

What Every Women Should Know About Menopause

What are the risk factors for osteoporosis? Why does libido decline? Are there safer alternatives to hormone replacement? Researchers and clinicians have begun to come up with some answers

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Most women today will live almost one-third of their lives after experiencing menopause, the cessation of menstruation due to a decrease in circulating estrogen levels. For many, the event and the surrounding transitional period (perimenopause) will bring distressing physical and emotional changes.

While there are many therapies available to alleviate some of the adverse symptoms associated with menopause, not all treatment choices are appropriate for all women. And while much research has been done on the effects of decreased estrogen levels on the quality of life and on interventions that promote health and prevent catastrophic illness and injuries, the findings to date are inconsistent, incomplete, and, in some cases, controversial. Not surprisingly, many women enter perimenopause with little factual knowledge about its effects and treatments, and often with expectations influenced by myths and misinformation.

Whether a patient is just beginning this new, and perhaps confusing, stage in her life or is well into perimenopause, your family nurse practitioner or nurse can play a vital role by providing individualized assessment, education, and support. Your familiarity with menopause's adverse effects, the pros and cons of traditional therapy, and alternative therapies will help you give her the information she needs to make educated decisions about appropriate treatment choices, encouraging her to be a partner in her care rather than a passive recipient of it.

The unusual case of Anne (name changed) illustrates the value of expert nursing care to women as they make the transition out of their reproductive years.

Anne, a 44 year-old teacher came to the emergency department (ED) complaining of extreme weakness, dizziness, and an overwhelming feeling of "impending doom." In her triage interview, she told the nurse that recently she's been having headaches and heart palpitations

and was feeling irritable, fatigued, and increasingly intolerant to cold. She also mentioned that she'd been smoking a half pack of cigarettes a day for the past 20 years, but didn't think her symptoms were smoking-related. Her personal and family medical history was other wise unremarkable, except for an elective total hysterectomy and bilateral salpingo-oophorectomy she'd had 12 months earlier for recurrent ovarian cysts and pelvic adhesion. Following the surgery, she had started on a regime of oral estrogen, 0.625 mg. daily, and supplemental calcium, 500 mg BID, which she was still following. She took no other medications.

As the interview progressed, Anne became increasingly anxious and apprehensive for no apparent reason. The nurse took her vital signs which were: pulse: 40; blood pressure 90/68; respiratory rate, 16; and oral temperature, 98 F. Anne was pale, cool and clammy, but denied having any chest pain, dyspnea, nausea, or recent viral infection. After being assessed by the ED nurse practitioner, Anne was admitted to the hospital and transferred to the cardiac care unit for observation.

Continuous cardiac monitoring showed she had an extremely labile blood pressure that ranged from 70/50 to 150/100 and was exacerbated by her slightest movements. A bedside ECG monitor displayed a brady-tachyarrhythmia was junctional escape beats. An echocardiogram, chest x-ray, and blood work were all normal.

Based on these findings, the cardiologist made a tentative diagnosis of sick sinus syndrome and ordered a consult with an endocrinologist. After discussion, they decided to change Anne's estrogen delivery from oral tablets to dermal patches to eliminate the fluctuating serum drug levels now suspected of causing her symptoms. Anne agreed with this changed. Despite continued mild fluctuations in blood pressure and pulse, on day 4 of hospitalization she was diagnosed with "unresolved estrogen deficiency" and discharged home.

She made an appointment to see her gynecologists 10 days later, but on the sixth day she returned to the ED, complaining of a severe headache and the feeling that she was going to lose consciousness, "even when lying down." She was admitted directly to the CCU where an ECT revealed a junctional rhythm of 40 bpm with labile blood pressure. After an MRI rules out pheochromocytoma, she was diagnosed with presyncope syndrome.

At this point, Anne began to suspect that it wasn't her heart that was causing the problem, but the estrogen. She removed her patch after morning care and, despite her physicians' concerns, refused to replace it. Twenty-four hours later, she felt well and requested discharge. Within three weeks her heart rate and blood pressure stabilized and all other symptoms had disappeared. She returned to work and remained asymptomatic.

Retrospectively, it was determined that Anne had been suffering from a severe idiosyncratic reaction to exogenous estrogen.

Approximately 75% of women experience some adverse symptoms surrounding menopause that are thought to be caused by the loss of estrogen and its beneficial effects. The use of exogenous estrogen to treat these symptoms dates to the 1920's. Women like Anne, whose menopause has been induced (by surgery, irradiation of the ovaries, or chemotherapy), are more likely to need treatment because their systems are subjected to an abrupt chemical imbalance rather than the gradual change of natural menopause.

The intensity and frequency of uncomfortable symptoms vary by episode and individual. The two most commonly reported symptoms are hot flushes or flashes and atrophic vaginitis. Other problems that may be associated with menopause include osteoporosis, increased risk for cardiovascular disease, skin changes, sleep disturbances, decreased libido, and psychological difficulties.

Before Anne was discharged

from the hospital, she'd decided to end her estrogen therapy. In her discharge teaching, her primary nurse helped Anne devise a strategy for coping with the changes of menopause without benefit of hormone replacement.

The nurse stressed the importance of performing daily weight-bearing exercises and eating an appropriate diet to maintain general good health. Since Anne enjoyed walking, she scheduled regular nature walks into her weekly routine. Though Anne's cholesterol level was only 167/mg/dL (below 200 is considered normal for a woman her age), the nurse gave her some pamphlets explaining ways to reduce her intake of saturated fats and cholesterol to maintain her healthy level.

Because of the need for calcium to maintain bone health, Anne chose to continue her supplemental calcium and vitamin D. She also decided to switch to decaffeinated coffee and drink alcoholic beverages only occasionally, since caffeine and alcohol increase calcium elimination in the urine. And she set a personal goal of cutting her smoking down to five cigarettes a day as an initial step toward quitting altogether.

When she returned home, Anne scheduled an appointment to see her primary physician in six months. That way, she'd be able to judge the effectiveness of her new regimen for maintaining good health and make any needed changes in her lifestyle or habits.

With all that's known about menopause and its effects, many more areas still need to be explored. Nursing research that focuses on understanding women's experiences of menopause, hormone replacement therapy, and alternative treatments will enable women to make well-informed decisions about the best ways to relieve their adverse symptoms. By educating yourself about the options available you can keep healthy and happy during this transitional phase of your life.

Next Week: The Role of Estrogen, Menopause Symptoms, Treatment and other Alternatives.