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Prevalence of Menopausal Symptoms and Their Health Seeking Behavior in Postmenopausal Women in a Tertiary Care Hospital

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ABSTRACT

Background & Objective: Menopause is a delicate phase in the life cycle of women; therefore, it is crucial to develop a national policy that takes a personalized approach to treating menopause-related symptoms. Such a Program would aid in ensuring elderly women's quality of life and healthy life expectancy, while easing the social and financial burden of the symptoms. This study is done to study the prevalence of menopausal symptoms and perceptions of postmenopausal women. The objective of the study was to elaborate the prevalence of menopausal symptoms, menopause related quality of life and treatment seeking behavior of postmenopausal women.

Materials & Methods: A descriptive cross-sectional study was done among 211 postmenopausal women attending Obstetrics and Gynecology OPD at Sree Balaji Medical College and Hospital. Questions were asked using a semi-structured, pretested questionnaire and menopause rating scale. The results were then analyzed.

Results: The median age of menopause in this study was 45 (44-46) years. 81% of the population had one or more symptoms. Almost 48% of women sought treatment for their symptoms.

Conclusion: The Majority of women did not seek advice for their symptoms due to a lack of knowledge. Improvement in awareness is a must to improve the quality of life in postmenopausal women.

Keywords: Menopause, Menopausal Symptoms, Treatment Seeking Behavior, Quality of Life

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Introduction

Menopause is a global phenomenon that is usually defined as the end of periods for 12 months or as the end of ovarian function, which leads to a permanent lack of periods (1). According to the historical data that is currently available, the population of people who are 65 and over is increasing every year and is anticipated to account for nearly 12% of the total population by the year 2022 (2). Since the average length of life is getting longer, the menopause will last longer for women. As the average postmenopausal life span increases, healthcare providers must pay more attention to the health of postmenopausal women to ensure that they enjoy their lives to the fullest. Menopause may be accompanied by vasomotor, somatic, sexual, and psychological symptoms that can have a substantial impact on quality of life (3). Menopause causes short- and long-term morbidity in Indian women, who spend 25 years postmenopausal (4, 5). The number of studies that investigate how menopausal symptoms impact Indian women's quality of life (QOL) with regard to their health is extremely limited. For this reason, it is of the utmost importance to examine how menopausal symptoms influence women in post-reproductive life spans in terms of health-related quality of life and their link to sociodemographic characteristics.

This study aims to investigate the perceptions and prevalence of menopausal symptoms among Indian women, as well as their treatment-seeking behavior. This can help reduce the gap between a woman's indicated need and the care she receives, thereby optimizing her health.

Methods

A descriptive cross-sectional study was conducted on 211 postmenopausal women attending the OPD at the Obstetrics and Gynecology Department at Sree Balaji Medical College and Hospital. The sample size was calculated taking a prevalence of 56%, an error of 7% and the sample size came out to be 211.

Inclusion Criteria

All women who have attained natural menopause and who are willing to give informed consent.

Exclusion Criteria

- Women with unnatural menopause, e.g., surgical or radiotherapy for cervix cancer.
- Women on medications such as anxiolytics, antidepressants
- Women who have an already existing psychiatric illness.

The data collection was done using a pre-tested, pre-validated and semi-structured questionnaire that assesses their sociodemographic parameters and menopause rating scale (MRS), after taking written informed consent of the patient. Study initiated after clearance from Institutional Ethics Committee.

Statistical analysis

Data was double entered the MS Excel 2019 version and analyzed using Medcalc software (MedCalc Ltd., Belgium) and Epi info 7software (Centers for Disease Control and Prevention (CDC) in Atlanta, USA). The qualitative variables were described as proportions and percentages. Quantitative data variables were first checked for normalcy of data using a histogram and D'Agostino-Pearson test. Quantitative variables described as mean (SD) in the case of a normal distribution and as Median (IQR) in the case of a non-normal distribution. Results were expressed with appropriate charts and tables.

Results

In this study, the MRS scale was used, which does not follow the normal distribution; non-parametric tests were used as tests of significance. For qualitative variables, the chi-square test was used as a test of significance. Kruskal-Wallis and Mann-Whitney U tests were used for comparing the quantitative variables. A p-value less than 0.05 was considered statistically significant.

