

ORIGINAL ARTICLE

Symptomatology of Postmenopausal Women Presenting at Punjab Rangers Hospital, Lahore

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ABSTRACT

Objective: To describe the immediate symptoms of the post menopausal women attending Punjab Rangers Hospital Lahore.

To see the effects of these symptoms on quality of life (QOL).

Study Design: This was a descriptive type of study that was carried out at the Department of Gynecology and Obstetrics at Punjab Rangers Hospital.

Setting: O&G OPD at Punjab Rangers Teaching Hospital

Sample Size: 100 patients with menopause were studied for symptomatology and these symptoms affect the quality of life.

Sample Collection: Sample collection was done by a non-probability convenient method.

Inclusion Criteria: All patients who attended gynae opd at Punjab rangers hospital with:

- Natural menopause
- Above 45 years
- Below 55 years
- With no other Gynecological problems

Exclusion Criteria: All those patients were excluded from the study that had

- Surgical menopause
- Perimenopause
- History of depressive illness
- Women on antidepressant
- Women on HRT
- Below 45 YEARS

Data Collection: The questionnaires based on menopausal rating scale for symptomatology and quality of life were generated to see the impacts of these symptoms on life.

The educated patients filled questionnaires. I filled out questionnaires of illiterate patients outdoors myself.

Data Analysis: An analysis of data was done by using computer software SPSS.

Data master sheet was developed.

Frequency tables and graphs were generated The data was analyzed by using computer software SPSS..

Confidence interval was calculated for important frequency tables.

Cross tabulation was done for marital status, parity, literacy, smoking and chi-square was applied as a test of significance. 65% patients described that their quality of life decreased after menopause especially due to vasomotor and psychological symptoms. 35% of patients were happy and satisfied after their menopause. Besides menopause there were other stresses of middle life, which made life worse.

Subject: The study was performed during the period November 2020 to May 2021. Sample was collected by a non probability convenient method and 100 patients were selected. Data was collected by questionnaire provided to patients attending the outpatient department. Data was analyzed with a computer software system by using SPSS.

Results: The mean age observed was 49 years and frequency distribution of symptoms were: Hot flushes 60%, Night sweats 55%, Insomnia 50%, Mood changes 60%, Anxiety 50%, Irritability 50%, Memory loss 30%, Vaginal dryness 10%, Dyspareunia 10%, Loss of libido 15%, Urethral symptoms 25%, Lethargy and general body aches 75%. 65% patients described that their QOL had decreased after menopause. 35% patients described no effect.

Conclusion: To promote the awareness in women about menopause, HRT and other alternatives which can improve their QOL

INTRODUCTION

The menopause marks the end of the menstrual cycle and declining of physiological fertility. The menopause is conventionally said to have occurred when all menstruation has ceased for 12 months. Although menstruation may

become irregular yet the period is scantier for several years preceding the menopause. This is the perimenopause period [a period of changing ovarian function].¹

Menopause is an outward manifestation of ovarian failure. Exhaustion of primordial follicles leads to an order

of magnitude of ten-fold decline in circulating oestradiol to a median of about 50-80 picomole per liter. A level below that found in many healthy age matched men. If the functions of the oestradiol are just limited to reproduction then there is no problem because fertility after fifty years is desired by very few. Instead some women will feel very relaxed after the end of their monthly problems. But the function of estrogens is also known to range beyond the regulation of ovulation, implantation and adaptation to pregnancy. The estrogens have been accorded a central role in the normal function of vasomotor control, skeletal, CNS, CVS, and immune system. An estrogen deficiency leads to the clinical consequences of ovarian failure. The high level of FSH, LH is irrelevant to the production of symptoms.

