Menopause / Climacteric

Homoeopathy Clinic
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- Menopause is a significant change in a woman's life, but it is not an illness.
- Menopause does not employ the end of sexual activity in marriage.

INSIDE

OVERVIEW

Between the age group of 45 to 60 years of age, 85 % of the women's displays the typical symptoms of climacterium 35 % of the affected women experience some weakness or not at all burdened by it, 35 % displays moderate symptoms, 25 % complaint of severe pain and 5 % of these are so affected that they are incapable of working.

If compared to other bodily organs, menopause (climacterium), characterized by a premature aging of the ovaries. It the rapid decline of the estrogen level and the progesterone contents in the blood which are responsible for many vegetative and psychical symptoms affecting the large number of women's. Because of the interrelationship between the endocrine and the nervous system, any decrease in the estrogen production affects the central equilibrium. For the major part this hormone deficit is responsible for the menopausal disorders. However, the significance of the manifestation of the symptoms originating from each independent psychogenic processes should not be under estimated. The processes occurring during menopause affect the complete individual. Each women reacts differently to the physical changes taking place and very often these changes also coincide with a change in the living condition. A women's own disposition and above all her attitude allowing her to adapt to new life activities in advanced age are decisive factors for the intensity at which many climacteric afflictions are manifested. Considerable strain ensues from these afflictions which tremendously affect the quality of the life of the patient.

DEFINITION

Menopause, refers to the end of women's menstruation. The word is derived from the combination of two Greek words, *Mens (Month) & Pausis (to stop).* Menses stop naturally with the decline of monthly hormonal cycles between 45 and 60 years of age. It may stop earlier in life as a result of illness or the surgical removal of the uterus or both ovaries. As the production of estrogen by the ovaries and pituitary gonad-stimulating hormones decreases, ovulation and menstruation happen less often and eventually stop. Variations in the circulating levels of the hormones occur as the levels decline. Hot flushes are the only general symptom of menopause that nearly every woman has.

Contrary to common misconception menopause does not employ the end of sexual activity in marriage. In fact, in many cases, menopause has a stimulating effect on women's sexual activity and interest because of the diminished possibility of pregnancy.

Climacteric, the period of physical and emotional change that precedes that accompanies menopause. These changes usually occur gradually over a period of year, though the time may vary from six months to as long as five years or more. It consists of three stages: pre-menopause (the transition between fertility and the last menstrual period); menopause (when periods have actually ceased for a year); and post-menopause (the years after the end of menstruation).

This article explains menopause and the signs that may accompany it, and suggests ways of coping with them.

PHYSIOLOGICAL CHANGES & SYMPTOMS

Pre-menopause comprises somewhat the period starting at the age of 40+ and extending to the last occurrence of the menstrual period. Approximately 75% of women undergoing this phase are affected by cycle disturbances(irregular periods, too rare, too frequent). It is the increasing shortage of progesterone (a corpus luteum hormone) which account for such disturbances. In some cases the first symptom such as hot flushes and mood swings are attributed to the onset of hormonal imbalance. The gradual decrease of the ovarian function lead to lack of estrogen and progesterone in turn affecting important hormonal cycles because of failure in feedback mechanisms. (Fig. 1 (1))