In our study, most of the females belong to the age group of 45–49 years contributing to 70.14% and only one female had age less than 45 years. 58.77% had a moderate working lifestyle. 61% of women belong to a joint family. The socio-economic class of women was classified according to the BG Prasad classification. In our study population, majority belong to middle class (48.82), while none of the women belonged to the upper class.

Treatment seeking behavior was more common in people over the age of 55. There was no statistically significant difference observed in health seeking behavior with marital status or education. There was a statistically significant difference between women's health-seeking behavior, family type, and working status. Although the p-value was found to be significant in moderate and heavy working classes, the number of women who sought care in these groups was lower. In addition, mild working pattern women are more likely to accept treatment than moderate and severe working pattern women. The acceptance of treatment was greater among women living in nuclear families than joint families. Lower middle- and lower-class, p-values were found to be statistically significant.

Median (IQR) Menopausal age in years was 45 (44-46) years. Table1 represents postmenopausal duration of patients. 74.41% of the women belonged to the early postmenopausal group and around 25% in late postmenopausal group of < 5 years.

Table 1. Association of Sociodemographic variables with health seeking behavior

Variables	N (%)	Health Seeking Behavior		P-value
		YES	NO	
Age-group (in years)				
<45	1 (0.47)	1	0	-
45-49	148 (70.14)	79	69	1
50-54	57 (27.01)	22	35	0.08
≥55	5 (2.37)	0	5	0.02
Marital Status				
Married (living with spouse)	179 (84.83)	92	87	0.10
Unmarried	11 (5.21)	4	7	
Widowed	21 (9.95)	6	15	
Working pattern				
Sedentary	2 (0.95)	0	2	0.09
Mild	69 (32.70)	49	20	1

Variables	N (%)	Health Seeking Behavior		P-value
		YES	NO	
Moderate	124 (58.77)	51	73	0.0008
Heavy	16 (7.58)	2	14	0.0002
Education				
Illiterate	2 (0.95)	0	2	1
Primary	45 (21.33)	7	38	0.10
Secondary	84 (39.81)	24	80	0.20
Higher secondary	60 (28.44)	52	8	0.10
Graduate	20 (9.48)	19	1	0.21
Family Type				
Joint	130 (61.61)	44	86	<0.0001
Nuclear	81 (38.39)	58	23	
Socio-economic status				
Upper Middle Class	18 (8.53)	17	0	1
Middle Class	103 (48.82)	66	5	0.57
Lower Middle Class	84 (39.81)	19	19	0.0001
Lower Class	6 (2.84)	0	4	0.0001

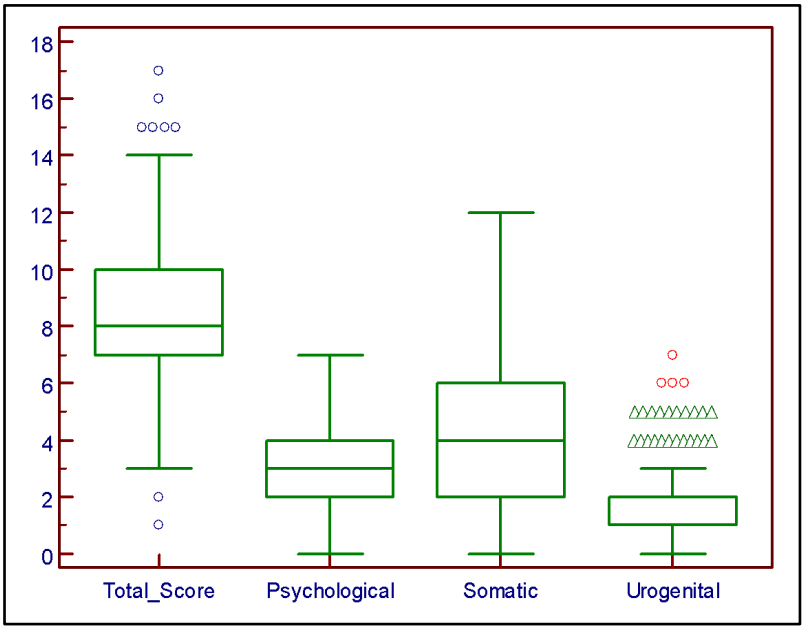


Figure 1. MRS Scale among Women

The above Chart (Figure 1) indicates the median (IQR) MRS scale among women at the median subscale. The somatic score was derived from the sum of individual symptoms such as hot flushes, heart discomfort, sleep problems, and joint-muscular discomfort. The psychological score was calculated using the cumulative scores of depression, anxiety, exhaustion, and irritability. The urogenital score was calculated using the cumulative scoring of symptoms like bladder problems, sexual problems, and dryness of the vagina. Then, the total score was calculated through the combined scoring of somatic, psychological, and urogenital scores.