This estrogen deficiency leads to various symptoms such as night sweats, hot flushes, psychological, urogenital, sexual and long-term sequelae like osteoporosis, cardiovascular problems and Alzheimer's disease. ²Due to these consequences of estrogens deficiency, it may have negative effects on quality of life in some women and may increase the morbidity and mortality secondary to osteoporosis or coronary heart diseases. ³Most women live long enough to become postmenopausal. Menopause is not a disease but it can be associated with discomfort and decreased quality of life due to its consequences. ⁴The onset of menopause is an excellent time for a women's primary care physician to assess her overall health and the need for health maintenance measures. The realization of profound changes and impacts of these changes on quality of life due to estrogens deficiency and relatively simple treatment make it imperative for the medical professionals to divert an increasing amount of attention to alleviating both the symptoms and the long-term effects. The menopause is an estrogen deficient state and it is thus logical that estrogen replacement will improve the problems.

Symptoms related to menopause are found in all regions of the world, everywhere. Large proportion of

women goes through menopause uneventfully. The evidence does not support that woman in developing countries report fewer symptoms than in industrialized countries.⁶

Much work has been done in this field. New drugs are introduced with fewer side effects and with different routes of administration. Few areas of medicines have such a diversity of therapeutic options.⁷

The data on menopause in Pakistan are scarce and scanty. The present study was undertaken to explore the symptoms complex associated with menopause and impacts of these symptoms on quality of life of women. It is therefore important and justified to provide all medical and psychological measures that may ameliorate the quality of life for all woman expecting a prolonged life.

Frequency of Postmenopausal Syndrome

Status of PMS	Frequency	Percentage
PMS Present	85	85.00
PMS Not Present	15	15.00
Total	100	100.00
Statistical analysis: 95% C.I for postmenopausal syndrome=76.14 to 91.08%		

Frequency of Various Symptoms among the PMS Patients

Symptoms	Frequency	Percentage	Statistical analysis 95% c.i
Hot flushes	60	60.00	49.70-69.52
Night sweats	55	55.00	44.75-64.85
Insomnia	50	50.00	39.9-60.09
Mood changes	60	60.00	44.70-69.52
Anxiety	50	50.00	39.90-60.09
Irritability	50	50.00	39.90-60.09
Memory loss	30	30.00	21.45-40.10
Vaginal dryness	10	10	5.16-18.04
Dyspareunia	10	10.00	5.16-18.04
Loss of libido	15	15.00	8.91-23.53
Urethral symptoms	25	25.00	17.12-34.17
Lethargy	70	70.00	59.89-78.54

Cross tabulations

Association of marital status with the PMS

Marital Status	Postmenopause Syndrome Status					
	PMS Yes		PMS No		Total	
	Number	%	Number	%	Number	%
Married	77	90.5	14	93.33	91	91
Unmarried	08	09.4	01	06.67	09	09
Total	85	100	15	100	100	100
Statistical Analysis Chi Square = 0.2 Degree of freedom = 2 P value = 0.7 (the association of marital status with PMS is statistically not established in this study)						

Association of parity status with the PMS

Parity Profile	Postmenopausal Syndrome Status					
	PMS Yes		PMS No		Total	
	Number	%	Number	%	Number	%
Parity 0	2	2.35	0	0	2	2
1-4	20	23.53	5	33.33	25	25
5 and above	63	74.11	10	66.67	73	73
Total	85	100	15	100	100	100
Statistical Analysis Chi Square = 0.94 Degree of freedom = 2 P value = 0.62 (the association of parity with PMS is statistically not established in this study)						

Association of smoking with PMS

Smoking status	Postmenopausal Syndrome Status					
	PMS Yes		PMS No		Total	
	Number	%	Number	%	Number	%
Non Smokers	70	88.61	06	85.71	76	88.37
Smokers	09	11.39	01	14.29	10	11.63
Total	79	100	07	100	86	100

Statistical Analysis
Chi Square = Not valid
Fisher exact test two tailed P value = 2
(the association of smoking with PMS is statistically not established in this study)

Association of Educational status with PMS

Educational status	Postmenopausal Syndrome Status					
	PMS Yes		PMS No		Total	
	Number	%	Number	%	Number	%
Illiterate	64	75.9	11	73.33	75	75
Elementary edu	10	11.76	3	20	13	13
Matric, F.A	4	4.71	6	6.67	5	5
Grad & above	7	8.24	0	0	7	7
Total	85	100	15	100	100	100