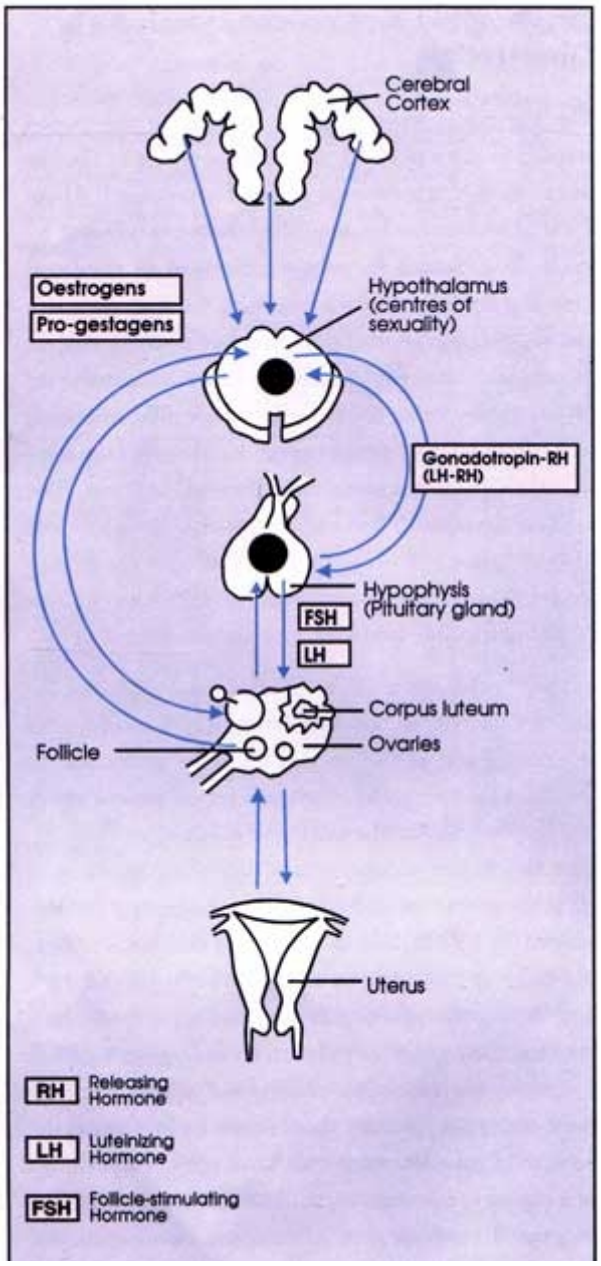
Following the reduction in hormone production form ovaries the pituitary glands reacts by increasing the release of gonadotrophins which will remain on average at a higher concentration until a women's senium (late post menopause). These hormonal changes are hardly noticeable at this stage.

These hormonal changes can turn into serious disorders during post menopause at times accompanied by organic changes. First of all the hot flushes, profuse perspiration, insomnia and depressive disposition develops. Some of the organic changes taking place include the atrophy of the vaginal epithelium (dry vagina) and of the skin, osteoporosis and atherosclerosis. The last two conditions manifests themselves in the late post menopause. The intensity of feeling varies from individual to individual. The changes can be felt in the following areas:

- In ones own body
- In her femininity
- In general well-being
- In sexuality
- In the relationship with the partner
- In the family
- At work

The ability to accept one's own coming of age and the areas stated above in the sense of maintaining one's self work, is of crucial importance in determining the degree to which an affliction will be felt. The diversity of symptoms that can occur at that time may trigger some feeling of anxiety which must be over-come. This anxiety will not always be depressed and the problem will shift to psychosomatic levels.

Generally the menopausal period coincide with the departure of children from home. In the case of many women this results in the need for a new life orientation away from the maternal rule.



A lack of progesterone especially deficiency in the estrogen production lead to functional abnormalities and dysfunctioning of the menopausal center in the brain stem in turn manifest themselves as menopausal regulation disorders. This is probably due to a connection taking place between the neurotransmitters and the catechol estrogens but without involving the gonadotrophins. The occurrence of hot flushes are closely correlated with the release of luteinizing hormone (LH) which is regulated through complex cycle. Each hot flush is preceded by a release of LH but not each LH peak is followed by a hot flush. Besides the LH level rises a few minutes after the beginning of hot flush, eliminating the secreting of LH as its cause. The frequency and occurrence of hot flushes vary among individuals. In the pre-menopause phase about 8% of women experience more than two daily hot flushes. The number of affected women increase with the menopause and clearly reaches its maximum 2-3 yrs later.

The sudden onset of hot flushes without any prior sign often leads to feeling of insecurity/ disturbances. In many cases hot flushes occur during the night resulting into insomnia as such no longer able to reach a deep sleep phase.

