

Impact of menopause on women's health

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Abstract

Perimenopause is the process of a gradual decline in the production of hormones by the female reproductive system, accompanied by various body changes. These changes cause both somatic and mental symptoms in women which vary in intensity, including *inter alia* vasomotor disorders and psychiatric issues. Urogenital atrophy and related sexual dysfunctions, as well as possible cardiovascular diseases, osteoporosis, and musculoskeletal disorders, occur at a later period. Perimenopausal symptoms negatively affect women's everyday lives, their functions and professional responsibilities, as well as their family relations, in particular if their family show neither interest nor support, and their partner is unwilling to be of assistance. Menopause involves several somatic and mental changes in women. Unhealthy lifestyle habits, such as poor nutrition and physical inactivity, may aggravate the condition of perimenopausal women. Women who lack a positive attitude frequently experience mental and somatic symptoms associated with menopause, exhibiting a lower esteem and low degree of satisfaction with life.

Contemporary women are professionally and socially active. They value satisfaction, fitness and attractiveness. These are also the social norms they are subjected to in their communities, and by failing to conform, women risk being regarded as negligent. Furthermore, hormonal changes related to perimenopause cause somatic and mental symptoms. These occur in a highly individual manner, depending on the situation of a given woman. They may affect her self-esteem and satisfaction with life.

The aim of the study is to present the impact of menopause on women's lives.

Key words

menopause, hormonal changes in the perimenopause, menopausal symptoms, perimenopausal symptoms

INTRODUCTION

The perimenopausal period is a natural process in a woman's life. It results from hormonal changes in the reproductive system and constitutes a transition from the reproductive phase to old age. Changes in the female organism leading up to menopause are a result of the decline in hormones responsible for female reproductivity [1].

Contemporary women are professionally and socially active. They value satisfaction, fitness and attractiveness. These are also the social norms they are subjected to in their communities, and by failing to conform women risk being regarded as negligent. Furthermore, hormonal changes related to perimenopause cause somatic and mental symptoms. These occur in a highly individual manner, depending on the situation of a given woman. They may affect her self-esteem and satisfaction with life [2, 3].

The experience of menopause varies for every woman, depending on the symptoms perceived. The physical sensations are frequently accompanied by contemplating a woman's changing physical and mental fitness, attractiveness, awareness of the ongoing aging process, and the possibility of being efficient in every aspect of her life [4, 5, 6].

Research on menopause has been optimised by the uniform definition of the phenomenon provided by WHO in 1996, whereby the natural menopause is the last menstruation

after which it does not occur for a period of 12 months and at the same time there are no pathological grounds for its absence [1, 7].

In respect of the activity of reproductive hormones, a woman's life may be divided into premenopause, i.e. the period preceding the menopause, and postmenopause, i.e. the time following it, while the perimenopausal period spans several years before the menopause and ends a year after the last menses. There is a change to the menstruation cycle whereby the follicular phase is shorter by about 3 days. Postmenopause denotes the time following a natural or artificial menopause. The term "artificial menopause" stands for the cessation of menses due to a surgical intervention after the removal of the ovaries, or uterus along with the ovaries, or the destruction of ovary tissue due to oncological treatment. Both in the period preceding and following the menopause, a woman experiences a number of changes in her organism called menopause symptoms, which affect daily activities [1, 8].

OBJECTIVE

The aim of the study is to present the impact of menopause on women's lives.

Determining the time of menopause. From the historical perspective, menopause was first mentioned in the literature by Aristotle in the 4th century B.C. He noted that women cease to menstruate and their fertility diminishes at the age of 40. The average menopause age has not changed over

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the centuries and there is a broad time-frame during which it is possible for menopause to occur, with the standard starting point at the age of 40 and the end point at the age of 60. Anything prior to or later than that time is considered abnormal. The average menopause age today is 50 – 51-years-old [1].

Individual differences regarding the menopause age are determined by several factors, including lifestyle and place of residence. It occurs earlier in women who smoke over 10 cigarettes per day [9]. In the developed countries, the average menopause age is 51.5 years. For Poles, at the moment it is assumed to occur, on average, between the ages of 48 – 52 [10, 11], and research on this topic (Błajda 2016) shows that the mean age of the last menstrual period in Polish women is 51.25 years old. Menopause symptoms resulting from hormonal shift affect everyday lives and professional activity of women as the vast majority of them are still professionally active [4, 5]. Menopausal symptoms impair relations within the family, notably if the family shows no interest or support, and their partner is unwilling to help [6].

