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Research Article

Menopausal syndrome: clinical presentation and management

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ABSTRACT

Background: Menopause is physiological stage in woman's life. Although most of women accept them, some do have a disturbed life due to various symptoms, mostly because of estrogen deprivation.
Methods: This is a prospective clinical study of 200 menopausal women attending the gynaecology OPD or admitted in the wards with various symptoms as well as some gynaecological problems. Young women with surgically induced menopause and women with psychiatric disorders were excluded.
Results: The duration between menopause and appearance of symptoms varied from 1yr to 10 yrs. The average age of menopause in our study was 46.5 yrs. Vasomotor symptoms (65%) were common followed by psychosomatic symptoms (62%), vaginal dryness (45%) and urinary symptoms (40%). Stress, irritability, sleep problem, weight gain were some of common presentations to OPD. Urinary incontinence and atrophic vaginitis were also seen predominantly. The management consists mainly of counseling and life style modification, exercise, yoga meditation etc. Some of the women required estrogen cream, 70 women required surgical treatment. Overall the response to various medications was satisfactory and on follow up the symptoms was found to be much less.
Conclusions: There is need of setting menopausal clinics and centres to help women with symptoms and signs of estrogen deprivation. Counseling and education are main treatment modalities.

Keywords: Menopause, Estrogen, Vasomotor symptoms

INTRODUCTION

Term 'menopause' is derived from the Latin word Meno (month) and Pausia (halt). Menopause essentially marks the end of a women's period of natural fertility. As a woman approaches menopause, the number of ovarian follicles decline, producing less estrogen and causing irregular menstrual periods. Eventually, the quantity of estrogen produced is too low to maintain the monthly menstrual cycle.[1] The next stage is referred to as the menopausal syndrome which ranges from hot flushes, irritability to osteoporosis and heart disease and is experienced by all women in varying degree. Climacteric syndrome is characterized by various symptoms like cessation of menstruation, hot flushes, insomnia, vaginal dryness, weight gain, mood swings, depression, slowed thinking. Urogenital atrophy causes vaginal dryness, dyspareunia, discharge, incontinence, dysuria and recurrent UTI. Epidemiological data indicates that menopausal women are at high risk of developing coronary heart disease. The cardioprotective effect of estrogen is due to its influence on lipid and lipoprotein metabolism as well as other chemical mediators which influence circulation. Osetoporosis affect women`s health and with increasing life expectancy, future incidence of osteoporosis related factors will increase greatly. Estrogen play an important role in maintaining bone balance and its deficiency causes rapid bone loss particularly in spinal column leading to osteoporosis. The average age of Menopause is 51 years old but there is no way to predict when an individual woman will enter Menopause. As most of communities in india are staying

in rural areas and are from low socioeconomic status, it will be worthwhile to find out the clinical presentation of women of naturally occurring menopause and effectively of natural estrogens along with dietary supplement and exercise to combat these menopausal symptoms.

In this study we have observed 100 cases of women with natural menopause, their demographic status, clinical presentation and general and specific management.

Aims and objectives

1. To study clinical presentation of menopausal women.
2. To study various gynaecological problems and management of symptoms if require.

METHODS

This is a prospective clinical study. 200 menopausal women taking treatment at General Hospital are included in the study from 1st January 2012 to 31 December 2014.

Inclusion criteria

All menopausal women either be attending the gynaecology OPD or admitted in the wards with some gynaecological disorders.

Exclusion criteria

Young women with surgically induced menopause and women with psychiatric disorders.

Initially consent of the patients was taken before subjecting them to any investigation and surgical and medical intervention if required. These patients were studied and evaluated in details with history including menstrual, obstetric, social and psychological background, socioeconomic background, and clinical symptoms if present. All these women were examined in details. The examination included general examination including breast examination, systemic examination, local examination, perspeculum and pervaginal examination. The women were subjected to following investigations: hemoglobin estimation, E.C.G., fasting BSL, vaginal cytology, pelvic ultrasound, mammogram, colposcopy etc which were carried out in the same hospital.