Table 2. **Grading of symptoms according to the MRS Scale**

Symptoms*	Median (IQR)
Somatic	
Hot flushes, sweating	0(0-3)
Heart Discomfort	0(0-0)
Sleep problems	0(0-2)
Joint and muscular discomfort	1(1-2)
Psychological	
Depressive mood	1(0-2)
Irritability	0(0-1)
Anxiety	0(0-2)
Physical and mental exhaustion	0(0-0)
Urogenital	
Sexual problems	0(0-1)
Bladder problems	1(0-2)
Dryness of vagina	0(0-1)

In our study, the Menopause Rating Scale was used to rate the severity of symptoms. The individual symptoms were given as "0" for no symptoms, "1" for mild symptoms, "2" for moderate symptoms, "3" for severe symptoms, and "4" for extremely severe symptoms. Women were scored based on the severity of their symptoms, and the median was calculated for all of them. (Median was taken as consideration as data was not following the normal distribution)

On the Somatic subscale, joint pain was the most frequently reported symptom (86%), followed by depression (51%), and hot flashes (49%). On the psychological subscale, depression was the most common symptom (51%), and exhaustion was the least common (20.3%). Bladder problems (48%) were the most common symptom in the urogenital domain, followed by dryness of the vagina (42.6%). The median duration of symptoms among women was 1(1-2) years.

Table 3. **Knowledge and Health seeking behavior among women**

Variable	Frequency	Percentage
Knowledge of menopause		
Yes	205	97.17%
No	06	2.84%
Health problem		
Present	82	38.86%
Absent	37	17.51%
Don't know	92	43.60%

Variable	Frequency	Percentage
Effect on life		
Yes	195	92.42%
No	16	7.58%
Symptoms were bothersome or not		
Not at all	15	7.11%
Little bit	186	88.15%
Extremely bothersome	10	4.74%
Treatment for the problem		
Yes	102	48.34%
No	28	13.27%
Don't know	81	38.39%
HRT		
Yes	93	44.08
No	118	55.93
Total	211	100
Symptoms for which HRT was taken		
Dryness of vagina	27	12.92%
Hot flushes	20	9.57%
Anxiety	8	3.83%
Irritability	7	3.35%
Sleep problems	6	2.87%
Depression	9	4.67%
Exhaustion	4	1.91%
Heart discomfort	3	1.44%
Joint discomfort	3	1.44%
Low mood	1	0.48%

The above Table 3 indicates the existing knowledge of menopause in postmenopausal women and their health-seeking behavior for the symptoms. 97% of the women in our study had knowledge regarding

menopause. Of those, 38.86% considered menopause to be a cause for health problems and 43% of women were not aware of the health problems associated with menopause. Out of the total 92% had observed the effect of menopausal symptoms on their everyday lives and 88% were bothered by the symptoms. Only 48% were aware of available treatment for these symptoms, such as HRT. Of those 44% of women were taking hormone replacement therapies. The most common symptom associated with starting HRT was vaginal dryness.

Table 4. Association of sociodemography with MRS Scale

MRS Scale	Age group				P-value
	<45	45-49	50-54	≥55	
Total Score	12 (12-12)	9 (7-10)	8 (5-10)	4(4-5)	0.000
p-value (Total Score)	-	1	0.04	0.02	
Psychological subscale	7(7-7)	3(2-4)	2(1-4)	0(0-1)	0.000
p-value (Psychological subscale)	-	1	0.06	0.04	
Somatic subscale	4(4-4)	4(3-6)	3(1-5)	1(1-3)	0.000
p-value (Somatic subscale)	-	1	0.07	0.03	
Urogenital subscale	1(1-1)	1(1-2)	2(1-4)	1(1-2)	0.000
p-value (Urogenital subscale)	-	1	0.04	0.08	
		Socio-economic class			P - value
	Upper	Middle	Lower middle	Lower	
Total Score	8.5(7-10)	8(6-10)	9(6.5-10)	8.5(8-13)	0.55
p-value (Total Score)	1	0.15	0.35	0.40	
Psychological subscale	3(2-4)	2(1-4)	3(1.5-4)	4(3-4)	0.06
p-value (Psychological subscale)	1	0.454	0.55	0.03	
Somatic subscale	3(1-4)	3(1-6)	4(3-6)	4(2-8)	0.08
p-value (Somatic subscale)	1	0.65	0.04	0.05	
Urogenital subscale	2(1-3)	2(1-3)	1(0.5-2)	1(0-2)	0.01
p-value (Urogenital subscale)	1	-	0.03	0.02	
MRS Scale		Family type			P - value
	Joint		Nuclear		
Total Score	8(8-9)		8(8-9)		0.52
Psychological subscale	2(2-2)		3(3-4)		<0.0001
Somatic subscale	4(3-5)		3(3-4)		0.09
Urogenital subscale	2(1-2)		1(1-2)		0.20

