The menopause experience: A study of symptom management


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Abstract
Menopause, typically occurring around the age of 50, is not just a natural aspect of aging for women. While it may alleviate menstrual issues such as PMS, it can also bring about hidden health problems. This stage offers an important opportunity to implement preventive measures that can enhance overall quality of life and decrease mortality rates. There is a worldwide demand for easily accessible, evidence-based information and safe treatment options to manage menopausal symptoms and related health conditions. By prioritizing proactive health strategies during menopause, women can more effectively oversee their health and protect against potential health challenges that may emerge during this significant transition. There remains a pressing global need for straightforward access to evidence-based information and safe, effective treatment alternatives for those in need of assistance.

Keywords: Menopause, PMS, Asymptomatic

1. Introduction
The period marking the shift from reproductive to climacteric life in women is known as the menopausal transition. The perimenopausal phase, leading up to menopause, can bring about physical and emotional changes that may require adaptation and self-care. The processes of chronological aging and ovarian aging are closely related and occur simultaneously, influencing the rate and length of the transition. As menopause approaches, it marks the end of one chapter and the start of a new one, offering opportunities for self-discovery and empowerment. By embracing this natural progression with openness and awareness, women can navigate the challenges and joys that come with this stage of life. It is a time to focus on health, well-being, and personal fulfilment, allowing for a positive transformation and a renewed sense of purpose in embracing the next chapter of life (1). There are some common terms that are used to explain this stage are given in table 1.

Table 1. Various aspects and stages of menopause

Terminologies	Definition	Ref.
Menopause	The final menstrual period or the permanent cessation of ovarian function	(2)
Early menopause	Menopause occurring at 40 to 44 years of age.	(3)
Premature ovarian insufficiency	Menopause occurring before 40 years of age; women may experience oligo menorrhoea and amenorrhoea during this time.	(4)
Perimenopause	From when the menstrual cycle starts	(5)
Post menopause	Changing until 12 months after menopause	(2)

The timeline of reproductive and hormonal changes associated with the menopausal transition can indeed provide valuable insights into the experiences of women during this phase. By understanding these changes, healthcare providers can offer more targeted support and interventions to help manage symptoms effectively. Table 2 shows different types of symptoms visible in this phase.

Table 2. Types of symptoms

Type	Symptoms	Ref.
Perimenopausal or menopausal symptoms	menstrual cycle changes in length (longer or shorter) and flow (heavier or lighter)	(2)
Vasomotor symptoms	hot flushes, night sweats mood changes cognitive concerns (‘brain fog’) sleep disturbance	(6)
Musculoskeletal symptoms	low libido formication (sensation of insects crawling under the skin)	(3)
Genitourinary symptoms	vaginal dryness, dyspareunia, urinary urgency, urinary frequency, recurrent urinary tract infections)	(7)

During the menopausal transition and post-menopause, women commonly experience a range of symptoms that can persist for a significant period. Vasomotor symptoms are frequently most severe in the first few years but can endure for more than ten years. Other important symptoms include hot flashes, night sweats, sleep issues, and discomfort in the genitourinary area. Genitourinary symptoms may worsen gradually. In addition to these, women may also encounter mood swings, cognitive changes, decreased sexual drive, lowered bone density, increased abdominal fat, and altered metabolic health. These symptoms may present in various combinations or orders, sometimes making it challenging to attribute them directly to menopause (8). For older patients aged 45 and above exhibiting menopausal or amenorrheic symptoms, routine laboratory tests and imaging are generally unnecessary unless an alternative diagnosis is suspected. However, it is crucial to confirm that pregnancy is not a factor for sexually active individuals not using contraception.

In contrast, clinicians should assess follicle-stimulating hormone (FSH) levels for those under 45 with irregular or absent menstrual cycles, acknowledging the wide variability during perimenopause (9). Additionally, it is vital to rule out endocrine disorders like hyperprolactinemia and hypothyroidism, as well as pregnancy, as potential causes of secondary amenorrhea. A difference of seven days or more in the length of successive menstrual cycles is indicative of the early menopausal transition. This transition phase can vary in duration, with younger women generally experiencing a longer early and total transition period. A woman enters the late menopausal transition when she has an amenorrhea (absence of menstruation) period of 60 days or more, which tends to last about one to three years. The early postmenopausal stage is determined retrospectively, starting after twelve months have passed since the last menstrual period. At this point, ovarian reserve is extremely low, often undetectable, while follicle-stimulating hormone (FSH) levels rise and estrogen levels decline, take more than 30 months to stabilize (10).

2. Menopausal health and relief of symptoms

During the end of a women's reproductive years, understanding and managing the physical and emotional changes are issue of concern. There is no need to treat menopause. The goal of treatment is to reduce symptoms and avoid or control chronic illnesses that may arise with aging. So, overall health screening is essential to manage as shown in figure 1 and based on individual symptoms treatment can be decided. The treatment options may consist of both nonpharmacological and pharmacological methods (including hormonal and nonhormonal treatments) (14).