Statistical Analysis
Chi Square = 2.01
Degree of freedom = 3
P value = 0.0571 (the association of literacy with PMS is statistically not established in this study)

Effects of Pms on Quality of Life

QOL	Frequency	Percentage
Affected	65	65%
Not-affected	35	35%
Total	100	100

DISCUSSION

This study investigated the prevalence of postmenopausal symptoms and health associated quality of life in a women of age range of above 45 years upto 55 year .⁸ In our study the results has revealed, the most of the psychological and vasomotor symptoms and one third of women were happy and satisfied after their menopause.⁹ In most of the Asian populations same results have been observed. My studies findings, showed incidence of hot flushes and night sweats (60% and 55% respectively) and lethargy is upto 70% ,later finding interestingly correlates with the findings of study by Aida AlDughaiter in King Saud Bin Abdul-Aziz University for Health Sciences in March 2015,¹⁰ their study has also revealed fatigue and stress up to 67.1%. They reported 80.1% of women had suffered joint and muscular discomfort as the most prevalent symptom post-menopausally.

A study conducted in Thailand showed a higher rate of: vasomotor symptoms 72%, psychological symptoms 93%, urological symptoms 80.7%, these findings are consistent with our study results.¹¹ Ceylan B, Özerdoğan From turkey showed that menopausal women suffered from hot flushes 73.9%, generalised aches and pains and joint pains 89%.¹² In Japanese the prevalence of the vasomotor symptoms was lowest(18), while increased prevalence of vasomotor symptoms among chinese, caucasian, Hispanic and African American (21%,31%,35% AND 46% RESPECTIVELY). Moreover, it has been hypothesized that diet plays a very essential role in the severity of menopausal symptoms.¹³ Diets rich in phytoestrogens were found to protect against vasomotor symptoms. The soya products are a rich source of

phytoestrogens.¹⁴ A Japanese diet contains high amounts of soya, and this has led to the conclusion that soya may be associated with a decrease in vasomotor symptoms. So a study by Nagata et al provided evidence leading to this conclusion.¹⁵ In this study 65% patients described decreased quality of life, which correlates with the report of Barati M, Akbari-Heidari H.¹⁶

Local study in Pakistan by Nisar N, Sohoo NA, also showed higher frequency of somatic and psychological symptoms, these are very similar to our study. It was a hospital based cross sectional survey conducted at the department of Obstetrics and Gynecology Isra University Hyderabad Sindh Pakistan from November 2007 to August 2008. ¹⁷ Most prevalent symptom within study subjects was body ache 165 (81.7%) as was observed in our study. Frequencies of some symptoms were (66.3%) reported hot flushes (68.8%) and (66.3%) reported lack of energy and decrease in physical strengths respectively. ¹⁸

Our study revealed that education level also affects the PMS illiterate who had suffered more symptoms 75% as compared to graduation and above showed 8.24%. Indicators of socioeconomic status also includes level of education and it may affect the lifestyle and reproductive health of women. However, it may also be that women with higher education simply better cope with their VMS.¹⁹

Other factors which were investigated in our study were, smoking, gravidity, parity, and menarche all of these factors are associated with onset of PMS as compared to study by Lingyan Zhang in China in 2020, that showed no association between post menopausal symptoms and smoking, level of education and parity.²⁰

The diversity in symptoms may be due to better education and awareness and low parity in other countries than Pakistan.

Although parity and educational status is not very significantly associated with PMS in our study. It may be due to the small sample size.

In future it is recommended that larger sample size and different geographic locations must be included in data collection regarding menopausal symptoms and quality of life during menopausal transition. Our selection of women in study may not represent the whole female population in Pakistan, since it was carried out in a health facility that serves only Punjab Rangers soldiers and their dependents. Most of the females in this sample had low levels of literacy, similar levels of physical activity, and were nonsmokers. In addition, some information taken during patients' interviews might be subjected to recall bias, which might affect median age at onset of menopause.

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