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## Quality of life of menopausal women: Kashmir experience

**Sana Ashfaq Naqash and Nighat Firdous**

### Abstract

**Introduction:** Menopause is a physiological event in a woman's life. It is caused by aging of ovaries which leads to decline in the production of ovarian gonadotropins estrogen and progesterone. The deficiency of these hormones elicits various somatic, vasomotor, sexual and psychological symptoms that impair the overall quality of life of women.

**Objectives:** (i) To determine the mean age of menopause in Kashmiri women. (ii) To evaluate the severity of menopausal symptoms among Kashmiri women. (iii) To analyze the impact of menopausal symptoms on quality of life among Kashmiri women visiting hospital.

**Methods:** The study was conducted in the Postgraduate Department of Obstetrics and Gynaecology, Lalla Ded Hospital, Government Medical College, Srinagar. Postmenopausal Kashmiri women between the age of 45-55 years with at least one year of amenorrhea and those who had attained natural menopause in last 5 years. Information regarding socio-demographic profile and reproductive parameters (such as parity, age of menarche, regularity of menses, age of menopause, and years since last menstruation) were recorded. For assessment of the menopausal symptoms Menopause Rating Scale (MRS) was used. MRS is an 11-item questionnaire. For the assessment of health-related quality of life (HRQOL), The Menopause Specific Quality of Life Questionnaire (MENQOL) was used.

**Results:** This study included 200 Kashmiri women aged 45-55 years with a mean age of  $50.7 \pm 5.29$  years. Age at natural menopause was found to be  $48.6 \pm 3.75$  years. The three symptoms reported to be most prevalent included joint and muscular discomfort (84.5%), physical and mental exhaustion (65.5%) and hot flushes and sweating (46.5%). Of those who reported muscle and joint discomfort, 42.6% considered the symptoms to be moderate to very severe. The highest mean score was obtained for physical domain ( $3.62 \pm 0.358$ ) followed by psychosocial ( $2.97 \pm 0.605$ ), vasomotor ( $2.73 \pm 0.945$ ) and sexual ( $2.41 \pm 0.909$ ) domains respectively.

**Conclusion:** The current study revealed that an increase in frequency, intensity of menopausal symptoms is related to poor physical, psychological, vasomotor, and sexual health-related QOL among women in the post reproductive period.

**Keywords:** Parental attitude, participation, sports, girls

### Introduction

Modern medicine has significantly increased the life expectancy of women throughout the world<sup>[1]</sup>. The world population of women aged over 60 years was below 250 million in 1960 and it is estimated that in 2030 1.2 billion women will be perimenopausal or postmenopausal and this will increase by 4.7 million a year<sup>[2]</sup>. Menopause is a physiological event in a woman's life. It is caused by aging of ovaries which leads to decline in the production of ovarian gonadotropins estrogen and progesterone. The deficiency of these hormones elicits various somatic, vasomotor, sexual and psychological symptoms that impair the overall quality of life of women<sup>[3,4]</sup>. Given the rise in the life expectancy, women can now expect to live approximately one third of their life in hormone deficient state with impaired quality of life (QOL). The study on QOL in menopausal women thus becomes an essential component in clinical practice<sup>[5]</sup>. It has been reported that the experience of menopausal symptoms involves not only a complex interaction between sociocultural, psychological and environmental factors but also the biological changes related to the altered ovarian hormonal status or deficiency<sup>[3,6]</sup>.

The World Health Organization defines QOL as an individual's perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns<sup>[7]</sup>. Host of studies have been conducted to

Measure the QOL of menopausal women from western world [8, 9, 10] with different sociocultural realities which may influence not only the perception of QOL but also the experience of menopause at different status of menopause. Very little information exists about QOL of menopausal women in developing countries [11, 12]. Unraveling these complex influences is a challenge to researchers. The current national programme on reproductive health focuses on women between 15-45 years of age and very less attention is being paid to women beyond reproductive age unless conditions become worse. The information on menopausal symptoms and the way women choose to treat these symptoms are essential for designing appropriate delivery of health care services and to ensure easy transition to old age.

**Aims and objectives**

1. To determine the mean age of menopause in Kashmiri women.
2. To evaluate the severity of menopausal symptoms among Kashmiri women.
3. To analyze the impact of menopausal symptoms on quality of life among Kashmiri women visiting hospital.

**Material and methods**

The study was conducted in the Postgraduate Department of Obstetrics and Gynaecology, Lalla Ded Hospital, an associated hospital of Government Medical College, Srinagar over a period of 18 months from September 2016-March 2018, after obtaining ethical clearance from institutional ethical committee.

