



## **Indian Menopause Society Member Country Session**

**Date:** Monday 27 September 2010

**Time:** 07.30am – 08.30am

**Session Chairs:** Dr Elizabeth Farrell, Dr Duru Shah

**Session Topics: Managing Menopause in the Changing Social Scenario of India**

**Dr Atul Munshi**

Problems of Menopause in rural India

**Dr Saroj Srivastva**

Addressing Sexuality issues in Indian Women

**Dr Meeta Singh**

Menopause - Is it a marker for disease?

**Dr Sonia Malik**

HT Usage – where do we stand?

**Dr Jignesh Shah**

Alternative therapy - what evidence says?

**Closing Discussion**

**Language: English**

## ABSTRACTS

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### Menopause & Management in Rural Women. Problems, Symptoms, Realistic Goals, Practical therapeutic & Preventive Options.

Munshi, Dr. Atul M.D.<sup>1</sup>  
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In 2025, India will reach 165 millions mark.

More than 12% of population will be above 60 yrs. of AGE! Almost 50% of these will be women! A staggering population in menopausal & post menopausal AGE!(Ref.# 1).  
70% of these population in Rural India!

Public Health Systems- both Govt. & Private, are over burdened with problems of women of child bearing age, adolescent girl & Infectious diseases .As a result, it hardly addresses the specific health needs of older women, - they are often neglected.This is more seen in rural set up where health care facilities are much less than urban or semi-urban counterpart! (Ref. # 2).  
They do suffer from Menopausal Problems!

**Incidence** - Exact Indian Incidence is difficult to get but from scattered studies from literature & similar studies from Asian & Western Countries Project:

- Average Age of Menopause is some what lower in Rural Population than Urban. (Mean Age 44.8/48.2).However, this is not clinically significant, pre-menopausal problems were definitely higher in Rural Population.(Ref. # 3).
- Incidence of various symptoms were also different in rural & non-rural population.

**Issues Increasing the Problems In Rural Population include** - Lack of Awareness of menopausal Problems, Busy Working Hours, Poverty, Gender Bias, Discussions of Sexuality-A Taboo, HRT Hardly Known, Cost of Drugs & Other Health Facilities. (Ref. # 4)

**Attitude** - Each Woman's reaction to MENOPAUSE is different. Cultural & Social attitudes do influence women's behavior & ultimate outcome.

#### **Effects Of Menopausal Symptoms In Rural Set Up.**

1. Stoppage of Menstration- A Welcome Change.
2. Get Seniority in Society.
3. Can attend all social functions.(Ref. # 5).

#### **Symptoms**

Short Term includes - Fatigue & Lack of Energy, Lack of Interest.( 73 to 93%). (Ref. # 6 & 7).Pressure, tightness, Headache. (55 to 83%).Mood Swings/Insomnia. (50 to 73%).Hot Flushes-Cold Sweats, Cold Hands.( 51 to 60%).Weight Gain. (30 to 40%).Urogenital Problems.(30to 40% ).(Develops little later).

Long Term includes - Cardiovascular Problems.(10 to 20%), Skeletal Symptoms. (20 to 30%), Prolapse & Urogenital Atrophy. (25 to 50%). (Ref. # 8).

## **Discussion**

Psychological symptoms are though more common, are usually taken care of By Joint Family Systems & Social Support. Low Fat, High Fiber Diet & Physical activities make Cardio Vascular Problems-less significant. Poor Nutrition, Gender Bias & Poor Health Care Facilities leads to Osteopenia & at times, Osteoporosis. Physical Activities, Diet high in Phytoestrogen & Sunlight exposure leads to relatively low Incidence of fractures. Urogenital Problems including Prolapse, more seen due to Lack of Hygiene, Multiparity & Lack of Regular Check Ups. (Ref. # 9 & 10).

Realistic Goals are to extend RCH Programme to Women Health Programmes., Education of Rural Masses , Creating Awareness of Health Care need & facilities available, To provide treatment at PHC Level, Providing Counseling & Cheaper Drugs at Rural Centers, Organising Periodical Health Camps including PAP Test/Breast Examination, To include MENOPAUSAL Problems in Curriculum & Private Health Care. (Ref. # 11).

## **Practical Prevention & Therapeutic Options.**

Strategies include Involving Govt./ Centre & State in Mature Women's Health Care. To involve NGO & Other Voluntary Organizations. Involve Media & Celebrities & even Corporate Houses for, Awareness, Education & Counselling, Personal Visits, Distant Education, Dietary Advice/ Food Fortification/ Lifestyle Advice, Family Support, HRT/Natural Substances when needed.

## **Future - India Poised!**

Slowly & Gradually, a Social, Cultural & Health Care Revolution is being set up!

- Low Cost Drugs. Natural Substitute, Option for Research, WIDE NETWORK for Primary Health Care Facilities.

