Does working women have less climacteric symptoms?

*Tarek R. Abbas, Adel A. Elboghdady

Department of Obstetrics and Gynecology, Al-Azhar Faculty of Medicine, Cairo, Egypt

Abstract

To detect the difference of climacteric symptoms among working and nonworking postmenopausal women. This prospective study was carried out in Bab Alshaaria Hospital- Al Azhar University (Cairo) from January 2014 to January 2016 and joined 166 women (83 working, 83 not working). Sociodemographic data were collected through a sociodemographic questionnaire. Menopausal symptoms were assessed in detail. All women had a similar sociodemographic background. A significantly greater percentage of nonworking women suffered from hot flushes, difficulty in sleeping, headache, irritability, depressive mood, muscle and joint pain, and urinary problems. Multivariate logistic regression analysis showed that the working status had a significant effect on the experience of climacteric symptoms. The present study revealed that working women have significantly less climacteric symptoms than nonworking women.

Keywords: Working women, Climacteric symptoms, Menopause.

INTRODUCTION

The menopause is a noteworthy event in women's lives and is related to ovarian failure and follicular atresia. It is characterized by the loss of ovarian function following the reduction in the secretion of estrogen, permanent cessation of menstruation and the loss of reproductive ability. It touches women's health in biological, psychological and social aspects. Menopause can lead to a wide range of symptoms including hot flashes, night sweats, sleeping problems, emotional and cognitive symptoms, irritability, anxiety, vaginal itching and dryness, and urinary symptoms. Reported hot flush rates for perimenopausal women range from 40 to 60% (Freeman and Sherif, 2007). The prevalence of vaginal atrophy in the early stages of the menopause increases as a woman advances through the postmenopausal years (Koko-Kierepa et al., 2012).

Although the nature and prevalence of menopausal symptoms are similar for most women, there are variation sacs and within cultures which are due to differences in lifestyle, socioeconomic status and the self-perception of individuals. Menopausal symptoms may become a problem not only for women, but also for their families, colleagues and communities. For this reason, clinicians who provide care during the menopause, have a significant opportunity for the provision of preventive medicine. To fully benefit from this opportunity, physicians should be equipped with the means to alleviate the symptoms of the menopause (Speroff and Fritz, 2005).

The Global Consensus Statement on Menopausal Hormone Therapy stated that hormonal replacement therapy (HRT) is the most effective treatment for vasomotor symptoms and urogenital atrophy, but it has a complex pattern of risks and benefits. The Current international consensus suggest that the hormonal treatment of menopause should be individualized and that the lowest dose of estrogen providing relief should be used for the shortest period of time in menopausal women (de Villiers et al., 2013).

Evidence from studies concerning the effects of physical activity and exercise on vasomotor and other menopausal symptoms is conflicting. There are studies stating that physically active women have fewer menopausal complaints (Moilanen et al., 2010; Mirzaijmabadi et al., 2006; Skrzypulec et al., 2010; Canário et al., 2012), or vice versa (Whitcomb et al., 2007). Despite the fact that many studies do not support...
a relation between physical activity and vasomotor symptoms (Greendale and Gold, 2005; Sternfeld et al., 1999; Daley et al., 2007; Li et al., 1999), a recent study in Brazil, indicated that most women with no hot flashes were observed to be very active (Canário et al., 2012). However there are also studies indicating no sufficient evidence to determine the effectiveness of exercise as a treatment for vasomotor symptoms (Aiello et al., 2004; Daley et al., 2011). Aiello et al. reported that the intervention group who underwent physical exercise experienced a significant increase in the severity of hot flashes (Aiello et al., 2004). A recent study suggested that moderate aerobic exercise decreases hot flashes; however, in women with lower fitness levels, more daily moderate physical activity leads to more self-reported symptoms (Elavsky et al., 2012). The objective of this study is to detect the difference of climacteric symptoms in working versus nonworking postmenopausal women.

PATIENTS AND METHODS

Our prospective study was carried out in Bab Alshaaria Hospital- Al Azhar University (Cairo) from January 2014 to January 2016. A priori power analysis was performed using 2-sided tests with analpha level of 0.05, a power of 0.8, and a moderate effect size. One hundred sixty six women (83 working and 83 nonworking) were involved to detect differences in climacteric symptoms.

At the beginning, using a random number generator program, a random sample of 188 women was selected. Of these, 22 women were excluded from the study because they declined to participate, could not be found at home, or had relocated. The final sample comprised 166 women, of whom 83 were employed and 83 were unemployed.

The inclusion criteria were: age 40–60 years; having had no menstruation for at least 1 year, no thyroid or psychological problems; and having undergone a natural menopause. Women who had undergone a surgical menopause or were taking hormone replacement therapy were excluded from the study. Data on sociodemographic characteristics such as age, BMI, age at menopause, employment status, and marital status were obtained by a sociodemographic questionnaire. A pilot study with 13 women was conducted to test the comprehensibility of the questionnaire. The phrasing of some questions was subsequently revised on the basis of the respondents’ feedback.

We asked about 12 symptoms related to menopause: hot flushes, difficulty in sleeping, headache, irritability, depressive mood, muscle and joint pain, weight gain, palpitation, increase in facial hair, vaginal dryness, loss of sexual desire, and urinary complaints.

The data were collected via face-to-face interviews (which lasted 15–20 minutes). In order to obtain more reliable replies, the women were informed about the confidentiality of the questionnaire when they were invited to participate in the study. Participation was on a voluntary basis.