**Inclusion Criteria**

- Postmenopausal Kashmiri women between the age of 45-55 years with at least one year of amenorrhea and those who had attained natural menopause in last 5 years.
- Women who had recently attained menopause (i.e. within 5 years) were included in the study to minimize recall bias.

Pretested semi-structured standard questionnaires were used to collect the relevant information. Information regarding socio-demographic profile and reproductive parameters (such as parity, age of menarche, regularity of menses, age of menopause, and years since last menstruation) were recorded.

For assessment of the menopausal symptoms Menopause Rating Scale (MRS) was used. MRS is an 11-item questionnaire [13]. It contains three independent dimensions: Psychological, somatic, and urogenital subscale. Each of the 11 symptoms in MRS contained in the scale can get 0 (no complaints) or up to 4 scoring points (severe symptoms) depending on the severity of the complaints perceived by the women completing the scale. The composite scores for each of the dimensions (subscales) are based on adding up the scores of each item of the respective dimensions. The composite score (total score) is the sum of the dimension scores, and is proportional to the severity of subjectively perceived symptoms.

For the assessment of health-related quality of life (HRQOL), The Menopause Specific Quality of Life Questionnaire (MENQOL) was used [14]. The Menopause-Specific Quality of Life Questionnaire (MENQOL) was introduced in 1996 as a tool to assess health-related quality

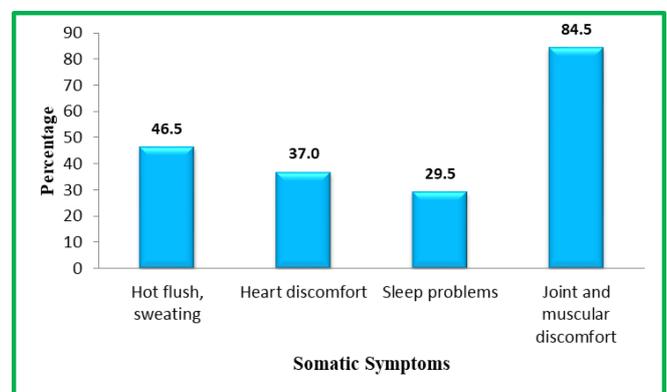
of life in the immediate post-menopausal period. An inherent assumption of the MENQOL is that disease states and conditions like menopause, which produce symptoms, may disrupt emotional, physical, and social aspects of an individual's life, which must be considered concomitantly with treatment decisions.

**Results**

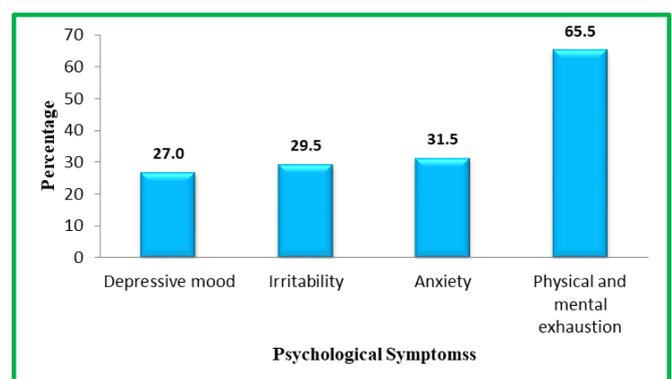
The study included 200 Kashmiri women aged 45-55 years with a mean age of 50.7±5.29 years. In this study, age at natural menopause was found to be 48.6±3.75 years. 74% of our study subjects were married, 21.5% widows and 4.5% were separated. Majority of the women in our study were illiterate (61.5%) while few had attended primary (20%), middle (10.5%) and high school (8%). Only 3% of the women were graduates. In our study, 86.5% women were housewives; only 13.5% were working. The three symptoms reported to be most prevalent included joint and muscular discomfort (84.5%), physical and mental exhaustion (65.5%) and hot flushes and sweating (46.5%). Of those who reported muscle and joint discomfort, 42.6% considered the symptoms to be moderate to very severe. The highest mean score was obtained for physical domain (3.62±0.358) followed by psychosocial (2.97±0.605), vasomotor (2.73±0.945) and sexual (2.41±0.909) domains respectively.

