms pertaining to bones, muscles etc. (55%). Then came the psychological (25%) and sexual (10%) symptoms.

In a study by Partha Mukherjee et al (1996) psychological symptoms were the commonest (79.33%) followed by vasomotor symptoms.

In a study by Anklesaria (1995) & Krishna (1995) genitourinary symptoms were commonest (50-74%) followed by psychological (20-36%) and vasomotor symptoms (30-33%).

This discrepancy could be because women attend a 'menopause' clinic with specific physical symptoms where as women with psychological symptoms tend to consult a general clinic more often.

Studd & Barber (1992) showed that the frequency of psychological symptoms (92%) was the highest in the west followed by vasomotor symptoms (75%) followed by genitourinary symptoms (20%).

These differences between the Western and Indian patterns may be accounted for by the differences in cultural, social, economic and sexual practices in the two societies.

g) Although the attendance at each follow up kept declining symptom score showed improvement with length of treatment irrespective of the type of symptoms.

Partha Mukherjee et al (1996) showed that physical symptoms showed (70%) more improvement as compared to the psychological symptoms (42-60%). Session D. R (1993) showed that the vasomotor and genitourinary symptoms showed (>50%) improvement by HRT.

h) Because it was a short term study no major side effect

was seen. The minor side effect prevailed mostly for the first few months and could be alleviated by adjustment of the dose of symptomatic therapy.

Other studies by Smith et al (1994), Marsh et al (1992), Leather et al (1991) also reported similar side effects although incidence varied to some extent in all studies. This could be again because of socio-economic, cultural and personal factors. This arena needs further detailed study.

Conclusion:

From the above study it can be concluded that

a) Awareness about menopause and its management is very low among the general population.
b) A lot of myths are prevalent and
c) Compliance is very difficult.

But proper management of menopause benefited all compliant women irrespective of the mode of treatment.

Therefore counseling and education along with treatment (as and when needed) is a must for all menopausal women.

References

1. Anklesaria B.S. 'Climacteric Symptoms and Urogenital problems' ;FOGSI book on 'Menopause'; Pg. 13., 1995.
2. Krishna U. R.; 'Climacteric Symptoms and Urogenital problems' ;FOGSI book on 'Menopause'; Pg. 13., 1995
3. Leather A.T, Samas and Studd J WW, Obst. Gynaecol. 78: 1008., 1991.
4. Mukherjee Partha, Animesh Nayak and Mullick.; J. Obst. Gyn Ind; 46:244, 1996.
5. Marsh MS and Whitehead MI, Br. Med. J 48 (2) 426, 1992.
6. Session DR, Kelly AC and Janelenricz R, Fertil Steril 59 (2); 277, 1993.
7. Studd JWW and Barber R. The menopause. In Shaw R W (Ed) Gynaecology. Churchill Livingstone, London, 1992.
8. Smith RNJ and Studd JWW. The menopause and Hormone replacement therapy. Martin Dunitz, London, 1994.