The women with menopausal symptoms were treated accordingly. Initially all were counselled and importance of meditation, yoga, exercises, proper diet. Medical management of diabetes, hypertension and urinary infection if any was given as per requirement. The surgical conditions diagnosed on clinical examination and ultrasonography like fibroids, prolapse, malignancies, ovarian tumours were treated accordingly. Cervical lesions diagnosed on colposcopy and biopsy was treated with cauterization, conisation, amputation or hysterectomy. Breast problems were referred to surgeons and were given treatment as per the case. The cases with oestrogen deficiency diagnosed on clinical findings and investigations are managed with local and systemic administration of oestrogen. Treatment with phytoestrogens and other non-hormonal therapy were given in many cases. All those cases were followed carefully and the response to various therapies was studied. All the findings were tabled and analysed statistically to study the importance of problems of management and need to study these women.

RESULTS

Maximum age was 53 yr and minimum age was 40 yrs. Average age of menopause of study is 46.5 yrs. Most of women presented within 1-5 yrs of menopause.

Table 1: Age at time of menopause and age of women attending opd with symptoms and duration of menopause and occurance of symptom.

SN	Age at time of menopause	Cases (200)	SN	Age at presentation	Cases (200)	SN	Duration of menopause and occurrence of symptoms	Cases (200)
1	<40 yrs	0	1	Less than 45	10 (5%)	1	1-2 yrs	64 (32%)
2	40-45 yrs	100 (50%)	2	45-50	140 (70%)	2	2-5 yrs	60 (30%)
3	46-50 yrs	50 (25%)	3	51-55	20 (10%)	3	5-10 yrs	36 (18%)
4	>50 yrs	50 (25%)	4	More than 55	30 (15%)	4	More than 10 yrs	40 (20%)

Table 2: Women general profile.

SN	Occupation	Cases (200)	SN	Education	Cases (200)	SN	Residence	Cases (200)
1	Housewife	124 (62%)	1	No education	50 (25%)	1	Urban	20 (10%)
2	Office going	20 (10%)	2	Up to 4th std	106 (53%)	2	Rural	160 (80%)
3	Farmer	48 (24%)	3	4th to 10th std	24 (12%)	3	Slums	20 (10%)
4	Other	08 (4%)	4	10th std onwards	20 (10%)	4		

Most of the women in this study were either housewives (62%) or working in the field (24%). Most of the women were residing in rural areas. The literacy status of the women was poor as only 53 % the women were educated upto 4th std and 25% women did not obtain any education. In our study only 2 women were not married. Most of women (90%) were from low socioeconomic status.

Table 3: Family size and response from family members and marital status.

SN	Response from family members		
1	Neglected by family/husband	8	4 %
2	Positive support from family/husband	120	60 %
3	Negative/ less support from family/ husband	72	36 %

Table 4: Menopausal symptoms.

SN	Symptoms	Cases	Duration between menopause & symptoms
A) Vasomotor symptoms			
1	Hot flushes and night sweats	130	2 yrs
B) Vaginal symptoms			
1	Vaginal dryness	90	2-5 yrs
2	Painful coitus	40	2-5 yrs
3	Prolapse	56	7-10 yrs
4	Vaginal discharge	50	5-10 yrs
C) Psychological problems			
1	Depression	50	3-5 yrs
2	Tension	124	3-5 yrs
3	Forgetfulness	100	2-4 yrs
4	Poor concentration	80	2-4yrs
D) Psychosomatic symptoms			
1	Dizziness	70	3-5 yrs
2	Palpitations	56	5-7 yrs
3	Numbness	62	3-5 yrs
4	Irritability	120	1-2 yrs
5	Tiredness	96	2-5 yrs
6	Headache	90	2-5 yrs
7	Sleep problems	90	2-5 yrs
8	Joint/backache	80	5-7 yrs
9	Weight gain	60	5-7 yrs
E) Urinary symptoms			
1	Dysuria	70	2-5 yrs
2	Frequency	80	2-5yrs
3	Incontinence urge+ stress	70	5-10 yrs
4	Incomplete emptying	60	2-5 yrs

Table 5: Abnormality on clinical examination and investigation.

SN	Abnormality	Cases	%
1	Anaemia (pallor)	84	42 %
2	Obesity	70	35 %
3	Hypertension	40	20 %
4	Abdominal mass(TO mass)	04	02 %
5	Prolapse (uterus +vaginal wall)	56	28 %
6	Vaginitis (mostly atrophic)	64	32 %
7	Incontinence (urge + stress)	70	35 %
8	Cervix malignancy	10	05 %
9	Uterine enlargement (>8weeks)	10	06 %
10	Cardiovascular disease	02	01 %

Table 6: Management.