Hormonal changes during perimenopause. Psychosomatic symptoms result from the physiological process involving the decline in the hormonal activity of ovaries associated with the depletion of ovarian follicles, whose disappearance begins already in the foetal period and its rate accelerates six-fold after the age of 39. Along with the reduction in the hormonal capacity of the ovaries and menstruation disorders, women in perimenopause are more likely to develop uterine leiomyoma and mammary dysplasia. Hormonal changes interfere with the menstrual cycle, initially reducing the cycle, to lengthen the interval between menses at a later stage. Long-lasting oestrogen deficiency in women after menopause has a negative impact on short-term memory. It also induces atrophic changes in the tissues such as skin which are affected by oestrogen function by reducing its thickness and flexibility as a result of water and collagen loss. The decrease in the level of oestrogen contributes to multiple metabolic disorders affecting the following: the skeletal system, leading to osteoporosis, the cardiovascular system, leading decreased vessel lumina, or carbohydrate metabolism, including attenuated insulin sensitivity [1, 3, 6].

A very significant reduction in oestradiol and, to a lesser extent, oestrone, is typical of the postmenopausal period. Oestrone is the dominant oestrogen produced in the stromal cells of the adipose tissue, muscles, liver, kidneys, brain and adrenal glands. An increase in oestrone results from obesity, aging, and hyperthyroidism. Excessive amounts of oestrone postmenopause lead to hyperplasia and an increased risk of endometrial cancer. Elevated levels of this hormone may cause uterine bleeding [1, 12]. Long-lasting postmenopausal estrogen deficiency prompts the so-called late onset menopause complications, including depressive and memory disorders. The decrease in oestrogen is also the cause of more common conditions in this group of women, i.e. various types of dementia, including Alzheimer disease and senile dementia [13].

Symptoms and consequences of menopause. Menopausal vasomotor and neurovegetative symptoms result from the non-reproductive activity of sex hormones. Early menopausal symptoms include hot flushes (or flashes), sweating, sleep disorders, mental and menstruation disorders. At a later

menopause stage, a woman experiences atrophic urogenital changes and related sexual dysfunctions, cardiovascular diseases, osteoporosis, musculoskeletal disorders. For professionally active women, particularly burdensome symptoms include irritability as well as reduced concentration and coordination [1].

Vasomotor symptoms. Vasomotor symptoms comprise hot flushes and severe sweating. In most women, these occur 6–12 months before the menopause. 60% of women indicate that these symptoms disappear within seven years, but in 15% they persist forever more than ten years. Vasomotor symptoms persist in 60–80% of patients into postmenopause. They are more frequent in women with premenstrual syndrome. Hot flushes are more intense in such pathological cases as hyperthyroidism or pheochromocytoma. Women who experience hot flushes report a sudden feeling of heat in the face, neck and chest, followed by severe perspiration. In most women, the heat starts in the lower parts of the body and spreads upwards to the neck and face. 90% of women who experience hot flushes also suffer from severe sweating. Hot flushes are particularly burdensome at night as they frequently result in awakening, whereas they may be more intense during the day, aggravated by stressful situations, high temperature, or hot food. Women often develop insomnia from waiting for the hot flushes at night. If this happens regularly, a woman may be deprived of the last phase of sleep (REM) during which the organism is supposed to rest. Hot flushes are inseparably connected with a decrease in the oestradiol concentration. The process is not aimed at the elimination of accumulated heat, but is rather a result of excessive activity of temperature regulation mechanisms. The occurrence of hot flushes starts in perimenopause and is most severe within two years after menopause [10, 14, 15, 16, 17].

Mental symptoms of menopause. Throughout the menopausal period, women suffer particularly badly from psychological problems. These often concern their body image, upset by the menopausal changes and increased sensitivity to criticism resulting from negative stereotypes of women with obesity [18, 19]. Other issues include irritability, mood swings, short-term memory issues, exhaustion, sleep disorders, deep fear manifested in anxiety, dread, and agitation. Some women may even experience depressive psychosis, sometimes leading to suicidal ideation. The risk of depression increases during premenopause and perimenopause, and decreases afterwards. The World Health Organization (WHO) suggests that depressive disorders will become the second largest source of the global burden of disease in 2020, just after ischaemic heart disease. They may occur in the course of chronic diseases characteristic for the menopausal age, such as the metabolic syndrome or osteoporosis [4, 20].

Vasomotor disorders may become a significant predictor variable for depression [3, 20]. Depression symptoms in menopausal women are 2 to 5 times more frequent than before or after menopause. Depression more often affects women who undergo surgical menopause [4].

Another problem reported by menopausal women are sleep disorders, which occur twice as often as in young women. This phenomenon is associated with a decrease in the oestrogen level and affects approximately 17% women, especially older ones [21].