2.1. Hormonal treatments

Hormone therapy (HT) that is based on estrogen. This is the most effective option for reducing vasomotor symptoms (VMS) and genitourinary syndrome of menopause (GSM). Women who undergo significant sleep or mood issues during the menopausal transition may also find relief through HT.

These treatments are regarded as safe and effective for women who are considered low-risk those without a prior history of coronary heart disease or breast cancer, who are under 60 years old and fewer than 10 years' post-menopause. The Women's Health Initiative (WHI) determined that women suffering from VMS experienced an 85% reduction in symptoms after receiving a combination of estrogen and progesterone therapy (15).

Women who experience premature or early menopause due to factors such as primary ovarian insufficiency, bilateral oophorectomy, or treatments like chemotherapy and radiation should be evaluated for hormone therapy. This treatment is vital for maintaining cardiovascular, genitourinary, bone, and cognitive health until they reach the average age for menopause. If hormonal replacement is not provided, these women face an increased risk of dementia, Parkinsonism, mood disorders, cardiovascular issues, osteoporosis, sexual dysfunction, and higher overall mortality rates. It is important to understand that they might need higher doses of estrogen compared to those generally given to women closer to the average menopause age, and both combined hormonal contraceptives (CHC) and hormone therapy should be considered (16).

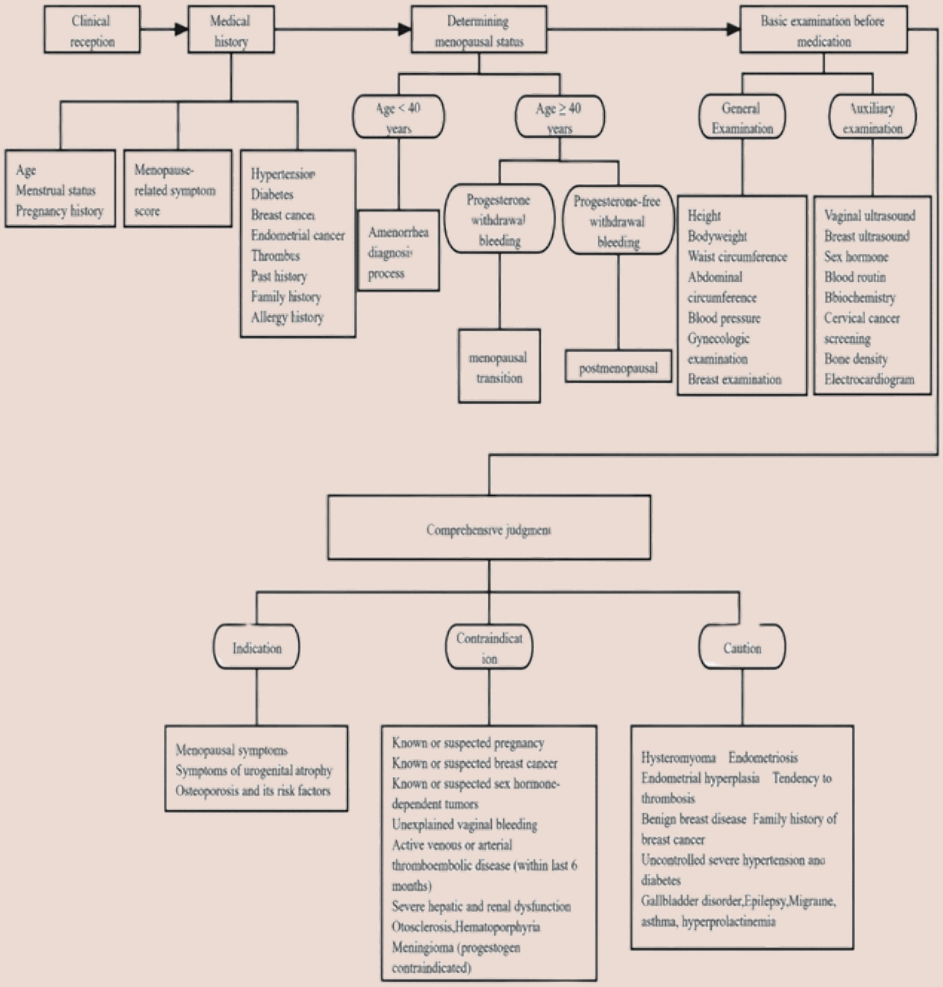

Figure 1. Management of menopause (17)

Women can continue to ovulate during the perimenopausal period until their final menstrual period (FMP) occurs. The need for contraception during this time cannot be overstated, as pregnancies during perimenopause carry heightened risks for both the mother and foetus. When selecting the most appropriate contraceptive method, it is crucial to consider the woman's hormonal status, perimenopausal symptoms, any co-existing conditions, current medications, and personal preferences. Hormone therapy is not an effective contraceptive, as it rarely prevents ovulation or significantly alters cervical mucus (18). For non-smoking women without a history of blood clots or stroke, low-dose combined hormonal contraceptives (CHCs) are suitable. However, CHCs containing ethinyl estradiol carry a higher risk of blood clots and stroke compared to those with estradiol or conjugated equine estrogens (CEEs), which are present in therapy of harmons. There are less limitations with progestin-only techniques, and if vasomotor symptoms are severe, low-dose estradiol can be added. Its appearance is in hypertensive women (19).