PHYSIOLOGICAL CHANGES & SYMPTOMS

This gives rise to typical physical complaints such as:

Profuse Perspiration	Insomnia
Palpitation	Tachycardia (accelerated heartbeat)
Headache	Dizziness
Tiredness	Irritability
Nervousness	High Blood Pressure
Lack of concentration	Nervous exhaustion
Reduction in productivity	Constipation

PSYCHIC SYMPTOMS

Decrease in concentration, energy, stimulation, intellectual performance, feeling of ones own value etc.

Increase in tension, exhaustion, irritability, aggressivity, mood changes, last minute panic, fear of failure, feeling of introversion, depression, fear of loss, alcohol or other stimulants, drug intake, carcinophobia etc.

FREQUENCY OF MENOPAUSAL AFFLICTION & THEIR EVALUATION

A quantitative assessment especially for the menopausal symptoms, is generally carried out with the help of Kuppermann Menopause Index (2). Ten typical symptoms such as hot flushes are classified and graded according to a corresponding multiplication constant. This constant is respectively multiplied by a subjective grading factor (each from 0 to 3 depending on the degree of severity). The resulting value are then added and the total score is used as an indication fro the severity of the climacteric syndrome. A score higher than 35 points corresponds to a severe degree of a symptomatic syndrome, a score 21-35 is moderate to average and a score of 15-20 points indicate a low degree of severity. During the course of treatment the efficacy can be established by recording a decrease in the menopause index. On the other hand the HAMA (Hamilton– Anxiety– Scale) rates the groups of psychic and somatic anxiety symptoms of the patients (3).

Table: Most frequently Observed Afflictions in Menopause.

Hot Flushes / Perspiration	60-80%
Insomnia	50-70%
Loss of Drive / Tiredness	50-80%
Nervousness / Irritability	70%
Forgetfulness	65-70%
Depression	20-80%
Headaches	40-80%
Loss of libido	20-80%
Arthralgia / Myalgia	40-55%
Palpitation	20-50%
Weeping Spasms	40%
Paresthesia	25%
Dizziness	20%

ORGANIC SYMPTOM COMPLEX

The decline in the production of estrogen leads to long term functional disorder and the degeneration of the genitalia, skin, mucus membrane and muscular sphincter. This lead to several kind of organic weaknesses and afflictions:

> Local atrophy of the epithelium of the vagina, urethra and bladder, atrophic colpitis and urethritis, prolapse of uterus, load induced incontinence, urge induce incontinence, functional incontinence, leucorrhoea, cohabitation problems, generalized skin atrophy, hair loss, hirsutism etc.

ORGANIC SYMPTOM COMPLEX

In late post menopause metabolic symptoms, with metabolic disorders, manifest themselves into decrease in HDL cholesterol, rise in LDL cholesterol, increase in bone metabolisms, degradation of structural proteins and calcium assimilation disorders etc. This results in disturbed fat metabolism, atherosclerotic changes in the blood vessels, disposition towards adiposis, weakening of connective tissues as well as functional cardiac circulatory disturbances.

METABOLIC CHANGES IN CLIMACTERIUM

In late post menopause metabolic symptoms complex with metabolic disorders like decrease in HDL cholesterol, rise in LDL cholesterol, increase in bone metabolism, degradation of structural proteins, calcium assimilation disorders etc., manifests themselves. Consequence of metabolic changes there is high risk of heart infarcts and apoplexy, arteriosclerosis, weakening of connective tissues, osteoporosis and osteoarthritis etc., manifests themselves.

POSTMENOPAUSAL OSTEOPOROSIS

Osteoporosis is a condition caused by decreased density, or thinning, of the bone accompanied by fractures.

There is relationship between a lack of estrogen and post menopausal osteoporosis. Osteoporosis is a condition caused by decreased density, or thinning, of the bone accompanied by fractures. This can be divided clinically into two: primary and secondary osteoporosis.

