GYNAECOLOGICAL PROBLEMS IN POST MENOPAUSAL WOMEN (Study of 100 Cases)

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SUMMARY

Menopause is considered as an endocrinopathy, associated with oestrogen deficinecy, pschyosocial and late symptoms. 100 postmenopausal women admitted to PGMI for various reasons were included in the study. The study showed that the main gynaecological complaint in these women was pressure perineum followed by urinary complaints. None had psychological or psychosexual problems though only 5 had sleep disturbance. 33% of the patients had hypertension, 11% had diabetes and 8% had gynaecological malignancies. Only 5% had hormone replacement therapy. As menopause is regarded as a hormone deficiency syndrome, hormone replacement therapy must be given either prophylactically to prevent osteoporosis or therpeutically to prevent vasaomotor symptom and atrophic vaginitis.

INTRODUCTION

The word menopause, taken from greek word, "Meno" means month and "Pause" means cessation. The other word "Climacteric" used synonymously as pre and post menopausal years, means "rung of ladder", or a critical period in human life, in which some critical body change takes place.[1] According to international menopause society, menopause was defined as beginning with the final menstrual period, which is typically around the age of 51 years.[2]

All women, if they lead a long life, have to go through menopause. Extensive research has been done, and is being done in changes brought about by menopause, and their management. This is because older women now constitute about 50% of female population, and the number is increasing still further, and by year 2000 women will be spending an increasingly greater portion of their lives in menopause and post menopausal states.[2]

This period in life is associated with both physical and psychological symptoms. Psychological symptoms have been so closely related with the menopause, that they have been in the definition of climacteric "the syndrome of endocrine, somatic and psychic changes occuring at the termination of reproductive period in females".[1]

A variety symptoms and clinical features have been reported with menopause, and it is difficult to decide which of the clinical features are due to climacteric, some other unrelated disease processes, or psychogenic causes due to changes in circumstances, personality problems or psychiatric back ground. The following classification has been suggested as being the most critical and easily related to clinical situation.

A. True oestrogen deficiency symptoms
a. Early:-
1. Hot flushes and perspiration.
2. Atrophic vaginitis.
b. Late:-
Resulting indirectly from the system affected. e.g. osteoporosis causing back ache, breast atrophy. degenerative arthropathy etc.
B. Non specific or psycho social symptoms:-

Depression, irritability, insomnia, frigidity, headache etc.[3]

The aim of the study was to find out gynaecological problems in post menopausal women, because with the increase in average life span of population, greater number of older population are coming for their problems to the hospital.

MATERIAL AND METHODS

The study was carried out in Postgraduate Medical Institute, Lady Reading Hospital Peshawar. It included 100 patients (Table-1)

All of the women were post menopausal (Table-2) and were admitted in hospital through outpatient clinic or casualty. These cases were selected at random.

A detailed history and clinical examination was performed in each case, followed by labarotory investigations like haemoglobin estimation, urine examination, random blood sugar, blood urea, electrocardiography and chest x-ray.

RESULTS

The results of the study (Table-3) showed that the main gynaecological complaint was pressure perineum, followed by urinary complaints. None of the women complained of psychological upsets and depression. Just five had sleep disturbances. None of the patients complained of sexual problems like dysparunia and loss of libido. Prolapse of genital tract so commonly seen may have been due to repeated child bearing, and menopause only aggravated the pre-existing prolapse.

Only 5 % had hormonal replacement therapy in the past. 33% of patients were found to have hypertension and 11% had diabetes mellitus. About 25% of these women had knowledge of their disease, while 75% were diagnosed during the hospital stay, (Table-4) 8% of patient had gynaecological malignancies. 4% had ovarian cancer. 2% had carcinoma cervix, and 2% had endometrial cancer.

DISCUSSION

Menopause can be considered as an endocrinopathy. Functional and morphological changes in ovary lead to a disturbance in hormonal levels, which in turn negatively effects the target tissue. These changes can be produced prematurely by ablation of gland, and appropriate hormone replacement should reverse them.[2]

At the time of menopause, ovary is essentially depleted of follicles. Although some follicles may remain, but for some reason they become unresponsive, or exhibit a break through response only occasionally. The major functional change is loss of reproductive

Table No. 1

AGE

Age Range	Number	%
50 - 60 YEARS	55	55
61 - 70 YEARS	38	38
71 - 80 YEARS	7	7

potential.[2] Due to decreasing number of follicles, less oestrogen is synthesized. A deficiency of follicular inhibin and estrogens leads to decreased negative feed back of the anterior pituitary gland, which results in an increase in levels of follicle stimulating hormone and luteinsing hormone. The predominant oestrogen in reproductive life, oestradiol, which is the active form, is replaced by estrone, a less active form in post menopausal women.

