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"Perimenopausal" Complaints in Women and Men: A Comparative Study

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ABSTRACT

The objective of this investigation was to study the hormonal aspects of aspecific (psychosomatic) complaints during the perimenopausal period. Data from health interviews with 8,679 women and men (age 25–>75 years) belonging to a sample of general practitioners' practices, with respect to the occurrence of complaints usually associated with the perimenopause and with respect to mental health (as evaluated through standardized questionnaires) were analyzed. Except for excessive transpiration, a typical perimenopausal symptom related to decreased estrogen secretion, none of the other complaints usually attributed to the climacteric increased more in women than in men during the perimenopausal period. This lack of correlation was observed also for the mental health status. It is concluded that psychosomatic complaints usually attributed to the climacteric are neither gender nor age specific and that, therefore, a hormonal cause for these complaints seems unlikely.

INTRODUCTION

THERE HAS BEEN MUCH DISCUSSION recently on whether the climacteric and the postmenopause should be considered as a normal physiologic life event or as an abnormal state of hormone deficiency. Gynecologic authors tend to take the latter position,[1] whereas behavioral authors generally defend the former.[2]

Although the climacteric and postmenopause are indeed characterized by a sharp drop in the production of female sex hormones, these events also coincide with a life phase in which much more is going on—on medical, social, and emotional levels—than can be explained by the accompanying hormonal changes. General complaints, such as dizziness, headache, tiredness, nervousness, sleeplessness, listlessness, palpitations, aggressivity, irritability, and depression, usually attributed to the climacteric,[3] are neither age nor gender specific.

In order to find epidemiologic support for the proposition that such aspecific complaints are not related to the climacteric, a study was made of data accumulated by the Netherlands Institute of Primary Health Care in a cross-national survey on morbidity and interventions in general practice.

MATERIALS AND METHODS

Data for analysis were obtained from the Dutch National Survey of General Practice, a

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large-scale survey carried out among a stratified disproportionate random sample of Dutch general practices.[4] This survey included a personal health interview among a random sample of 100 individuals selected from the total practice population per participating general practice. The overall sample consisted of 17,047 individuals (male and female), and the response rate was 76.6% (n = 13,066). The data from 52 individuals were incomplete, and for this reason, they were excluded from the survey. For the present study, only individuals older than 25 years were selected: 4,426 women and 4,253 men. A comparison of the original sample, the respondents, and the total Dutch population in relation to age and sex indicated only marginal differences. There was a slight overrepresentation of respondents between 25 and 44 years, equal representation of respondents between 45 and 74 years, and a slight underrepresentation of respondents over 75 years. The proportion of women and men was virtually equal for all age groups, except for the group older than 70 years. The overrepresentation of women in this latter group was similar to the corresponding age group in the total Dutch population, reflecting the difference in life expectancy between women and men.

The health interview included a variety of complaints experienced during the 14 days preceding the enquiry. In addition, two mental health questionnaires were delivered, the General Health Questionnaire (GHQ)[5] and the Biographic Problem List (BIOPRO).[6] The GHQ, designed for the detection of psychiatric disorders, consists of 30 questions. Individuals who give positive answers to more than 5 of these questions have an increased risk of psychiatric disease. The BIOPRO is used as an indicator of psychosocial problems in relation to a number of life conditions (e.g., relationships, occupation, housing) and consists of 22 questions. Psychosocial problems are indicated by a positive answer to more than 1 of these questions.

The analysis for the present study included only those complaints that are usually attributed to the climacteric (Kupperman Index) (Table 1).[3] Comparisons were made between different age groups and between female and male populations.

TABLE 1. SELECTION OF PERIMENOPAUSAL COMPLAINTS ACCORDING TO KUPPERMAN INDEX[3]

Dizziness	Incontinence
Headache	Joint pains
Tiredness	Transpiration
Nervousness	Palpitations
Aggressivity	Insomnia
Irritability	Listlessness

RESULTS

The results of this study are shown in Figures 1, 2, 3, and 4, in which the female/male ratio in relation to the frequency of complaints in different age groups is shown.