The table above 4 (Table 4) depicts the relationship between the MRS scale and its subscales by age group. First, the Kruskal-Wallis test was used to compare scale to age group. The age group under 45 years was excluded from the comparison because only one patient was present. In all the subscales, there was a statistically significant difference between the median age group and the other groups. The median MRS score and urogenital score were higher in the 50–54 age groups as compared to other age groups. In addition, the difference was statistically significant in the psychological and somatic subscales in the 55-year-old age group.

There was no significant difference observed in the total score between different socio-economic classes. In the urogenital subscale, the median urogenital score was lesser in the lower middle and lower class as compared to the upper class. The difference was statistically significant. In the somatic subscale, the median score was statistically significant for the lower

middle class. And in the psychological subscale, median score was statistically significant for the lower class. Although a statistically significant difference was observed in the psychological subscale, no statistically significant differences were found between the total score, the somatic score, and the urogenital score. In nuclear families, the psychological score was higher than in joint families.

Table 5. Association of working pattern with MRS Scale

MRS Scale	Working pattern				P-value
	Sedentary	Mild	Moderate	Heavy	
Total Score	10(8.5-12.5)	9(7-11)	8(6-10)	10(8-12)	0.03
p-value (Total score)	1	0.054	0.03	0.06	
Psychological subscale	1(0-2)	2(1-3)	1.5(1-2)	1(0.5-3)	0.25
p-value (psychological scale)	1	0.07	0.54	0.68	
Somatic subscale	3(1-5)	4(2-6)	4.5(4-5)	5.5(4-7.5)	0.006
p-value (somatic subscale)	1	0.56	0.04	0.03	
Urogenital subscale	4.5(3-6)	3(2-4)	2.5(1-4)	2.5(2-4)	0.29
p-value (urogenital subscale)	1	0.32	0.02	0.001	

There was a statistically significant difference in the total score, as well as the somatic and urogenital scores between different working pattern groups, but no significant difference in the psychogenic subscale. The MRS total score was higher in the sedentary group as compared to the mild and moderate working groups, and the difference was statistically significant.

There was no significant difference in MRS score between women who had taken the treatment and women who had not taken any treatment.

Table 6. Association of MRS Scale with treatment taken

MRS Scale	Treatment taken		P-value
	Yes	No	
Total Score	8.5(7-10)	8(6-10)	0.59
Psychological subscale	3(2-4)	3(1-4)	0.22
Somatic subscale	4(1-6)	4(3-6)	0.56
Urogenital subscale	2(1-2)	1(1-3)	0.69

Discussion

Present study was conducted to investigate the onset age and menopausal symptoms prevalence and to assess their treatment-seeking behavior for menopausal symptoms and its correlation with quality of life.

In one of the study, the average age of the participants was 45 (4.42 years) **(4)**. A pan- India survey by Indian Menopause Society (IMS) in 2016 also concluded that the mean age at menopause is 46 (4.9 years) **(6)**. The median (IQR) age of menopause in our study was 45 (44–46) years. As a result, we may say that the average age of menopause is about 45. The median MRS score and urogenital score were higher in the 50–54 age groups as compared to other age groups. In addition, the difference was statistically significant in the psychological and somatic subscales in the 55-year-old age group.

