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Prevalence of menopausal symptoms and its impact on Quality of life among menopausal women

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ABSTRACT

Background: The life expectancy of midlife women has grown as a result of demographic and epidemiological shifts, which has led to an increase in the burden of morbidities associated with menopausal symptoms and has also had an impact on quality of life (QOL). Among rural midlife women in Gudur, India, aged 40 to 60 years, the purpose of this study is to investigate the prevalence of menopausal symptoms and its impact that these symptoms have on quality of life. The Components and Procedures: Using a random sample method, a community-based cross-sectional study was carried out on four hundred midlife women. For the purpose of determining the prevalence of menopausal symptoms and the quality of life, the menopause rating scale was utilised. Additionally, data were gathered for socio-demographic parameters, relevant menstrual history, and other variables. End Result: There was an 87.7% prevalence of menopausal symptoms, according to the findings. Anxiety was experienced by the majority of the people who participated in the research study (80%), followed by physical and mental tiredness (71.5%), sleep issues (61.2%), irritability (60.7%), joint and muscle discomfort (56%), and cardiac problems (54%). There were 36.7% of women who reported experiencing hot flushes, which is the most common symptom of menopause. Menopause occurred at a mean age of 47.53 years, with a standard variation of 4.5 years. Between the post-menopausal and peri-menopausal groups, a statistically significant difference was seen in the mean score of a few symptoms, including hot flushes, sweating ($P < 0.003$), and joint and muscle soreness ($P < 0.014$). Seventy-two percent of the people who participated in the research had a worse quality of life. The psychological symptoms were responsible for 70.8% of the lack of quality of life. The conclusion is that a comprehensive strategy, which includes modifications to lifestyle and behaviour, is essential in order to improve the quality of life (QOL) of these women and to reduce the menopausal symptoms they experience.

Keywords: *Menopausal symptoms, menopause rating scale, middle aged women, prevalence, and quality of life*

1. INTRODUCTION

In the course of a woman's life, the shift from the reproductive phase to the non-reproductive phase is typically referred to as the natural or spontaneous menopause. The last menstrual period, which is known to occur after a period of twelve months of amenorrhoea for which there are no evident medical or physiological reasons, is the time when it takes place. In addition to hastening the progression of noncommunicable illnesses, it also lays the scene for the ageing process. Menopause often occurs between the ages of 45 and 55 for women all over the world. Not only do the symptoms of menopause manifest themselves in the female genital tract, but they also manifest themselves in the skeletal system, the cardiovascular system, and the physiological system. As the average lifespan of women continues to rise, they are more likely to experience menopause for extended periods of time, which accounts for around one third of their age. Consequently, this has led to an increase in the burden of morbidities. The transition from perimenopause to menopause occurs during the time period that begins shortly before menopause and continues for up to one year following the last menstrual cycle. It might last anywhere from three to five years. Variability in menstrual cycles and shifts in the levels of reproductive hormones are two of the characteristics that define the male transition towards menopause. Numerous factors, including genetics, culture, lifestyle, socioeconomic status, education, behavioural patterns, and food, all contribute to a significant amount of variation in the way individuals react to menopause. Those who experience postmenopausal symptoms also experience social repercussions, which ultimately have an impact on their quality of life (QOL). Given the high number of women who are in the menopausal period, the poor quality of life of these women will create a major strain on the public health care system in developing nations such as India. Therefore, the purpose of our research is to investigate the prevalence of menopausal symptoms and the impact that these symptoms have on quality of life among rural middle-aged women in Gudur, India, who are between the ages of 40 and 60.

2. MATERIALS AND METHODS

Community-based descriptive research with a cross-sectional design was carried out in the rural block of Mythili Maternity Hospital in Gudur, India. This hospital serves as the rural field practice area for the Department of Community Medicine. Our research participants were women of a middle-aged demographic, ranging in age from 40 to 60 years old. Women who were either in the perimenopausal phase or the postmenopausal phase, as well as those who had given their agreement to participate in the study and had lived in that region for more than one year, were eligible for inclusion in the study. Women who had reached an unnatural menopause, women who were taking medication such as anxiolytics, antidepressants, antipsychotic drugs, and women who were undergoing any form of hormone replacement therapy, women who were known to have systemic diseases, thyroid disorders, and/or any genital pathology, and women who had not had their period in the previous year due to other physiological conditions other than menopause. At a level of significance of 95%, the sample size was determined to be 400, with the assumption that the prevalence of menopausal symptoms was fifty percent and that the permitted error was ten percent. The selection of the people who will take part in the study was done using a random sample approach. The authorisation of the institutional Ethics Committee was acquired prior to the beginning of the research project.

