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Original Research Article

To Determine the Clinico-Demographic Profile and Morbidity Pattern in Menopausal Women: Cross Sectional Study

Rashmi Raginee

Senior Resident, Department of Obstetrics and Gynaecology, Mahila chikitsalaya, Sawai Man Singh Medical College, Jaipur, Rajasthan, India

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Corresponding author: Dr. Rashmi Raginee
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Abstract

Aim: To determine the clinico-demographic profile and morbidity pattern in menopausal women.

Materials & Methods: It is a cross sectional study carried out in the Department of Obstetrics and Gynaecology, Mahila chikitsalaya, Sawai Man Singh Medical College, Jaipur, Rajasthan, India**.** over a period of one year.Patients will be examined for their symptoms and gynaecological examinations. On a decided proforma the age, socio economic demographic data, symptoms will be noted. General, systemic and obstetric examination findings will be noted.

Results: About 50% of women have menstrual disturbances of varying degrees for about 6 months to 2 years in premenopausal period before attaining menopause.

Conclusion: Health promotion must address obesity, hypertension and smoking to reduce the negative effects of menopause.

Keywords: Pre-eclampsia, imminent eclampsia, outcome

Introduction:

Today, with increasing life expectancy, women spend one-third of their lifetime after menopause [1]. There were about 43 million women of menopausal age group in India in the year 2011 and by 2026, it is projected to be 103 million. The average life span of Indian women has also increased to 71 years (68.7 years in rural and 73.5 years in urban areas) [2,3].

On an average, one third of women's life consists of postmenopausal years and very few health care programmes address them. This study aims to describe the pattern of health care seeking behavior in menopausal women and awareness regarding menopausal symptoms.

Menopause is the permanent cessation of menstruation which is retrospectively determined following 12 months of amenorrhea. It is an important transition in a

women's life and can be smooth in some while varyingly difficult in others. The year immediately preceding and the decade afterwards however, are of much clinical significance. The immediate symptoms of menopause are effects of hormonal changes on various systems of the body, mainly cardiovascular and musculoskeletal system thus affecting their quality of life. The common climacteric symptoms experienced by them can be grouped into vasomotor, physical, and psychological complaints.

There were 467 million women in the post-menopausal age group in the 1990's and this number is projected to increase to 1200 million by 2030 in the world. It has been proposed that nearly 76% of them will be living in the developing countries. The annual growth rate of menopausal women is estimated to be 2 to 3.5% in developing countries. Most frequent menopausal symptoms were aching in muscle and joints, feeling tired, poor memory, lower backache and difficulty in sleeping. The vasomotor and sexual domains were less frequently complained when compared to physical and psychological domains.[4]

Menopause is a retrospective diagnosis, which is said to have occurred when there is absence of menstrual periods for 12 months. The average age of menopause in Indian women is 47.5 years [5]. The hypo estrogenic state heralded by the onset of menopause affects various organ systems of the body. These effects can be classified with respect to the time since menopause as, immediate (vasomotor symptoms, mood swings, insomnia, urinary symptoms, cognitive dysfunction and sexual dysfunction), intermediate (genital atrophy, skin changes, urodynamic effects and pelvic organ prolapsed) and long-term (cardiovascular effects, osteoporosis and dementia) [6].

Demographic transition is a recent phenomenon in developing countries characterized by decline in fertility, mortality and increase in life expectancy. The impact of demographic transition on women's status is important in terms of health, economy and gender. The life cycle factors like reduced family size, changes in marital status, increased dependency ratio, changes in disease pattern, and aging can affect women varyingly.[7]

The estimates of Global Burden of Disease Study (1990–2016) show that cardiovascular deaths account for 26.7% of total deaths in Indian women, while the crude prevalence of high blood pressure was 21.2%, high total cholesterol, 24.5% and high fasting plasma glucose, 7% [8]. In a previous study, it was observed that women of rural areas experienced more of physical, genitourinary and psychological problems than their urban counterparts, but less of non-communicable diseases (hypertension, diabetes mellitus and cardiac problem) [9]. As majority of the population of India live in rural areas (68.84%) [10]and women in rural areas face more gender bias and hence seldom come out with their complaints.

Material and Method:

It is a cross sectional study carried out in the Department of Obstetrics and Gynaecology, Mahila chikitsalaya, Sawai Man Singh Medical College, Jaipur, Rajasthan, India over a period of one year.

Inclusion criteria

1. Women > 40 years
2. Resident of the area
3. At least one year of amenorrhea at the time of the study

Exclusion criteria

1. Women younger than 40 years
2. Women in transit of residence at the time of survey
3. Suffering from amenorrhea from other causes other than menopause

Methodology:

It is a cross sectional study. This study is carried out in the Department of Obstetrics and Gynaecology, Mahila chikitsalaya, Sawai Man Singh Medical College, Jaipur, Rajasthan, India a period of one year.

Patients will be examined for their symptoms and gynecological examinations. On a decided proforma the age, socio economic demographic data, symptoms were recorded. General, systemic and obstetric examination findings also noted.