In our study, nearly 87% of patients exhibited somatic symptoms. In approximately 52% of the women, psychological symptoms were observed, and in 51% of the women, urogenital symptoms were observed. In contrast, yet another study found that the prevalence of urogenital-sexual symptoms was 76.88%, somatic symptoms were 75.62%, and psychological symptoms were 73.33%.[6] In an Iranian study, somatic symptoms were observed in 70% of patients, followed by psychological symptoms in 66% of patients, and urogenital symptoms in 35% of patients in the perimenopausal age group **(7)**.

Joint problems were the most frequently observed symptom in the somatic subscale, depression in the psychological subscale, and bladder difficulties in the urogenital subscale. Yet other study, showed similar results in an assessment of menopausal symptoms using the modified MRS scale **(8)**. In that study, it was found joint problems (87%) were the most prevalent somatic symptom, depression (70%) the most common psychological symptom, and bladder problems (26%) the most prevalent urogenital problem in women. In a study conducted at Kochi, it also found that muscle and joint problems (90%) and hot flushes (63%) were the most common menopausal symptoms in women **(9)**.

The MRS total was higher in the sedentary group as compared to the mild and moderate working groups, and the difference was statistically significant. There was no significant difference observed in the MRS scale among sedentary and heavy workers. A Korean study concluded that higher physical activity was associated with severity of menopausal symptoms **(10)**.

In our study, the median (IQR) total score was 8 (range: 7-10) and the individual domain scores were as follows: psychological subscale 3 (2-4), somatic subscale 4 (2-6), and urogenital subscale 2 (1-2). In one of the study the mean total score, psychological score, somatic score, and urogenital score were 11, 4.5, 4.2, and 2.3, respectively **(11)**. In another study, the mean MRS score in women was 11 **(12)**.

97% of women in our study were knowledgeable about the menopause. As the majority of the women in our study were literate, this high level of knowledge may be attributable to their educational background. Idris also found that women with a high school diploma or higher level of education had 2.12 times greater awareness about menopause **(13)**.

38% of women were aware that their health issues were menopausal symptoms. Nearly 92% of women had faced the fact that their symptoms were having an effect on their daily routines (ranging from mild to severe), but only 4% of women had extremely bothersome symptoms. Almost 48% of women had taken treatment for their symptoms. Nearly 44% of women were prescribed HRT. The most common reason HRT was prescribed was vaginal dryness, followed by hot flashes. In a cross-sectional survey, it was observed that only 22% of women visited a gynecologist for menopausal symptoms **(14)**. Another study showed that only 44% sought care from health practitioners **(15)**.

There may be a number of reasons why women do not visit a health care facility, such as taking medication from a traditional healer as well as a local pharmacy, and not recognizing the health problem as menopausal symptoms, which was a finding of our study (i.e., only 38 percent of women recognized the health problem as menopausal symptoms) and necessitates consultation. In yet another study, it was revealed that 45% of women were taking hormone replacement therapy **(16)**.

There was no statistically significant association observed among health seeking behavior of the women with age group. Other significant factors associated with health seeking behavior were socio-economic class, family type and working pattern of the women. In another study, they found a significant association between health seeking behavior of the women and socio-economic class. However, they didn't find any association with family type and working pattern **(17)**. In our study, finding significant with working pattern maybe related due to wage loss of women prevent them to come to the hospital **(18)**.

Conclusion

Menopause is a notable transitional phase in all women's lives. It has been observed that our population women attain menopause at an early age (45 years). These women spend a substantial portion of their lives postmenopausal. Even though the prevalence of menopausal symptoms is high in our study population, the majority do not seek advice for these symptoms due to a lack of knowledge. Therefore, it is necessary to raise awareness about menopause and menopausal symptoms so that women will seek medical advice to make their lives more comfortable. At the most fundamental level, educating the public through health camps, social media, and the use of health care workers as well as non-governmental organizations (NGOs) can improve rural and urban postmenopausal women's quality of life and health care seeking attitudes. Data from all community-based studies can be used to formulate strategies and to focus on the demand-based needs of postmenopausal women. This can be utilized to plan the health programs in order to improve the quality of life of postmenopausal women. To help these women live a healthy and independent life, the current primary health care systems must include a dedicated menopause clinic.

Limitation of the study

- As it was a hospital-based study, the findings cannot be generalized to the community.
- Complementary and alternative therapies like analgesics, AYUSH and natural therapies were not included in the study.

Other variables like cultural beliefs around menopause and HRT were not assessed in this study.

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Conflict of Interest

None.

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