3. DATA COLLECTION PROCEDURE

We employed a semi-structured interview schedule that had been pretested in order to collect information from the people who participated in the study. This information included their socio-demographic profile, menstrual history, and personal history. For the purpose of determining the frequency and severity of menopausal symptoms, the menopause rating scale (MRS) is one of the instruments that is utilised extensively. Specifically, it is comprised of eleven questions that are divided into three categories: psychological, somato-vegetative, and uro-genital subscales. The somato-vegetative subscale is comprised of four items, which are as follows: hot flushes or sweating, discomfort in the heart, difficulties sleeping, and discomfort in the joints or muscles. Depressive mood, irritability, anxiety, and physical or mental tiredness are the four elements that make up the psychological subscale which consists of four items. There are three items that make up the uro-genital subscale. These items include sexual issues, bladder problems, and dryness of the vagina. On the Likert scale, each symptom is given a value between 0 and 4, with 0 indicating that there is no symptom at all and 4 indicating that the condition is highly severe. The total score for the somato-vegetative domain may range anywhere from 0 to 16, the total score for the uro-genital domain can be anywhere from 0 to 12, and the total score for the psychological domain can be anywhere from 0 to 16. In total, the score can vary anywhere from 0 to 44. The degree of menopausal symptoms is determined by this total score, which ranges from 0 to 4 for no or little symptoms, 5 to 8 for light symptoms, 9 to 16 for moderate symptoms, and 17 to 44 for severe symptoms after that. When a domain's score is higher, it indicates that the problem is more serious and higher scores indicate a larger degree of impairment in quality of life. With a cut off value of up to eight, the quality of life (QOL) was found to be satisfactory, which indicates that there were no or very mild symptoms. On the other hand, a score of nine or higher, which indicates moderate to severe symptoms, indicated a low quality of life.

4. RESULTS

The participants had a mean age of 53.6 years, with a standard deviation of 5.1 years. All of the people who participated in the study were Hindus. The majority of the subjects were housewives who were married and had a poor level of literacy. Three hundred and forty-four women, or 86%, were postmenopausal, whereas fifty-six women, or 14%, were in the perimenopausal group. As far as the menstrual cycle status of the research subjects was concerned, the majority of the participants (n = 394, or 98.5%) had regular periods, and 340 of the participants (or 85%) did not experience dysmenorrhea. A median age of 48 years was found, with a range of 38 to 58 years. The mean age of menopause was 47.5 years, with a standard deviation of 4.5 years. Menarche occurred at a mean age of 15.33 years, with a standard deviation of 1.4 years. Eighty-seven percent of them, or 348 people, did not smoke. According to the data shown in Table 1, the majority of the people who participated in the research project experienced anxiety (80%), followed by physical and mental tiredness (71.5%), sleep issues (61.2%), irritation (60.7%), joint and muscle discomfort (56%), and cardiac problems (54%). There were 36.7% of women who reported experiencing hot flushes, which is the most common symptom of menopause. According to the scoring of all domains, 351 of the study subjects (87.7%) had experienced one or more of the symptoms listed above within the previous month, which contributed to the prevalence of menopausal symptoms being 87.7%. A comparison of the two groups' mean scores for menopausal symptoms is presented in Table 2, which can be seen below. After menopause, women had a mean score of 12.07 standard deviations, whereas perimenopausal women had a mean score of 12.48 standard deviations. The perimenopausal group had a higher mean score in the somato-vegetative and psychological domains, whereas the postmenopausal group had a higher mean score in the uro-genital domain. However, this difference was determined to be statistically insignificant. The statistically significant difference between the post and peri menopausal groups was observed in twelve menopausal symptoms, including hot flush, sweating ($P < 0.003$), and joint and muscle discomfort ($P < 0.014$). These symptoms were shown to be significantly different from one another.

Table1: Prevalence of menopausal symptoms according to menopause rating scale (*n*=400)

Serial number	Domains	Symptoms	*n* (%)*	Overall prevalence in each domain (%)
1	Somato-vegetative domain	Hot flush, sweating	148 (36.7)	79
		Heart discomfort	215 (54)	
		Sleep problems	246 (61.2)	
		Joint and muscular discomfort	223 (56)	
2	Psychological domain	Depressive mood	191 (48)	88.2
		Irritability	244 (60.7)	
		Anxiety	321 (80)	
		Physical and mental exhaustion	285 (71.5)	
3	Uro-genital domain	Sexual problems	39 (9.5)	32.7
		Bladder problems	81 (20)	
		Dryness of vagina	55 (14.2)	
Prevalence total of menopausal symptoms			351(87.7)	

*Multiple responses

Table 2 demonstrates that there is no correlation between sociodemographic features and quality of life, and Table 4 demonstrates that the quality of life was bad in 281 (70.2%) of the study subjects (with moderate severe symptoms), and for 119 (29.8%) of the study subjects (with minimal or light symptoms), the quality of life was excellent. The psychological problems were mostly related to the unsatisfactory quality of life (70.8%).