Results:

Most common age group at menopause is 46 to 48yrs. Lower socio economic group women have a late age at onset of menopause compared to higher socio economic group women. Early age at onset of menarche is associated with early age at onset of menopause. Presence of chronic diseases like anemia, HT, Tuberculosis has no influence in the age at onset of menopause. Most common presenting physical symptom in menopausal women is UTI, vaginal dryness and senile vulvovaginal Pruritus. About 50% of women have menstrual disturbances of varying degrees for about 6 months to 2 years in perimenopausal period before attaining menopause. Most common associated comorbid condition in menopausal women is diabetes mellitus, followed by hypertension and coronary artery disease. Awareness regarding treatment of menopausal symptoms and knowledge on Hormone replacement therapy is very low among menopausal women. Menopausal clinics should emphasize on health education to perimenopausal women regarding the physical and psychological transit they undergo. Increase in BMI leads to early age at onset of menopause and increase in morbidity by addition of co-morbid conditions like, diabetes, CAD, hypertension, etc. As the life expectancy at birth is increased, the number of years women spends in the post menopausal age also increases. Hence the concept of healthy menopause can be implemented as a national program which specifically addresses the needs of menopausal women (Table 1-2)

Table 1: clinico-demographic profile

Variables	Early Menopause	Late Menopause
Age		
<=50	187	103
51-60	78	132
Socioeconomic status		
Upper middle	20	4
Middle	55	31
Lower Middle	98	135
Lower	87	70
Marital Status		
Yes	208	258
No	34	0
Age at Menarche		
11-12	69	77
13-14	159	178
>=15	49	12
Menstrual C/O		
No	79	198

Yes	179	44

Table 2: Morbidity pattern

Variables	Early Menopause	Late Menopause
Abortion		
Nil	188	87
1	52	123
2	10	40
Chronic Illness		
No	180	160
Yes	97	63
Diabetes		
No	196	180
Yes	35	89
Hypertension		
No	209	190
Yes	57	44
Coronary artery disease		
No	212	208
Yes	38	42
Hypothyroid		
No	236	247
Yes	17	0
Life style modification		
No	180	198
Yes	83	39
Sexual Health		
No	213	185
Yes	59	43
Urinary Tract Infection		
No	112	108
Yes	92	88
Vulvovaginal pruritus		
No	170	162
Yes	70	98
Urinary Incontinence/Prolapse		
No	173	197
Yes	74	56
Hot flashes, Sweating		
No	196	187
Yes	68	49
Insomnia		
No	165	147
Yes	108	80
Depression		

No	209	182
Yes	33	76
H/O CA		
No	238	225
Yes	9	9
VIT D/CAL Deficiency		
No	209	39
Yes	187	65
Awareness regarding menopausal symptoms		
No	187	198
Yes	69	46
Awareness regarding screening for ca cervix		
No	89	90
Yes	188	170
Awareness regarding treatment of menopausal symptoms		
No	235	226
Yes	20	19

Discussion:

A retrospective analysis on 136,985 women received in 24 medical centers, noted a prevalence of 72% for natural menopause, 23.9% for surgical menopause and 3.8% for early menopause [11]. In France it is estimated the number of postmenopausal women was 10 million in 2004, which corresponds to 13.7% of France population at the time.

Among the authors who have studied the menopause, apart from smoking, disagreements exist about the factors that may influence the age at menopause. Menopause is known to occur earlier in postmenopausal women who smoke than those who do not smoke. This difference also exists within the same smokers among heavy smokers and those who smoke less [12].

In the study of Osinowo [13], menopausal women Nigerians living in Ibadan had better psychological health than women in Nigerian perimenopause. In one meta-analysis concerning 67714 women showed that the duration of reproductive period influences the psychological troubles of menopausal. Menopause at age 40 or more years compared with premature menopause was associated with a 50% decreased risk for depression [14].

Epidemiological data on weight gain at onset of menopause are not frequent, although anecdotally many women complain of weight gain during this lifecycle period [15]. Between 42 and 50 it is noted a mean weight gain of 0.8 kg/year in women. However there is considerable individual variation in the intensity of this weight gain, as 20% of women take 4.5 kg or more in 3 years, while only 3% lose weight. Predictors of weight gain are essentially race (black women gain more weight than white) and decreased physical activity [15].

In other studies, 10-20% of osteoporosis in postmenopausal women are reported to be linked to a secondary cause [16,17], which implies the need to confirm and eliminate a possible secondary cause before considering therapeutic management of any osteoporosis [18]. Because of the high cost of this care, treatment of these osteoporotic fractures remains prohibitive in developing countries such as India.Prevention is the best solution

in these countries. It is based on the eviction of risk factors such as smoking, excessive alcohol consumption, a balanced diet rich in calcium and vitamin D and the promotion of regular physical activity should be in all postmenopausal women, fall prevention.

Finally, although the proportion of postmenopausal women on hormonal replacement treatment (HRT) is very low in our survey, the use of HRT is increasing over the last 10 years from a proportion of women in this treatment was 0.54% in 2004 However, access to hormonal treatment of menopause remains limited due to lack of information and financial barriers. Often prescribed to mitigate the effects of menopause, the hormonal treatment of menopause experienced a drastic reduction of its requirements in the world following a publication in 2002, the first results of the US study, Women's Health Initiative (WHI). This study found indeed more risks than benefits in hormonal menopause treatment over the long term. The WHI study (Women's Health Initiative) and MWS (Milllion Women Study) have helped draw the attention of prescribers and women on these "alternative" treatments [19, 20].

Conclusion:

A holistic approach to attend to the specific needs of perimenopausal women, in the form of Education regarding menopausal symptoms, in both physical and psychological domain and Family based counselling at menopausal clinics to ensure social and emotional support and wellbeing of menopausal women.

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