

2 Menopausal symptoms

At a glance

- ▶ Vasomotor symptoms (hot flushes and night sweats) are the most common symptoms of the menopause.
- ▶ They may start before periods stop but are most prevalent in the first year after the final menstrual period.
- ▶ The median duration is 7 years but symptoms can persist beyond the age of 60 in some women.
- ▶ Other common menopausal symptoms include dry skin, dry hair, arthralgia and headaches.
- ▶ Psychological symptoms such as depressed mood, anxiety, irritability, mood swings and lack of energy are often experienced around the menopause, although other factors may also be contributory.
- ▶ Symptoms of urogenital atrophy include vaginal dryness, dyspareunia, frequency and dysuria.
- ▶ Urogenital atrophy is now also referred to as genitourinary syndrome of the menopause.
- ▶ Urogenital symptoms can impact on sexual dysfunction.
- ▶ Urogenital symptoms are usually readily corrected with vaginal estrogens.

The change in hormone levels that occurs during the menopausal transition, particularly the decline in levels of estrogen, can cause acute menopausal symptoms. About 70% of women in Western cultures experience vasomotor symptoms such as hot flushes and night sweats. Other physical symptoms can include dry skin, dry hair, arthralgia and headaches. Many women also report psychological symptoms, which can be related to their experience of vasomotor symptoms or menstrual changes, or to concurrent life events.

Menopausal symptom reporting varies between cultures. Japanese women, for example, report fewer and less severe vasomotor symptoms than their North American counterparts, although they do appear to suffer more from psychological symptoms, and the most reported physical

symptom is shoulder stiffness. A study comparing white British women and women from the Indian subcontinent living in the UK and Delhi showed that both groups of women living in the UK reported the greatest number of hot flushes while Indian women living in Delhi reported the fewest flushes.¹ The Study of Women's Health Across the Nation compared women living in the United States from a range of ethnic communities: African American and Hispanic women reported most hot flushes, Japanese and Chinese ethnicity fewest, and white European women were in between.²

The reasons behind the variations in symptom prevalence are not clearly understood but evidence suggests that factors such as diet, smoking, exercise, reproductive history, genetics, climate, socioeconomic status, beliefs and attitudes towards the menopause may all contribute. In particular, current smoking and high body mass index may predispose a woman to more severe or frequent hot flushes.

Vasomotor symptoms

Hot flushes and night sweats are the most common symptoms of the menopause and, although they may begin before periods stop, the prevalence of flushes is highest in the first year after the final menstrual period. Vasomotor symptoms occur in around 75% of postmenopausal women and are reported as severe in 29%. Although they are usually present for less than 5 years, the median duration is 7 years and 42% of women aged 60–65 will continue to experience hot flushes and night sweats, with 6.5% of this group reporting vasomotor symptoms as moderate to severe. Hot flushes are commonly defined as transient periods of intense heat in the upper body, arms and face, which are often followed by flushing of the skin and profuse sweating. Many hot flushes are followed by chills and often are accompanied by palpitations and a sense of anxiety.

The pathophysiology behind the development of vasomotor symptoms is not fully understood, although the most likely explanation is a narrowing of the thermoneutral zone within the hypothalamus, perimenopausally, such that increases in core body temperature are more likely to result in sweating and, conversely, a drop in core temperature promotes shivering.³ While low estrogen levels are key in this process, not all women with low estrogen levels develop vasomotor symptoms, and there is a huge variation between women in the duration and severity of vasomotor symptoms. It is therefore likely that there are other factors involved, possibly within the central nervous system and involving neurotransmitters such as serotonin or noradrenaline.

Psychological symptoms

Psychological symptoms, including depressed mood, anxiety, irritability, mood swings, lethargy and lack of energy, have been associated with times of hormonal fluctuation such as premenstrually, postnatally, the perimenopause and the menopause. While transition to menopause confers a higher risk of developing depression, most women do not experience major changes in mood during this time. Many women do, however, find mood changes, anxiety and fatigue distressing, out of character and unexpected, and such changes can have a detrimental impact on personal, social, home and work life.