Interpretation of these data, in the context of the aim of the study, rests on the following reasoning. During the age period 45–55 years, more than 80% of the women reach menopause. If one of the complaints was specifically climacteric (thus hormonal), the female/male ratio of such a complaint should be higher than in the younger age groups. As can be seen from Figures 1, 2, 3, and 4, this is only the case for excessive transpiration, a typical climacteric complaint. The female/male ratios for all other complaints show variations between the different age groups but do not increase during the perimenopausal period. The same applies to the mental health status. It is noteworthy that for nearly all complaints and in all age groups, the female/male ratio is higher than 1, which means that women have (or report) complaints more often than do men. This sex difference in morbidity might be related to the possibility that data based on verbal reports are influenced by the respondent's readiness to perceive and report symptoms.[7] From this epidemiologic study among 8,679 women and men in The Netherlands, it can be concluded that there is no evidence that complaints usually attributed to the climacteric (as suggested by the Kupperman Index) are either gender or age specific and that a hormonal cause of these complaints, therefore, seems unlikely.

DISCUSSION

This investigation largely confirms the findings of the only study published so far in which

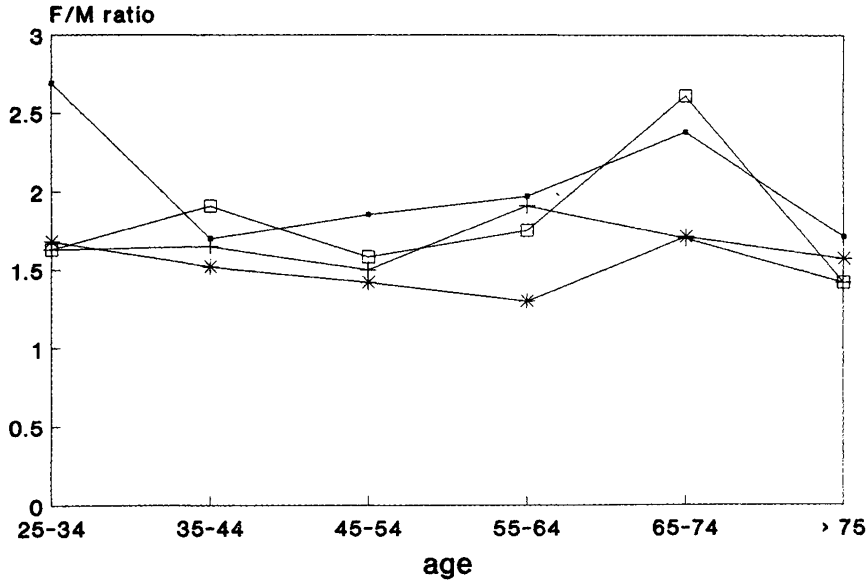

FIG. 1. Perimenopausal complaints: female/male (F/M) ratio according to age. Dizziness (●—●); headache (+—+); tiredness (*—*); nervousness (□—□).

women and men were compared in relation to perimenopausal complaints.[8] Our results are in agreement with other epidemiologic studies showing that climacteric and menopause do not affect women's well-being and that, rather than hormonal changes, psychosocial factors are more likely to be the cause of emotional distress and psychiatric morbidity during midlife.[9–12] From this, it follows that there is no rationale in prescribing estrogens for psychologic problems or mood disorders occurring during the climacteric or the postmenopausal period. Most clinical trials that have shown a positive effect of hormonal replacement therapy (HRP) on mood and psychologic symptoms suffer from selection bias because the studied population consisted either of women attending a menopause clinic[13,14] or of women