Lipid and carbohydrate metabolism disorders. Women in perimenopause are frequently affected by metabolic disorders, such as dyslipidaemia in the form of substantial elevation of total cholesterol and LDL cholesterol levels, with reduced concentrations of HDL cholesterol. These lipid metabolism disorders result from a decrease in the concentration of free oestradiol in blood serum in postmenopausal women. They may lead to unintentional weight gain due to both subcutaneous and visceral adipose tissue accumulation [15, 18, 19, 22].

In the postmenopausal period, visceral adipose tissue grows by more than 40%, whereas abdominal subcutaneous adipose tissue increases by approximately 20% as a result of the deceleration of basic metabolism, in compliance with dietary restrictions and low physical activity. Visceral obesity prompts the release of large quantities of free fatty acids. This slows down the cellular glucose uptake, hyperinsulinaemia and ultimately insulin resistance, which, in turn, gives rise to glucose metabolism disorders [19, 22].

After the age of 50, women are more prone to develop diabetes than men. Although the clinical picture of diabetes and cardiovascular complications in women is similar to that in men, the prognosis is typically much worse. The risk of acute coronary syndromes and sudden cardiac death in women with diabetes and hyperinsulinemia increases already in premenopause, much earlier when compared to women without diabetes. The relative risk of death due to ischemic heart disease associated with diabetes is 50% higher in women than in men. One of the main risk factors in women, both in respect of diabetes and cardiovascular diseases, is abdominal obesity in the form of the high deposition of visceral adipose tissue. The risk of diabetes and cardiovascular diseases in women increases with age. These diseases cause the deterioration in the functioning of the entire organism, therefore contributing to an increased mortality and disability [23].

Musculoskeletal disorders. As the oestrogen level decreases, so does bone mineral density, beginning in premenopause. From the age of 40 until the menopause, the annual cortical bone loss is approximately 0.3–0.5%. After the menopause, the process accelerates to around 3%, and only eight years after the menopause does it return to levels observed initially. One of the reasons is the inhibition of calcium absorption from the digestive tract. The loss of bone tissue results in the disease called osteoporosis. The word 'osteoporosis' originates partly from the Greek language, where 'osteon' denotes bone, and from Latin, where 'porus' means a hole or loss [22, 24, 25].

Current works on osteoporosis describe it as a skeletal disorder where bone strength is reduced, thus increasing the risk of fracture. Osteoporosis is extremely common in women, and is often referred to as the 'silent epidemic', as well as the 'silent killer', due to the serious effects of fractures in the elderly. There is ample evidence for a correlation between the incidence of osteoporosis and age, as well as between age-related bone loss and gender, as it is greater in women than in men. Osteoporosis affects four times more women than men, which is connected both with menopause and the fact that the peak bone mass in women is 25–30% lower than in men [22].

Urogenital changes and disorders. Oestrogen deficiency during menopause gives rise to urogenital disorders resulting from atrophic changes of skin, mucous membranes and

muscle tissues. The genitourinary syndrome of menopause is associated with overly tight pelvic floor muscles due to vaginal dryness, resulting in dyspareunia, i.e. painful sexual intercourse. The prevalence of sexual disorders in all women is estimated at 25% – 63%, while in postmenopausal women this number is even higher, amounting to 68% – 86.5%, depending on cultural, religious, ethnic, and individual differences [3, 26].

Studies on the bacterial flora in postmenopausal women have shown more normal results in patients undergoing hormonal therapy. 68.9% of them exhibited *Lactobacillus* bacteria flora, whereas among patients who were not on a hormonal therapy, this bacteria species was found only in 34.1%. In the postmenopausal period, there are visible changes occurring on the vulva: pubic hair loss, protruding labia minora, flattened labia majora, and shrinking of the clitoral hood. Within the vagina, vaginal atrophy occurs, small petechiae appear on the epithelium, vaginal rugae disappear, whereas the size of the vulval vestibule and the length of the vagina are reduced. There are also changes in the urogenital tissues which may lead to the descent and prolapse of pelvic organs or urinary incontinence [26, 27, 28].

The loss of bladder control or urinary incontinence is the unintentional passing of urine. According to the WHO, urinary incontinence is considered as one of the major health problems in the 21st century, and has the status of a social disease now that it affects people of all ages, although the incidence increases with age. On average, about 30% of women before the menopause and up to 60% after menopause suffer from this disease worldwide. Urinary incontinence occurs most frequently in the fifth decade of life, i.e. in early menopause. In women aged 55–60 years this percentage is slightly lower and then increases again after the age of 80 [26, 29, 30].