**Table 1:** Age at menopause in study patients

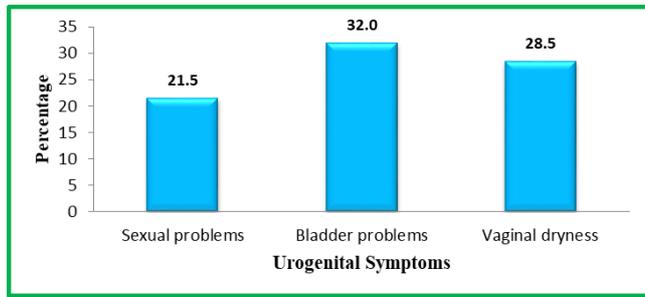
Age at menopause (years)	Frequency	Percentage
45-47	69	34.5
48-50	92	46.0
51-53	39	19.5
Total	200	100
Mean±SD=48.6±3.75		



**Fig 1:** Prevalence of menopausal symptoms according to MRS



**Fig 2:** Prevalence of menopausal symptoms according to MRS



**Fig 3:** Prevalence of menopausal symptoms according to MRS

**Table 2:** Impact of menopausal symptoms on quality of life according to vasomotor domain

Vasomotor Domain	Mean	SD	Min	Max
Hot flushes	3.38	1.61	1	6
Night sweats	2.49	1.68	0	5
Sweating	2.33	1.74	0	5

**Table 3:** Impact of menopausal symptoms on quality of life according to psychosocial domain

Psychosocial Domain	Mean	SD	Min	Max
Being dissatisfied with my personal life	2.45	1.78	0	5
Feeling anxious or nervous	3.61	1.14	1	6
Experiencing poor memory	3.31	1.20	1	5
Accomplishing less than I used to	3.18	1.38	0	5
Feeling depressed, down or blue	2.57	1.69	0	5
Being impatient with other people	2.98	1.43	1	5
Feelings of wanting to be alone	2.68	1.72	0	5

**Table 4:** Impact of menopausal symptoms on quality of life according to sexual domain

Sexual Domain	Mean	SD	Min	Max
Change in your sexual desire	2.81	1.26	1	5
Vaginal dryness during intercourse	1.94	1.41	0	4
Avoiding intimacy	2.46	1.74	0	5

**Discussion**

In the present study, the mean age of menopausal women was  $48.6 \pm 3.75$  years, which is in good agreement with the findings of earlier studies of Cyriac *et al.* [15] in Kerala ( $49 \pm 3.6$  years), Sagdeo and Arora [16] in Nagpur ( $49.67 \pm 6.53$  years), Ruchika *et al.* [17] in Agra (48.26 years), Borker *et al.* [18] in Kerala (48.26 years), Kaulagekar [19] in Pune ( $48.3 \pm 1.9$  years), Sharma and Mahajan [20] in Jammu (47.35 years), and Singh and Pradhan [21] in Delhi ( $46.24 \pm 3.38$  years). However, higher mean age at menopause was reported from developed [22] countries (51.6–52.8 years). These differences could be ascribed to variations in genetic, environmental and lifestyle factors. As regards to the severity level of menopausal symptoms; the highest mean score was obtained in the physical domain ( $3.62 \pm 0.358$ ) with the commonest symptom being joint and muscular discomfort reported by 84.5% of women in the study. Karmakar *et al.*, [23] who conducted a study on QOL among menopausal women in West Bengal, reported consistent findings that 93% of the women experienced physical symptoms of poor physical stamina (88%), musculoskeletal pain (84%), flatulence or pain due to gas (81%), pain in the neck and headache (76%), low back pain (69%), frequency in urination (63%), and dryness of skin, changes in the appearance, and skin tone (40%). A cross-sectional [18] survey in Kerala showed that nearly 92.7% of the women in the menopausal stage experienced musculoskeletal pain, (88%) headache, (62.1%)

numbness in hands and feet, and (61.1%) breathing difficulties.

Whether menopause results in poor psychological health continues to be debated and women may experience mood disorder, anxious feelings, nervousness, irritability, and emotional outburst. The mean score of psychosocial domain in our study was  $2.97 \pm 0.605$  with the commonest symptom being anxiety reported by 31.5% of women. A study in Daerah village of West Bengal, India, [23] among menopausal women corroborated the findings, showing that 94% of the participants reported anxiety and nervousness and feeling tired, decrease in physical stamina (93%). A study by Satpathy [24] at Western Odisha, India, reported that 75% of the menopausal women were suffering from various psychological problems such as forgetfulness (59%), irritability (42%), anxiety (42%), worry about body image (75%), confusion (46%), loss of control over emotions (27%), feeling that something is crawling on skin (24%), and poor concentration (17%).