By 2027, we may see a new India with a Difference!

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## Managing Menopause In The Changing Social Scenario Of India Addressing Sexuality issues in Indian Women –

Srivastva, Dr Saroj<sup>1</sup>

<sup>1</sup>President Elect IMS India 2011

Sexuality had always been an important element universally, more so in Indian subcontinent. Indian sculptures are the immortal evidence of depicting sexuality issues so candidly that while viewing these arts and studying kamasutra the modern world is spell bound. Changing scenario in Indian history modified the concept of sexuality in India. During the course of time Indian society had an impact of Mogul and thereafter of English culture, however the current scenario is influenced by globalization; nevertheless people still feel that sexuality is something very personal and is meant for perception rather than for discussion.

As such, globally the subject of Sexuality remained neglected even in modern civilization for a long time. It was in 1953 when for the first time Kinsey A. published the study on 'Sexual Behavior of the Human Female, however, it was Masters, Johnson and Kaplan who first studied the traditional human sex response in females. The specific study of postmenopausal sexuality did not begin until 1990.

Indian women attain menopause around the age of 47, but due to poor longevity many had not witnessed menopause. Till 1953 the mean age of Indian population was only 37years. The longevity now is about 71 years and therefore majority of them spend more than one third of their life span during postmenopausal period. India is a developing country, and a large population still lives below the poverty line. It is imperative that the QOL must improve else there will be increased social burden. QOL is related to physical, mental and environmental health. In addition to this women's attitude & perception towards menopause in different cultures are responsible for sexual dysfunction. One wonders if low sexual desire is the cause or the result of marital disharmony during postmenopausal period.

Sexual Behavior of the Human Female is relatively a new subject to be talked about. Social taboos did not allow these women to know the difference between normal/ physiological sexuality and sexual dysfunction. Due to lack of knowledge many couples might have suffered in silence.

An effort is being made to study how the postmenopausal women view the subject of sexuality in Indian subcontinent. One wonders if their negative attitude is responsible for their sexual dysfunction. Or is it because of cultural differences? Has their perception of sexuality changed from reproductive period to postmenopausal period? An endeavor will be made to find out as to how many of them considered that sexuality issue has an important role in postmenopausal period.

## Menopause Marker for Disease.

Singh, Dr. Meeta<sup>1</sup>

<sup>1</sup>President Elect 2012, IMS, India

Menopause is a defining point in the transition phase of a woman's life with declining levels of estrogen, progesterone and androgens. This brings about metabolic, structural and physical changes in the immediate postmenopausal period.

Is Menopause a physiological event or a hormone deficiency state? Marking the onset of Chronic Non Communicable Diseases. Numerous trials have been conducted to understand the effects of Menopause and Hormone Therapy on the various systems in the immediate and late postmenopausal period. Women's Health Initiative, an elaborate large scale Randomized Control Trial was designed primarily to study the effect of Hormone Therapy on the leading cause of disability in the postmenopausal women i.e. Heart disease, Breast Cancer, Osteoporosis, Colon Cancer and many secondary outcome were also analyzed. The study in spite of its shortcomings unraveled grey areas and gave a better understanding of the pathophysiology of menopause.

Menopause is a physiological event but with a potential for precipitating chronic disorders in vulnerable women. According to Barker's theory chronic disease have their origin in utero and the clinical presentation would depend on genetic, environmental, social and cultural factors. Risk factor for Non Communicable Disease have modifiable and non modifiable factors, female gender being one of the non modifiable ones. Epidemiological, Observational and Randomized Control Trials suggest that the menopause predisposes to non communicable disease like Heart Disease, Osteoporosis, Urogenital Atrophy, Metabolic Syndrome.

Reproductive period has fluctuating levels of estrogens i.e. 0.07 to 0.8ng/day depending upon the phase of the menstrual cycle. The bouncing back of estrogen prevents the adverse effect of low estrogen levels on the tissues. The scene changes at menopause, with the tissues exposed to a persistent and progressive decline of estrogen levels i.e. < 10pg/ml leading to a decline in function over a period of five to ten years. At this point of time replacing the deficient hormone and preventive measures would help in tackling the onset of chronic disorders. Estrogen has an important role as an anti oxidant in prevention of Non Communicable Diseases. Ageing and other multifactorial factor play a major role in the progress of the non communicable disorders. At this stage replacement of the Hormone Therapy may do more harm than good as was shown in the WHI Study.

The average age of Menopause in India is 46 years and non communicable diseases present themselves almost a decade earlier than the Caucasians. Osteoporotic Fracture occurs 10-20 years earlier in Indians as compare to Caucasian<sup>1</sup>

Prevalence of Osteopenia is 34.5% at Hip and 47.2% at Spine, Osteoporosis 3.6% at Hip and 12.7% at Spine<sup>3</sup>.