The **primary osteoporosis** include the relatively real idiopathic osteoporosis (juvenile osteoporosis, adult osteoporosis), the post menopausal (**type I**) and the senile osteoporosis (**type II**). The Post menopausal osteoporosis is the most occurring form and found in the spongiest skeletal parts (body of vertebra). It manifests itself between the age of 45-70 yrs of age. The high incidence of type I osteoporosis in women has lead to the post menopausal osteoporosis designation (Women : Men Ratio=8:1). The senile osteoporosis with a women to men ratio of 3:1 only appears after 70 yrs of life. This form of osteoporosis is characterized by a generalized manifestation with distinctive loss of substances from trabecular and cortical bone tissues like body of vertebra, femur, humerus etc. **Secondary osteoporosis** occur within the frame of other basic diseases such as hyperthyrosis, disease of immune system and others. On an average osteoporosis manifests with damaged vertebra or back pain are found in approximate 8% of the population.

Etiopathogenetically, osteoporosis is attributed to an interplay of various factors on the calcium metabolism and the skeleton. The higher rate of incidence of osteoporosis in women and the increase in the incidence of osteoporosis in the post menopausal fields certainly points towards a casualty with regard to estrogen. However not all women will be diagnosed as having osteoporosis. Apart from estrogen deficiency, in the development of osteoporosis other factors are also very important. Different risk factors based on a multifactor genesis are responsible for the appearance of osteoporosis. It is presumed that in an individual case depending upon the intensity, one or other factors or the concurrence of several factors could be decisive (see Table).

Absolute bone mass and speed of bone deterioration play an important role in the development of osteoporosis. This disease can develop as a consequence of an insufficient bone mass growth in childhood or adolescence. It can be also a result of pathologically accelerated bone deterioration which leads to premature structural and functional damages.

Weight-bearing exercises such as walking and jogging are crucial to maintaining or building bone mass. Good nutrition is a basic tool in the prevention of osteoporosis. A lifelong, well-balanced diet that includes generous amounts of calcium-rich foods is the best protection against this condition and other bone disorders.

Risk factors associated with Osteoporosis.

1. Lack of Physical activities: Sedentary occupations, lack of sports activity, and immobility.
2. Diet poor in calcium, Lactose intolerance, phosphate and fiber rich diet.
3. Genetic disposition, positive family history.
4. Low levels of estrogen, early menopause, secondary amenorrhea, absence of pregnancy.
5. Slim physical appearance, light thin skin, blond hair, delicate physical build.
6. Heavy smoking, alcohol, tea or coffee.

POSTMENOPAUSAL OSTEOPOROSIS

Practically all foods contain calcium, but those highest in calcium include (in order of calcium content in an average serving): low-fat, plain yogurt; sardines; skim milk; low-fat milk; whole milk; Swiss cheese; cottage cheese; kale; cheddar cheese; ice cream; turnip greens; salmon (with bones); broccoli; and sunflower seeds.

HORMONE REPLACEMENT THERAPY

Women desiring hormone replacement therapy (HRT) to relieve symptoms before and after menopause and to protect their heart and bones are often bewildered by the array of choices and barrage of information about HRT's risks and benefits.

Worldwide endocrinologists recommends a long term hormonal substitution after consideration of several **benefits—risks—relationships** in the following situations:

- Appearance of primary ovarian insufficiency through premature inactivation of the ovarian functions or the deactivation of the ovaries prior to the age of 50. For example in the case of ovariectomy.
- The presence of osteoporosis at the time of menopause.
- The presence of urogenetical atrophy with related afflictions at the time of menopause.
- Typical menopause related reactive disphoria (psychosis).

The incidence of systematic circulatory disease is also influenced by estrogens. A protective estrogen therapy has been reported to reduce cardiac infarct and coronary heart disease in post menopausal women's.

The HRT however, **caries considerable risks**.