SN	Management	Cases
1	Counselling	200
2	Medical management (Hematinics, Calcium supplementation, Antihypertensive, Antidiabetics, Antibiotics, Local estrogen, Other drugs-soya , phytoestrogen, Chemotherapy for malignancy)	140
3	Surgical management (Exploratory laparotomy, Vaginal hysterectomy and repair, Wertheim' hysterectomy, Vaginal wall prolapse repair without hysterectomy, Surgery for stress incontinence)	70
4	Other therapies (Yoga, meditation, lifestyle ,exercises, diet)	200

DISCUSSION

This was prospective, observational, informational and analytic study of 200 menopausal women coming to outpatient department with various symptoms and signs. Many of symptoms were mentioned by patients while some women narrated them on direct questioning. Some women presented with gynecological problems like prolapse, malignancies, incontinence etc. but they also had vasomotor and psychosomatic manifestations.

Maximum age of menopause was 53 yr and minimum age was 40yrs. Average age of menopause of our study is 46.5 yrs, as most of women (50%) had menopause before 45yrs. Most of women presented in 1-5 years after reaching menopause and only 30 women who had slight late menopause or had few vasomotor and psychosomatic symptoms presented after 55 year of age (Table 1). The age of presentation depends on severity of symptoms, mental and physical condition of women, dependency on spouse and socioeconomic status of women.

Occupation, residence and educational status

In our study most of women (62%) were either housewives or were working in farms. As traditionally believed that menopausal symptoms are more in office going women or in educational field, it was not seen in our study, as only 10% of our group were working in offices (Table 2) so it seems menopausal symptoms are equally common in rural population. The educational status of those women was also poor, as 25% of them never attended the school, 53% educated only upto 4th standard (Table 2). Thus contrary to belief, our study had women with low education status and also were from rural area and were either housewife or in farming. This indicates that menopause is no more an urban problem but also women from rural do present with symptoms and require proper attention. In our study 40% women had no or very little support from the family and came to the hospital with their neighbour. 60% women mostly from educated family, working in offices, were accompanied by their husbands and they were well aware of their symptoms (Table 3).

Menopause and symptoms

Hot flushes and night sweats are the symptoms most consistently associated with menopause, although their prevalence varies in different cultures. For example, the prevalence has been reported to be 23% in Thai women (Chompootweep et al), 32% in Pakistani women (Yahya and Rehan), 45% in North American women (McKinlay et al).[2-4] In our study, the prevalence of hot flushes and night sweats was 65%. Many menopausal women complained of dry vagina (45%) and 25% women had vaginal discharge (Table 4). Senile atrophic changes due to estrogen deficiency are the commonest cause for these vaginal discharges. Symptoms of dryness in vagina occurred earlier (1-2 yrs) than vaginal discharge which was found after 5-10 yrs of menopause. Something coming out of vagina (uterine and vaginal prolapse) was present in 112 women and this developed after >10 yrs of menopause. 20% women who had dry vagina also complained of painful coitus, but this occurred after 4-5 years.

In our study the psychosomatic symptoms were significantly present in many women. Most of them had more than one complaint and in many cases these were the leading symptoms next to vasomotor ones. Dizziness (35%), palpitations (28%), numbness of extremities (31%), irritability (60%), tiredness (48%), headache (45%), sleep disturbances (45%), muscle and joint pains (40%) and weight gain (30%) were the various complaints of those women (Table 4). An organic or medical disease was ruled out for some of the symptoms. Most of those symptoms developed in 2-5 yrs of menopause. Similar study was done in Eastern India by Doyeb Dasgupta and Subha Roy.[5] They found higher psychosomatic and psychological symptoms in their study but our findings are comparable with those of Sharma S et al on menopausal women in Jammu.[6] Urogenital problems were very common and had a significant effect on their daily routine activity. Dysuria (35%), frequency (40%) and emptying of bladder were significant complaint in 2-5 yrs while stress or urge incontinence occurred in 15-20% cases after 5-7yrs of menopause (Table 4). Thus overall 35% women had urogenital problems in our study. Shah found that uro-genital prolapse was in around 40%. For urinary incontinence it was found that 25% had stress incontinence, 30% had mild incontinence whereas urge incontinence was found in 45% of postmenopausal women.[7]

After analysing the history and presentation all those women were examined in detail. General, breast, thyroid examination, systemic examination and pre abdominal, speculum and vaginal examination was carried out. On examination anaemia (42%), obesity (35%), hypertension (20%), cardiovascular disease (1%), abdominal mass (2%), prolapse of vagina and uterus (28%), vaginitis (32%), incontinence (38%), cervical malignancy (5%) and uterine enlargement in 6% cases (Table 5).