2.2. Non hormonal therapy

Table 3. Non hormonal therapy include lifestyle and home remedies (20)

Cool hot flashes	Put cold packs under pillow & turn pillow often so head is on cool side.
Ease vaginal pain	Try a water-based vaginal lubricant (Astroglide, Sliquid, others) or a silicone-based lubricant or moisturizer (Replens, K-Y Liquibeads, others). You can get these without a prescription.
Get enough sleep	Skip caffeine and alcohol
Find ways to relax	Deep breathing, massage, and muscle relaxation
Strengthen your pelvic floor	Pelvic floor muscle exercises, called Kegel exercises, can improve some forms of urinary incontinence.
Eat a balanced diet	Include a variety of fruits, vegetables, and whole grains. Limit saturated fats, oils, and sugars.
Manage weight	Studies show that being obese is linked to having more and worse hot flashes. Losing weight and keeping it off may help ease them.
Don't smoke	Smoking increases your risk of heart disease, stroke, osteoporosis, cancer, and a range of other health problems. It also may increase hot flashes and bring on earlier menopause.
Exercise regularly	Get regular physical activity or exercise on most days to help protect against heart disease, diabetes, osteoporosis, and other conditions associated with aging.

3. When to avoid MHT (Menopausal hormone therapy)

Relative and absolute contraindications for patients suffering from cervical cancer, severe thromboembolic condition and mammary gland nodules are listed in Table 4.

Table 4. Condition for caution (MHT) (21)

Hormone dependent cancer	Conditions where caution is recommended with MHT	Code meaning
Breast and endometrial (NB1)	Past myocardial infarction, transient	NB1: MHT is generally safe to use in patients with treated stage 1 endometrial malignancy.
Undiagnosed vaginal bleeding	Ischaemic attack or stroke [NB3] [NB4]	NB2: Consider transdermal estrogen for MHT if the patient is anticoagulated.
Acute cardiovascular event	High risk of venous thromboembolism [NB3]	NB3: Exercise caution with oral estrogen; transdermal estrogen is preferred for MHT.
Acute venous thromboembolism [NB2]	Active liver disease [NB3]	NB4: Treated hypertension is not a contraindication to MHT use.
Porphyria cutanea tarda	High risk of breast cancer	NB2
Severe liver disease	Age older than 65 years and no prior use of MHT	NB3

4. Risk of harms associated with MHT

Depending on whether hormone therapy is being started for the first time or is being continued, different decision-making processes are used. It is recommended that women under 60 years of age begin hormone therapy within 10 years of menopause. Women may be permitted to continue treatment for more than ten years if therapy is started during this crucial period, provided that there is a clinical basis for doing so. When possible, medical practitioners should prescribe the lowest effective dosage and favour risk-reducing administration techniques including transdermal and intravaginal routes (22). Women who are not receiving systemic hormonal therapy are likely to face the genitourinary syndrome linked to menopause. Even those who are on systemic hormone replacement therapy might need extra local estrogen treatments to relieve urogenital symptoms. Systemic hormone replacement therapy by itself does not significantly reduce the occurrence of recurrent urinary tract infections; however, local estrogen therapy can lower this risk by acidifying the vaginal

environment and enhancing the dominance of lactobacillus in the flora. For atrophic vaginitis, localized estrogen treatments delivered via vaginal rings, creams, or tablets have shown to improve blood flow and reverse vaginal atrophy. Numerous women who cannot take systemic hormonal replacement therapy may still gain advantages from local estrogen treatments without requiring progesterone (23).

Many women are reluctant to seek medical help when they notice symptoms associated with the transition to menopause. There are a number of reasons for this hesitancy, such as a lack of knowledge about what is "normal" in terms of the kind, severity, and duration of symptoms as well as the available treatment alternatives. Additionally, people who did not seek medical assistance for their symptoms often believed that menopause was a natural process, were uneasy about the idea of seeking medical assistance, or preferred non-pharmacological methods like dietary changes, lifestyle modifications, complementary therapies, or over-the-counter remedies over prescription drugs. Women's willingness to seek medical assistance may also be influenced by social views on aging and femininity (24).

5. Conclusion

Developing specialized knowledge, putting strategic practices into place, allocating roles, encouraging strong interprofessional communication, and ensuring coordinated care are all necessary for an effective menopausal management strategy. The delivery of patient-centered care for individuals going through menopause can be enhanced by utilizing the diverse skills of healthcare workers. This will lead to better outcomes and greater teamwork within the healthcare system.

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