Table2: Association of socio demographic variables with quality-of-life categories

Sociodemographic variables	Good QOL(*n*=119)	Poor QOL(*n*=281)	Total (*n*=400),*n*(%)	χ^2(*P*)
Age group (years)				
40-44	9 (6.7)	9 (3.56)	18 (4.5)	2.63 (0.452)
45-49	17 (13.4)	41 (14.9)	58 (14.5)	
50-54	35 (29.4)	75 (26.33)	108 (27.25)	
55-59	59 (50.4)	154 (55.16)	215 (53.75)	
Marital status				
Never married	2 (1.68)	1 (0.36)	3 (0.8)	3.62 (0.16)
Married	87 (73.11)	190 (67.6)	277 (69.3)	
Widow	30 (25.2)	90 (26.7)	120 (30)	
Type of family				

Nuclear	41 (34.4)	94 (33.5)	135 (33.8)	0.26 (0.88)
Joint	17 (14.3)	36 (12.8)	53 (13.3)	
Three generation	61 (51.3)	151 (53.7)	212 (53.1)	
Living arrangement				
With spouse	89 (74.8)	193 (68.7)	282 (70.5)	1.50 (0.22)
Without spouse	30 (25.2)	88 (31.3)	118(29.5)	
Socioeconomic status				
Lower	7 (5.88)	26 (9.3)	33 (8.3)	5.8 (0.22)
Lower middle	20 (16.8)	68 (24.2)	88 (22)	
Middle	30 (25.2)	73 (26)	103 (25.8)	
Upper middle	33 (27.7)	62 (22.1)	95 (23.8)	
Upper	29 (24.4)	52 (18.5)	81 (8.3)	
Occupation				
Home maker	55 (46.2)	155 (55.2)	210 (52.5)	2.98 (0.56)
Farmer	2 (1.68)	5 (1.78)	7 (1.75)	
Laborer	5 (4.2)	12 (4.27)	17 (4.25)	
Milkmaid	42 (35.3)	79 (28.11)	121 (30.25)	
Others	15 (12.6)	30 (1.01)	45 (11.25)	
Educational status				
Illiterate	82 (69)	195 (69.4)	277 (69.25)	0.009 (0.92)
Literate	37 (31)	86 (30.6)	123 (30.75)	

QOL: Quality of life

Table3:Domain wise quality of life (*n*=400)

Domain	QOL*	
	Good(%)	Poor(%)
Somato-vegetative	168 (42.3)	232 (57.8)
Psychological	118(29.3)	282 (70.8)
Uro-genital	291(73)	109(27)
All domains	118(29.8)	282 (70.2)

*Based on scoring of MRS questionnaire. QOL: Quality of life, MRS: Menopause rating scale

5. CONCLUSION AND RECOMMENDATION

The findings of this study indicated that more than three-quarters of women experienced menopausal symptoms, with over two-thirds of them having a low quality of life. Women who were perimenopausal experienced considerably more symptoms, such as hot flushes, sweating, and sadness, in comparison to women who had reached post menopause. On the other hand, postmenopausal women experienced more soreness in their joints and muscles. Therefore, we get to the conclusion that women who are perimenopausal are at a greater risk of acquiring both physical and psychological symptoms. As a result, these people require a greater amount of care in contrast to women who have reached post menopause. To accomplish holistic treatment for menopausal women, the primary health care practitioner should instruct them to address these symptoms using

a variety of modalities, including exercises for the pelvic floor, a healthy diet, an increase in physical activity, and meditation, with their mutual involvement. Due to the fact that menopause is a normal biological process, it essentially does not require any kind of medical treatment.

Individualised and individualised treatment for menopause hormone therapy (MHT) is required in accordance with the symptoms. In addition to enhancing sexuality, the administration of individualised MHT may also enhance quality of life overall. Politicians and other interested parties can make use of the findings of this study to guide their decisions. It is thus necessary for the government to establish a menopausal clinic in order to tackle these issues and assist in raising knowledge and sensitivity among them. However, due to the cross-sectional design, it is not possible to conclude the causal link between the two variables. In light of this, further longitudinal study may be undertaken for the future.

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