Medical management

As anaemia, diabetes, hypertension and infections, mostly urinary tract infections were common medical problems in our study, they were treated adequately. Vasomotor symptoms are decreased by various drugs like soyproteins (6µg/day), isoflavones (100mg/day). Similarly Kronenberg F, Fugh-Berman used complementary and alternative medicines for menopausal symptoms.[8] Albertazzi and Etal used dietary soy supplementation on hot flushes.[9] Medical management was given in 140 cases and 70 required surgical treatment for gynaecological diseases in addition. All the women were also given proper advice about diet, exercise, meditation, and change in lifestyle, weight control and yoga therapy in some cases (Table 6).

As is shown in various studies, those symptoms due to urogenital atrophy respond well to systemic or topical estrogen therapy. In Shah study uro-genital problems can be managed by – Non-hormonal therapy – reassurance, good diet and antioxidant drugs or Hormone replacement therapy – may be systematic and local HRT.[7] In our study, we didn't use systemic estrogen & any other hormone. Genitourinary atrophy and symptoms due to the atrophy was treated with local estrogen therapy, and the response was seen in most women. Vaginal estrogen therapy also reduced the urinary symptoms like frequency and urgency and produced the risk of urinary tract infections in post-menopausal women.

In this study 10 cases more subjected to laparotomy with hysterectomy, 36 required vaginal hysterectomy with repair, wertheims hysterectomy was done in 2 case, 12 cases required only vaginal prolapse repair (for cystocoele and rectocoele) and 10 more operated for

stress urinary incontinence (Table 6). All these women were also subjected to medical treatment, counselling, yoga therapy, meditation, excision and lifestyle changes and collectively the results were analysed.

Counselling and other therapies

In our study we have adopted basic means of management of menopausal symptoms with various methods like counselling, dietary advice, lifestyle changes, exercise, yoga, meditation, pelvic floor exercise etc. The response was very satisfactory and change in attitude and approach was found after some sessions. Other therapy like vit-E (800 iu/day), acupuncture, exercise show an improvement in vasomotor symptoms. To remain in cool temperature, use of light layered clothing, weight reduction and stoppage of smoking also help in minimizing hot flushes. Physical exercise like walking, running, aerobics in groups and singly were very effective method of change in lifestyle of those women. Though the initial response was not good encouraging, a constant advise about exercise and change in life style helped many women to overcome the symptom, mostly psychosomatic and psychological one (Table 6). Studies by Nelson D. B. Sammel M. D. Freeman E. W. Lin H. Schmitz K also reveal not the anxiety, stress, depression, vasomotor symptom were low in active postmenopausal women compared with inactive women in the same group.[10] Use of yoga therapy under supervision was advised to more than 50 women. Although the response was slow and not very encouraging, the symptoms were gradually less in the women who practiced yoga regularly. The impact on health and relief from menopausal symptoms were also studied at the Fertility Research Centre and Max Healthcare Centre, New Delhi.[11] They also found that bone mineral density increased and other menopausal symptoms decrease in women who practiced yoga regularly.

CONCLUSIONS

This study was conducted in 200 women with menopausal symptoms over period of 3yrs.Average age of menopause of our study is 46.5 yrs in our study. The symptoms were more common in housewives and rural women. The presenting women were mostly from illiterate class or with education upto 4th standard. 60% were well supported by their family and husband. Vasomotor symptoms, coital problems, psychological and psychosomatic problems were most common presentations. Counselling, medical management, yoga, meditation, lifestyle changes, phytoestrogens and in selected cases use of local estrogen, were the modalities for treatment. Most of patients responded well.

There is need of setting menopausal clinics and centres to help women with symptoms and have signs of estrogen deprivation. Counselling and education are main treatment modalities.

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