Hot flushes, generalized sweating, and night sweats are the most common prevalent vasomotor symptoms in menopausal age. The physiological mechanisms contributing to these symptoms in the postmenopausal period are incompletely understood but believed to be the consequences of estrogen [25]. These vasomotor symptoms such as hot flushes and sweating may result in emotional outburst, poor concentration at work, and sleep disorders. Study of Women's Health Across the Nation reports that nearly 65%–80% of the women experience vasomotor symptoms and it may last for 1–10 years or longer than that in postmenopausal life [26]. The mean score of vasomotor domain in our study was  $2.73 \pm 0.945$  with the commonest reported symptom being hot flushes (46.5%). A study by Dasgupta *et al.* [27] among tribal and caste women in West Bengal, India, reported that 40.4% versus 38.4% of the tribal and caste women experienced hot flushes and night sweats 54.7% vs. 53.9%. Chowtaet *al.*, [28] Kaulagekar, [19] and Poomalar and Arounassalame [29] validate our findings by saying that 89%, 80%, and 70%, respectively, experienced more frequent attacks of vasomotor symptoms of hot flushes and night sweats in the menopausal period.

Sexual dysfunction after menopause is a complex problem with many etiologies. The dramatic cessation of estrogen may lead to vaginal dryness, and dyspareunia, which in turn decreases sexual drive. The prevalence rate of sexual problems among the postmenopausal women ranges from 68% to 86.5% [30]. This study found that nearly 21.5% of the women experienced sexual problems with changes in sexual desire and intimate relationship with partners. A cross-sectional study by Santpure *et al* [31]. In Maharashtra among postmenopausal women corroborated that sexual activity decreased from 54.4% to 5.6% in menopause and women avoided sexual activity related to decreased sexual energy (10.7%), vaginal dryness (55.36%), and painful intercourse (10.7%). A study in West Bengal [23] among tribe and caste women showed that genital complaints such as vaginal dryness (45.9 vs. 7.1%), burning sensation (9.3 vs. 5.0%), vaginal discharge (32.6 vs. 13.5%), vaginal itching (14.0 vs. 12.1%), and bad smell (11.6 vs. 2.1%), and urinary problems – burning micturition (25.6 vs. 17.7%), inability to retain urine (47.1 vs. 64.5%), frequent urination (29.1 vs. 38.3%), and urine leakage (23.8 vs. 51.1%) – were the most frequently reported menopausal symptoms.

In the present study, menopausal women showed a considerably poor QOL in the physical, psychological, vasomotor, and sexual domains. These findings were homogenous with a study in Pakistan<sup>[32]</sup> that reported 99% of the menopausal women suffer from physical problems, 96% with psychological disorders, 71% with vasomotor symptoms, and 66% with sexual dysfunction. Consistent findings were reported by Karmakar *et al.*<sup>[23]</sup> that mid-life women suffer with the occurrence of vasomotor symptoms – hot flushes (60%) and sweating (47%), and of psychosocial symptoms – feeling of anxiety and nervousness (94%) and depression (88%). The prevalence (93%) of physical symptoms was related to poor stamina (88%), aches in muscles or joints, difficulty in sleeping (84%), flatulence or gas pains (81%), pain in the neck or head (76%), low backache (69%), frequent urination (63%), dryness of the skin and changes in appearance, texture, and tone (40%), and with hair growth in the face (5%).

### Conclusion

In conclusion we would like to assert that postmenopausal women are those women who have just sprung from the spring board of middle age into the pool of old age. Therefore they form a special vulnerable group and it is high time that we think, work out and execute all feasible, appropriate and practical measures to give them a happy and joyful life. With the increase of life expectancy greater thrust on their health care activities as well as social security mechanisms is the need of the hour. Our research work has very modestly tried to elicit some of the risk factors which affect the quality of life of these women beyond their reproductive years. These, we feel should be the basis of activities and health education on healthy lifestyle for promoting positive attitudes towards coping up with the stress of the post-menopausal phase. The problems of this special group must be dealt with efficiently at all levels individual, family and community with meaningful and relevant contributions of different stakeholders. Positive will is a very useful and quick process of implementation of a plan and therefore separate policies need to be formulated which are more gender sensitive and should specially focus on this vulnerable group of post-menopausal women who fall in a transitional population between the reproductive age group and geriatric population. The current study revealed that an increase in frequency, intensity of menopausal symptoms is related to poor physical, psychological, vasomotor, and sexual health-related QOL among women in the post reproductive period. From the patient's perspective, primary care health personnel should engage menopausal women to discuss sensitive issues and reassure them that they are being cared for in a holistic manner. An integrative approach of care addressing mind, body, and spirit would ensure that women engage in lifestyle modifications and health-promoting behaviors to improve their QOL in the next one-third of lifespan development.

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