The estrogen quantity, depending upon the doses and the period of intake lead to an **endometrium hyperplasia** which could possibly become precancerous and later give rise to an endometrium carcinoma. The chances of women developing such a cancer with the sole substitution of estrogen is 4 to 8 times higher than in the case of untreated women. In order to reduce the risk of carcinoma, an additional dose of gestagen is strongly recommended. This treatment however fails because of menstrual irregularities rendering it intolerable to many post menopausal women.

Another controversy associated with the intake of hormones is appearance of **mastocarcinoma (breast cancer).** This type of carcinoma is one of the leading causes in mortality rates in the ratio (10 times higher than the endometrium carcinoma).

The risk of developing **hypertonia** or a **thromboembolism** in the course of an hormonal therapy is negligible in the case of proper doses. **An increase in weight** observed in patients undergoing an estrogen substitution treatment is also seen as an undesirable effect.

Even though HT lowers the bad LDL cholesterol and raises the good HDL cholesterol, HRT may slightly **increase** the risk of **heart attacks and strokes** in women who already have heart disease.

Keeping in view of the above facts HRT is not generally recommended. The relationship between benefits and the risks should be assessed individually. It has been seen that women generally refuse to undergo an HRT because of its numerous side effects.

- The chances of women developing endometrium carcinoma , a cancer with the sole substitution of estrogen is 4 to 8 times higher than in the case of untreated women.
- Breast Cancer is one of the leading causes in mortality rates in the ratio (10 times higher than the endometrium carcinoma).

HOMOEOPATHY REMEDIES

Most effective and commonly used medicines for menopausal problems are:

1. **Cimicifuga Racemosa:** This is especially suitable for arthralgic—mialgiac—neuralgic conditions in climacterium and similar states of endocrine genesis. Leese & Mezer have advised its use in menstrual disorders, migraine, depressive psychosis, hot flushes, cardiovascular disorders like palpitation or pain in heart. Many researchers finding's has shown its effect on hypothalamus which specifically affect the sexual functions. Due to its action on central nervous system it works well on hot flushes and depressive psychosis.
2. **Lachesis:** Used in vasomotoric disorders which are expressed in climacterium as hot flushes alternated with periods of cold sweats, palpitations and headaches. It also ameliorates psychic symptoms such as apprehension or depressive conditions, anxiety or lack of sleep due to internal agitation.
3. **Sepia:** Useful to those women whose symptoms are associated with a disturbance in the balance of hormones from the adrenal cortex, sexual and pituitary glands. This is probably due to an ovarian insufficiency resulting in a relative shortage of estrogen which in turn leads to an excess of adrenal androgen. Its main action is in the physic domain which includes depression, irritability or apathy. Somatic disorders too influenced by its use, which include hot flushes and localized perspiration, headaches of various nature, venous congestion, neuralgia, exhaustion and tiredness.
4. **Ignitia:** Its main action is in depressive psychosis, mood swings, irritability and insomnia caused by internal restlessness. Somatic symptoms like migraines and irregular menstrual cycles often in connection with abdominal cramps respond well to it.
5. **Sanguinaria Can:** Useful in menstruation related migraines, hot flushes with flush like plethora in the head and accelerated cardiac activity, Climacteric metorrhagia (prolonged bleeding).

Sulphur & Medorrhinum are sometimes required when indicated remedies fails to cure.

For Osteoporosis **Cal Carb, Cal.Phos, Sepia, Symphytum & Conchiolinum** are commonly used for treatment.

REFERENCES

1. Nocke W.

   Osteoporose durch endokrines Defizit-Syndrome

   Vermeidbar durch Sexualhormon-Substitution!

   Therapiewoche 42, 7:350-357 (1992)

2. Kuppermann, HS., Wetchler BB, Blatt, MHG

   Contemporary therapy of Menopausal Syndrome

   J. Am. Med Assoc. 171:1626-1637 (1959)

3. Hamilton M

   Diagnosis and Rating of Anxiety

   Brit. J. Psych. Spec. Publ. 3: 76-79 (1969)