International Journal of Trend in Scientific Research and Development (IJTSRD)
Volume 6 Issue 3, March-April 2022 Available Online: www.ijtsrd.com e-ISSN: 2456 – 6470

Menopausal Symptoms and Management

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ABSTRACT

The ceasing of menstruation is menopause. The term can describe any of the changes through just before or after stoping period, marking the end of reproductive years. The important symptoms and the health concerns of menopause are: ™ Vasomotor symptoms, Urogenital atrophy, Osteoporosis and fracture, Psychological changes, Skin and Hair, Sexual dysfunction. Management is lifestyle modification, hormonal therapy, psychotherapy and antidepressants. A better understanding of the nature of the risk for these common symptoms in menopausal women will help in prevention, detection, and treatment.

KEYWORDS: *Menopause*

How to cite this paper: Pooja Chand "Menopausal Symptoms and Management" Published in International Journal of Trend in Scientific Research and Development (ijtsrd), ISSN: 2456-6470, Volume-6 | Issue-3, April 2022, pp.421-423, URL: www.ijtsrd.com/papers/ijtsrd49486.pdf

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INTRODUCTION

Menopause is defined as the time of cessation of ovarian function resulting in permanent amenorrhoea. It takes 12 months of amenorrhoea to confirm that menopause has set in, and therefore it is a retrospective diagnosis. Menopause sets in when the follicular number falls below 1000. Menopause normally occurs between the ages of 45 and 50 years, the average age being 47 years. During climacteric, ovarian activity declines. Initially, ovulation fails, no corpus luteum forms and no progesterone is secreted by the ovary. Therefore, the premenopausal menstrual cycles are often anovulatory and irregular. Later, Graafian follicles also fail to develop, oestrogenic activity is reduced and endometrial atrophy leads to amenorrhoea. Cessation of ovarian activity and a fall in the oestrogen and inhibin levels cause a rebound increase in the secretion of FSH and LH by the anterior pituitary gland.[1]

Sign and symptoms

The important symptoms and the health concerns of menopause are: ™ Vasomotor symptoms, Urogenital atrophy, Osteoporosis and fracture, ™ Psychological changes, Skin and Hair and™ Sexual dysfunction.

Vasomotor symptoms

Under the vasomotor symptoms Hot flush that is characterized by sudden feeling of heat followed by profuse sweating. There may also be the symptoms of palpitation, fatigue and weakness.

Urogenital atrophy

Estrogen deficiency produces atrophic epithelial changes in vagina, urinary bladder and the urethra. This may cause vaginal dryness, dyspareunia and dysuria.

Osteoporosis and fracture

Bone loss increases to 5% per year during menopause. Osteoporosis may be primary (Type 1) due to estrogen loss, age, deficient nutrition (calcium, vit. D) or hereditary. It may be secondary (Type 2) to endocrine abnormalities (parathyroid, diabetes) or medication. Osteoporosis may lead to back pain, loss of height and kyphosis. Fracture may involve the vertebral body, femoral neck, or distal forearm (Colles' fracture).

Psychological changes

Estrogen is thought to protect the function of central nervous system. Dementia and mainly Alzheimer disease are more common in postmenopausal women.

There is increased frequency of anxiety, headache, insomnia, irritability dysphasia and depression.

Skin and Hair

There is thinning, loss of elasticity and wrinkling of the skin. Skin collagen content and thickness decrease by 1–2% per year. "Purse string" wrinkling around the month and "crow feet" around the eyes are the characteristics. Estrogen receptors are present in the skin and maximum are present in the facial skin.

Sexual dysfunction

Estrogen deficiency is often associated with decreased sexual desire.[2]

Management

Every woman with postmenopausal symptoms should be adequately explained about the physiologic events. This will remove her fears, and minimize or dispel the symptoms of anxiety, depression and insomnia. Reassurance is essential. The management of Menopause is mainly based on symptoms and causes; Lifestyle modification includes: Physical activity (weight bearing), reducing high coffee intake, smoking and excessive alcohol.[3] If hot flushes drink cold water, sit or sleep near a fan, and dress in layers, use an over-the-counter vaginal moisturizer or lubricant for dryness., exercise regularly to sleep better and prevent conditions like heart disease, diabetes, and osteoporosis, strengthen pelvic floor muscles with Kegel exercises to prevent bladder leaks, stay socially and mentally active to prevent memory problems, practice things like yoga, deep breathing, or massage to help relax.[4] There should be adequate calcium intake (300 mL of milk), reducing medications that causes bone loss (corticosteroids), Supplementary calcium—daily intake of 1–1.5 g can reduce osteoporosis and fracture, Vitamin D—supplementation of vitamin D3 (1500–2000 IU/day) along with calcium can reduce osteoporosis and fractures, In hormone replacement therapy certain drugs or combinations can help with hot flashes and vaginal symptoms, as well as making bones stronger. Short-term therapy is required to relieve the woman of hot flushes, night sweats, palpitations and disturbed sleep.[5] Oestrogen should however be given in the smallest effective dose for a short possible period of 3–6 months. Progestogens are used for 10–12 days in each cycle to avoid the risk of endometrial hyperplasia and cancer in nonhysterectomized women. Tibolon elevates the mood, relieves the vasomotor symptoms, improves the sex drive and reduces bone resorption First-line treatment of a major depressive episode may involve psychotherapy, antidepressants.[6]

Discussion

A study was conducted on menopausal symptoms, and perceptions about menopause among women at a rural community in Kerala the study results were following ; The mean age of attaining menopause was 48.26 years. Prevalence of symptoms among ladies were emotional problems (crying spells, depression, irritability) 90.7%, headache 72.9%, lethargy 65.4%, dysuria 58.9%, forgetfulness 57%, musculoskeletal problems (joint pain, muscle pain) 53.3%, sexual problems (decreased libido, dyspareunia) 31.8%, genital problems (itching, vaginal dryness) 9.3%, and changes in voice 8.4%. Only 22.4% of women knew the correct cause of menopause.[7]

A Population-based, epidemiologic study was conducted on menopausal symptoms and their Management. This article addresses the core 4 symptoms and includes cognitive issues because they are of great importance and concern to aging women. Vasomotor symptoms afflict most women during the menopausal transition, Hot flashes are reported by up to 85% of menopausal women. Both hormone therapy and nonhormonal regimens can help to relieve vasomotor symptoms. Community-based studies confirm that about 27% to 60% of women report moderate to severe symptoms of vaginal dryness or dyspareunia in association with menopause in Vulvovaginal atrophy. Women report more trouble sleeping as they enter into the menopausal transition, and sleep has been shown to be worse around the time of menses. Treatment of sleep complaints depends on the clinical findings. For insomnia, the reader is referred to the practical clinical review by Buysse. Sleep apnea is often treated with continuous positive airway pressure devices. Restless leg syndrome can be treated with dopamine agonists, gabapentin, and opioids. Hormone therapy can be considered for women with difficulty maintaining sleep In one study of 205 menopausal women, 72% reported some subjective memory impairment. Women experiencing a surgical menopause after hysterectomy and bilateral oophorectomy have also been a focus of study, because cognitive complaints are common in this subgroup and hormonal changes are certainly more abrupt and clearly defined. There is evidence that these women do develop impairments in verbal memory that can be prevented by administration of estrogen therapy. [8]

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