Prospective epidemiological studies suggest that psychological problems reported during the menopause may be associated with past problems and current life stresses. It is important, therefore, to take account of other factors such as prior negative mood, history of premenstrual complaints, negative attitudes to ageing or the menopause and poor health. In the past, the emphasis was on a woman's change of role – for example, the result of an 'empty nest'. In contrast, a wide range of other issues are relevant to women today (Box 2.1).

These physical and life changes can combine to make a woman feel that she is unable to cope. It is essential that these feelings are recognised and that the woman is offered the opportunity to discuss and clarify their possible causes in her particular case. Treatment, if requested, should be targeted to the individual needs of the woman.

Box 2.1

Factors associated with menopausal psychological symptoms

- ▶ Ageing parents and their possible increasing dependency
- ▶ Death of a parent, relative or friend
- ▶ Loss of partner through death, separation or divorce
- ▶ Lack of social support
- ▶ Educational or marital difficulties of young adult offspring
- ▶ Ill health
- ▶ Demanding workload or threat of redundancy
- ▶ Economic problems
- ▶ Coming to terms with ageing in a culture that values youth and fertility
- ▶ Vasomotor instability leading to sleep problems and tiredness

Urogenital atrophy or genitourinary syndrome of the menopause

Urogenital atrophy, the combination of symptoms due to the effects of estrogen deficiency on the lower urinary and genital tracts, is also now known as genitourinary syndrome of the menopause. The lower urinary and genital tracts have a common embryological origin and are approximated closely in adult women. Estrogen and progesterone receptors are present in the vagina, urethra, bladder and pelvic floor musculature. Loss of estrogen is associated with urogenital atrophy, causing the vaginal epithelium to become thin and lose its collagen support and elasticity, leading to loss of rugae, as well as becoming pale, or erythematous, with fine, petechial haemorrhages. An increase in vaginal pH, due to lower production of lactic acid, permits the growth of pathogens. Vaginal and cervical secretions also decrease, leading to reduced lubrication. The resulting symptoms include dyspareunia, itching, burning and dryness, which can coexist with urinary symptoms (Table 2.1). Genitourinary syndrome of the menopause is common, affecting around 50% of postmenopausal women and about 25% of women who are taking systemic estrogen replacement.

Table 2.1

Symptoms of urogenital atrophy

Site of atrophy	Symptoms
Vagina	Dryness Burning Pruritus Dyspareunia Prolapse
Urinary tract	Urgency Frequency Dysuria Urinary tract infection Incontinence Voiding difficulties

Sexual dysfunction

Sexual problems in women are common. It has been estimated that they affect about one in two women. Interest in sex declines in both sexes with increasing age and this change is more pronounced in women.

Genitourinary syndrome of the menopause contributes to vaginal dryness, soreness and dyspareunia, which can lead to the avoidance of intimacy and intercourse. Many women do not seek help for these symptoms, for many reasons, including lack of knowledge about treatment options, regarding the symptoms as simply part of ageing, or embarrassment. The symptoms are, however, easily and very effectively treated by vaginal estrogens, moisturisers and lubricants. Other factors, both hormonal and non-hormonal can also have an effect on female sexual dysfunction, and are covered in more detail in Chapter 6.

References

- 1 Hunter MS, Gupta P, Papitsch-Clark A, Sturdee DW. Mid-aged health in women from the Indian Subcontinent (MAHWIS): a further quantitative and qualitative investigation of experience of menopause in UK Asian women, compared to UK Caucasian women and women living in Delhi. *Climacteric*, 2009; 12(1): 26–37.
- 2 Avis NE, Stellato R, Crawford S, Bromberger J, Ganz P, Cain V, Kagawa-Singer M. Is there a menopausal syndrome? Menopausal status and symptoms amongst racial/ethnic groups. *Social Science and Medicine*, 2001; 52(3): 345–56.
- 3 Freedman RR. Pathophysiology and treatment of menopausal hot flashes. *Semin Reprod Med*, 2005; 23(2): 117–25.

Further reading

- Gartoulla P, Worsley R, Bell RJ, Davis SR. Moderate to severe vasomotor and sexual symptoms remain problematic for women aged 60 to 65 years. *Menopause*, 2015; 22: 694–701.
- Portman DJ, Gass MLS. Genitourinary syndrome of menopause: new terminology for vulvovaginal atrophy from the International Society for the Study of Women's Sexual Health and the North American Menopause Society. *Climacteric*, 2014; 17: 557–63.