Cardiovascular diseases. Low oestrogen levels mean they no longer exert a protective effect on the cardiovascular system by maintaining the flexibility of blood vessels, thus preventing the deposition of cholesterol, ensuring correct vascular flow by preventing the occlusion of lumina or maintaining a healthy lipid profile. Therefore, a decrease in oestrogen poses the threat of cardiovascular diseases. This risk increases several years after the natural menopause or earlier in the case of premature ovarian failure [1, 31].

Cardiovascular diseases in women include vascular atherosclerosis, ischemic heart disease, hypertension or venous thromboembolism. It is cardiovascular diseases that are the main cause of mortality in women over 65 years of age. In Poland, they are a major cause of death, comprising 52% of all female deaths. Excessive weight is one of serious risk factors of cardiovascular diseases in women, which contributes to the development of metabolic syndrome. According to the current definition of the International Diabetes Federation (IDF), the metabolic syndrome cluster is diagnosed on the condition that central abdominal obesity is reported (waist circumference in women > 80 cm), as well as two of the following four factors: an increased triglyceride level exceeding 150 mg/dl, reduced HDL cholesterol (< 50 mg/dl in females), raised blood pressure equal to or greater than 130/85 mm Hg, and raised fasting plasma glucose greater than or equal to 100 mg/dl.

Smoking tobacco is another risk factor of cardiovascular diseases in women, much more harmful than for men. Oestrogen deficiency causes an increase in vascular resistance, doubling the prevalence of hypertension in postmenopausal

women, especially in overweight women. The coexistence of diabetes is yet another risk factor in women, as it quadruples the incidence of myocardial infarction in this case. Risk factors in the group of Polish postmenopausal women constitute a serious problem since 24% of women in this age group admit to smoking and 29% have hypertension, whereas 61% have increased cholesterol. It would be possible to reduce the number of women who develop myocardial infarction 25 times by eliminating all of the main risk factors, and ischaemic heart disease would no longer pose a social problem in Poland [19, 26, 32].

CONCLUSIONS

Menopause involves several somatic and mental changes in women. Unhealthy lifestyle habits, such as poor nutrition and physical inactivity, may aggravate the condition of perimenopausal women. Women who lack a positive attitude frequently experience mental and somatic symptoms associated with menopause, exhibiting a lower esteem and low degree of satisfaction with life.

However, some women underline positive aspects of their menopause, such as a sense of relief as menstruation stops and there is no longer a need for contraception. Women who regard menopause as a 'normal physiological transition' cope with it perfectly and even notice a number of positive changes [2, 3, 5, 10].

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Wpływ menopauzy na zdrowie kobiet

■ Streszczenie

Okres okołomenopauzalny to proces polegający na wygasaniu czynności hormonalnej układu rozrodczego kobiety oraz zmianach zachodzących w organizmie. Zmiany te powodują objawy somatyczne i psychiczne, które występują u kobiet z różnym nasileniem. Do zaburzeń tych należą m.in.: objawy naczynioruchowe, problemy psychiczne oraz występujące w późniejszym okresie zmiany zanikowe układu moczowo-płciowego i związane z nimi dysfunkcje seksualne oraz mogące się pojawić choroby układu krążenia, osteoporoza, zaburzenia mięśniowo-stawowe. Dolegliwości okresu okołomenopauzalnego wpływają niekorzystnie na codzienne życie oraz pełnienie ról i zadań zawodowych, jak również rzutują na stosunki w rodzinie, zwłaszcza przy braku wsparcia od bliskich czy braku zainteresowania i chęci pomocy ze strony partnera.

Okres menopauzy niesie zmiany somatyczne i psychiczne, które przy zaniedbaniach zdrowotnych, takich jak nieprawidłowe odżywianie czy brak aktywności fizycznej, mogą pogarszać kondycję zdrowotną kobiet w wieku okołomenopauzalnym. Kobiety mające mało pozytywne nastawienie doświadczają w związku z tym częstszych objawów psychicznych i somatycznych związanych z menopauzą, mają niższą samoocenę i satysfakcję z życia.

Współczesne kobiety aktywne zawodowo i społecznie pragną czerpać satysfakcję z życia, być sprawne i atrakcyjne. Takie też są wymagania ich otoczenia, a wszelkie odstępstwa uznawane są za niedbanie o siebie. Przemiany hormonalne związane z okresem okołomenopauzalnym powodują objawy somatyczne i psychiczne, występujące w sposób zindywidualizowany zależnie od sytuacji danej kobiety. Zmiany te mogą rzutować na odczuwaną samoocenę i satysfakcję z życia.

Cel pracy. Przedstawienie wpływu menopauzy na życie kobiet.

■ Słowa kluczowe

menopauza, zmiany hormonalne okresu okołomenopauzalnego, objawy wypadowe, dolegliwości okresu okołomenopauzalnego