To analyze the sample as a whole, the two groups of employees were merged. Descriptive analysis was used to determine possible differences between the two groups. Descriptive characteristics, such as frequency, and summary characteristics were calculated for the variables of interest. Continuous variables were compared using the t test. Differences between categoric variables were analyzed using the χ2 and Fisher exact tests. P≤0.05 was considered to be statistically significant. All statistical calculations were performed using Excel version 7 (Microsoft, New York, NY, USA) and SPSS (SPSS, Chicago, IL, USA).

RESULTS

One hundred sixty six women participated in the study (83 women each in the working and nonworking groups). Their demographic characteristics are presented in (Table 1). The mean age of the participant's was 47.8±3.8 and 48.1±4.6 years, the mean age at menopause was 44.7±1.9 and 44.8±1.8 years; the women had 3.3±0.8 and 3.5±0.6 living children in working and nonworking groups respectively.

No significant differences between the groups for age, age at menopause, BMI, parity, number of living children and marital status (Table 1).

One hundred fifty four women (92.7%) suffered from at least 1 menopause related symptom and 50 (30.1%) complained of 5 or more symptoms. The most prevalent climacteric complaints in both groups were hot flushes, irritability, muscle and joint pain, difficulty in sleeping and headache (Table 2).

The nonworking women suffered significantly more often from hot flushes, difficulty in sleeping, headache, irritability, depressive mood, muscle and joint pain, and urinary complaints than working women (Table 2).

DISCUSSION

Our study showed that menopausal symptoms are common and vary depending on working status. The age at natural menopause in the present study was 44.8 years. In previous studies carried out, the mean age at menopause was cited as 45–48 years. The mean age at menopause differs from country to country. In the USA, the mean age of women entering menopause is 51 years (Uncu et al., 2007; Kwawukume et al., 1993; Agwu et al., 2008).

Menopausal symptoms also differ between cultures. Western women are prone to suffer from vasomotor symptoms such as hot flushes or night sweats. However, such problems are not seen in Japanese women and there is not even a word in Japanese for “hot flush” (Anderson et al., 2004).
The present study showed that, menopausal symptoms are frequently encountered. Of the participants, 92.7% suffered from at least 1 symptom and 30.1% complained of 5 or more symptoms. The most striking symptoms in both groups were hot flushes, irritability, difficulty in sleeping, and muscle and joint pain. This is consistent with findings from other studies (Sahin and Coskun, 2007). In one study, 82% of women experienced muscle/joint/bone pain, 74% had hot flushes, and 68% complained of irritability (Uncu et al., 2007).

Our study exposed significant differences in menopausal symptoms between working and nonworking women. The findings were significant and need further inquiry. The literature on this topic is limited. To our knowledge, the few studies that have been carried out among Western women and Asian women show considerable variation in their results (Kuh et al., 1997 and Peeyananjarassri et al., 2006).

In our study, urogenital symptoms, such as urinary problems and dryness of the vagina, were more common among nonworking women. The reason could be that working women take more care of their personal hygiene. They might also be more likely to contact a physician and receive appropriate treatment if the need arises. Economic independence and/or being more mobile could be further factors that enable working women to receive prompt treatment, rendering them in a better position to deal with chronic urinary problems. The present results are in line with those of Kakkar et al. 2007, who also found that urogenital problems were more frequent among nonworking women.

Nonworking women also complained more frequently of somatic symptoms such as hot flushes, sleep problems, and joint and muscular problems than working women did. This could be explained by the more sedentary lifestyle adopted by nonworking women and their tendency to place less emphasis on making changes to their diet and lifestyle (walking, exercise). Kakkar et al. 2007 also found somatic symptoms to be
more frequent among nonworking women.

Psychologic symptoms such as irritability and being in a depressive mood were also more common among nonworking women. A previous study conducted in the USA found a correlation between employment and an increase in perceived stress (Woods et al., 2009). Higher stress levels were associated with heavy responsibilities, role overload, and being forced to work owing to income inadequacy (Woods et al., 2009). In studies conducted in Asia, however, no association has been found between working status and depressive symptoms (Pradhan and Srivastava, 2003; Kaur et al., 2004). In fact, most cross-sectional studies of employed women found that employment has a positive effect on psychologic symptoms (Cochrane and Stopes-Roe, 1981; Rosenfield, 1980). The present study, in keeping with results from another recent study of middle-aged menopausal women (Bromberger and Matthews, 1994), found an association between nonworking status and an increase in depressive symptoms. According to the enhancement hypothesis (Baruch and Barnett, 1986), taking on multiple roles increases self-confidence and feelings of self-worth and extends the network of sources of gratification and social support, reinforcing the notion that employment enhances a woman’s mental health. However, it is also possible that sleep problems, which were more frequent in the nonworking group, contributed to the mood disturbances (Kakkar et al., 2007).

A strong point of the present study was the collection of data by interviewing the patient’s face-to-face, rather than by using postal questionnaires.

The current study is limited by the fact that the cultural and individual differences that are to be expected among women not only of different societies but also within the same society. Such differences should be taken into consideration because of their likely effect on the study results. There is a need for research involving larger samples that include a variety of socioeconomic and ethnic groups.

CONCLUSION

The present study revealed that working women have significantly less climacteric symptoms than nonworking women.

REFERENCES