India has the highest number of Diabetes in the world<sup>4</sup>. The Burden of Cardiovascular disease is projected to increase by 115% from 1990 to 2020<sup>5</sup> and Cerebrovascular incidence by 104%<sup>6</sup>. The prevalence of Hypertension in urban India is 20-40% and in rural India is 12-17%<sup>7</sup>.

Age wise distribution of Non communicable disease shows an increasing trend after age of 40<sup>8</sup>

Does an early age at menopause in India predispose women to chronic health disorder a decade early? Appropriate Risk Assessment and screening modules for Non Communicable Disease need

to be created and implemented at an early age of 40 years in India. This would aid the Indian Menopause Society to achieve the mantra, “Fit at Forty Strong at Sixty Independent at Eighty.”

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### HRT Today – Where do we stand today

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The Indian mindset is traditional and conservative where any treatment is concerned .This is more so when the medication is for long term and is a hormone. Hence even when the west was using hormones as primary prevention for all disorders after menopause, Indians were still wary of them and did not use them even in definite indications. In addition to this was the total lack of information and knowledge about hormones even amongst the treating physicians. The prescription of hormones and their substitutes was low as compared to the rest of the world. Menopause management was unheard of.

The Indian Menopause Society was formed in 1995 with one of its prime objectives being to spread awareness about menopause amongst doctors and general public.. This started giving results and by the time the 2<sup>nd</sup> Consensus meeting on the use of hormones was called in 2004, the society was sure that they had achieved what they wanted. But it was not to be so. The WHI report was released just then with all its adverse findings. This proved to be the death knell for hormones and menopausal medicine in India.

This presentation aims to present the effects of the WHI and Million women study on India , the struggle to bring back confidence in the treating physicians ,hormones and the status of Menopausal medicine & HT today in the country

## Role Of Alternative Therapy , What Is The Evidence

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Any therapy used in place of conventional or more traditional treatments is called alternative therapy.

In India , to some women,menopause is considered a relatively clean state and therefore enables women to attend social and religious functions. Since there is no bleeding and no risk of pregnancy, menopause is considered a welcome change to some women. Psychological symptoms are less commonly seen, possibly due to the availability of the joint family support. Even though, In Indian Subcontinent, because of increase in life span, improved standard of living & widespread awareness- more women seek relief for menopausal symptoms. Therefore HT as well as Alternative therapy is being widely used & accepted.

Hot flushes and vasomotor symptoms are relatively less common than their western counterparts. There is no word for 'Hot Flushes' in Indian languages. Urogenital symptoms and Osteoporosis are more common in some areas. Majority of Indian families pay out of their pockets for any medicine prescribed. Medicines for which they do not perceive an immediate advantage or effect is not easily accepted in a household which is already financially strained. However, after the publication of WHI reports and MWS alternative medicine is finding acceptance among gynecologists and patients.

In western countries, alternative therapy refers to any type of medicine that supplemented or is used in lieu of allopathic medicine. In other parts of the world, where traditional medicine predominates the term may refer to biomedicine itself.

Evidence from randomized controlled trials that alternative therapies improve menopausal symptoms or have same benefits as hormone replacement therapies is poor. Many women however use them in the belief that they are safer and 'more natural'.

Is there a need of an alternative therapy?

Alternative therapy is used in the following instances:

- a) Women who do not want hormone therapy
- b) Women who cannot have hormone therapy – in whom HRT is contraindicated
- c) Increasing number of gynecologists who are averse about prescribing estrogen to their menopausal patients (unless must) for their own strong reason

What alternative therapies are available?

- a) Allopathic alternative treatment for various symptoms of menopause e.g. clonidine for vasomotor symptoms, atenolol for palpitation and tachycardia, alprazolam for restlessness and anxiety, amitriptyline for depression, polycarbophil gel for vaginal dryness, xylocaine jelly 2% for dyspareunia, calcium and vitamin D for prevention of osteoporosis, melatonin for symptoms related to circadian rhythm, vitamin E and B complex for hair loss, anti-androgens for facial hirsutism .
- b) Natural remedies which include i) Phytoestrogens, ii)phytoprogestosterone and iii)phytoestrogens.
- c) Diet which is rich in calcium, low in fat and cholesterol.

d) Exercise and yoga.

e) Acupuncture & Acupressure.

Even though alternative medicines are widely used and growing in popularity after WHI and MWS reports, the exact role is yet to be defined. Number of clinical trials are done with promising results but yet large sized, multicentered, multiple randomized controlled trials and meta-analyses with critical reviews are to be done before ascertaining its role.

Stringent norms for manufacture and quality control do not exist for nutraceuticals & herbal products as compared to pharmaceutical products.

If proved useful by RCTs and meta-analyses and quality control studies it can bring about a revolution in treating menopausal symptoms by way of acceptance by health care providers and beneficiaries.