Changes occur in tissues having oestrogen receptors, i.e, ovary, endometrium, vaginal epithelium and hypothalamus. Certain tissue may be indirectly affected by changes in the endocrinoligic profile, e.g. oestrogen may indirectly affect osseous tissues by alternative mechanisms. The cause and effect relation-ship between menopausal hormonal changes and target tissue effects is not always apparent because menopause is a syndrome that occurs over a time, further more, the general aging process and even psychological factors further obscures the cause and effect relation-ship.[2]

There has been recent tendency to regard the climacteric as a hormone (oestrogen) deficiency syndrome. Three grounds of indications exist for the use of oestrogen in menopausal, symptoms related to oestrogen deficiency, such as vaso motor symptoms, atrophic changes of vagina and other genito urinary tissues psychologic/mood changes, osteoporosis prophylaxis and treatment, and prevention of cardiovascular morbidity and death.[4]

A profound psychological, euphoric, or mental tonic effect of oestrogen administration on ageing women has long been described[3] but several other studies show that oestrogen is not an effective treatment for anxiety or depression. These studies stress the influence of changes in family

Table No. 2

DURATION OF MENO PAUSE

Range of Meno pausal duration	Number	%
1 - 5 YEARS	33	33
6 - 10 YEARS	33	33
10 - 15 YEARS	15	15
16 - 20 YEARS	15	15
21 - 30 YEARS	4	4

Table No. 3

PRESENTING COMPLAINTS

Presenting Complaints	Number	%
1. Pressure perineum	76	76
2. Urinary problems	46	46
Difficulty in passing urine	14	14
Dysuria	10	10
Retention	7	7
Stress incontinence	6	6
Frequency	5	5
Urgency	3	3
Incontinence (True)	1	1
3. Back ache	27	27
4. Something coming out of vagina	24	24
5. Pain hypogastrium	22	22
6. Defaecation problems	8	8
7. Discharge per vagina	15	15
8. Bleeding per vagina	6	6
9. Constipation	6	6
10. Abdominal distension	6	6
11. Mass lower abdomen	6	6
12. Sleep disturbances	5	5
13. Bleeding Per rectum	2	2

structure and social factors on the way in which a woman adapts at this time. In addition they also have a beneficial effect on bone collagen. Estrogens have a beneficial effect only in prevention of osteoporosis, but not in the treatment of osteoporosis.[5] The use of estrogens in prevention of cardiovascular disease in post menopausal women has been controversial. In three important trials, a risk reduction for stroke, myocardial infarction and cardio vascular death was associated with this therapy's use.[4] It is stated that oestrogens exert their beneficial effects by inducing reduction in low density lipo-protein cholesterol and an increase in high density lipo-protein cholesterol.

This study showed that the commonest complaint was genital tract prolapse, none of the subjects had complaints of psychological symptoms and depression. This is in marked contrast to studies carried out in the western countries, where the psychological upsets are one of the main presenting complaints. One of the factor, which may be responsible for this variation may be that menopause is not an unwelcoming change in the lives of these women. Having a combined family system, these elderly women attain a higher value and prestigious position in the family. More over, they are also happy to offer their prayers regularly, Another contrasting point in this study, as compared to studies in the western world, was that none of the patients complained of sexual problems like dysparunia, or loss of libido, which may be because of infrequent sexual activity. Only 5% had hormonal replacement therapy in the past. This reflects lack of interest and concern of these women for thier complaints. This may also be due to ignorance . about the physiology of menopause, its complications and hormonal replacement therapy.

Table No. 4

CO-EXISTING DISEASE

Co-Existing Disease	Number	%
Hypertension	33	33
Diabetes	11	11
Anaemia	19	19
Asthma	2	2
Tuberculosis	1	1
Ischaemic heart disease	1	1

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