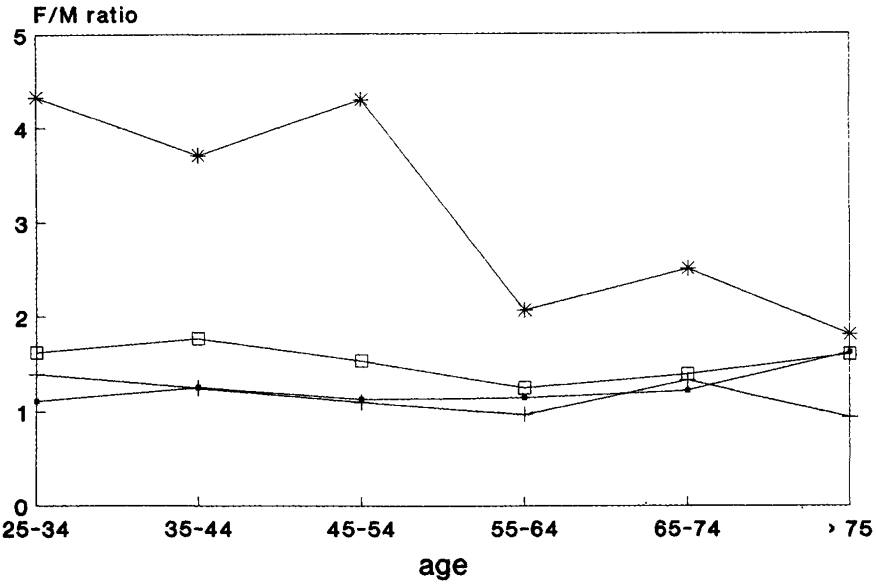

FIG. 2. Perimenopausal complaints: female/male (F/M) ratio according to age. Aggressivity (●—●); irritability (+—+); incontinence (*—*); joint pains (□—□).

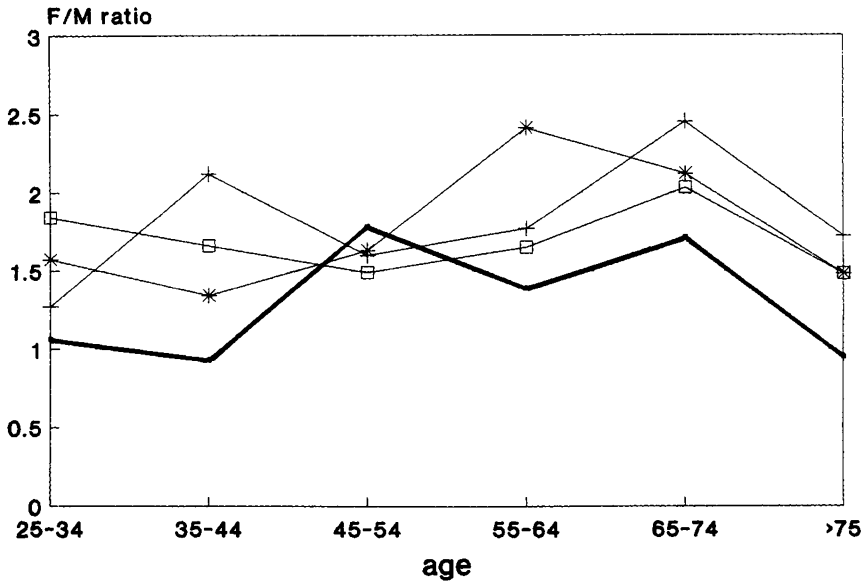

FIG. 3. Perimenopausal complaints: female/male (FM) ratio according to age. Transpiration (——); palpitations (+—+); insomnia (*—*); listlessness (□—□).

who had undergone a premenopausal hysterectomy and oophorectomy.[15,16] Both groups are known to have a high incidence of vasomotor complaints and a high expectation of the effect of hormone treatment.[17] The only clinical trial we are aware of that is not subject to such selection bias failed to show any effect of hormone treatment on mood ratings and sexual behavior despite significant reduction of hot flashes.[18]

The presence of such vasomotor symptoms, however, can lead secondarily to the previously mentioned aspecific complaints, which then will respond favorably to HRT.[19] Unfortunately, the studies published do not discriminate between women with and without hot

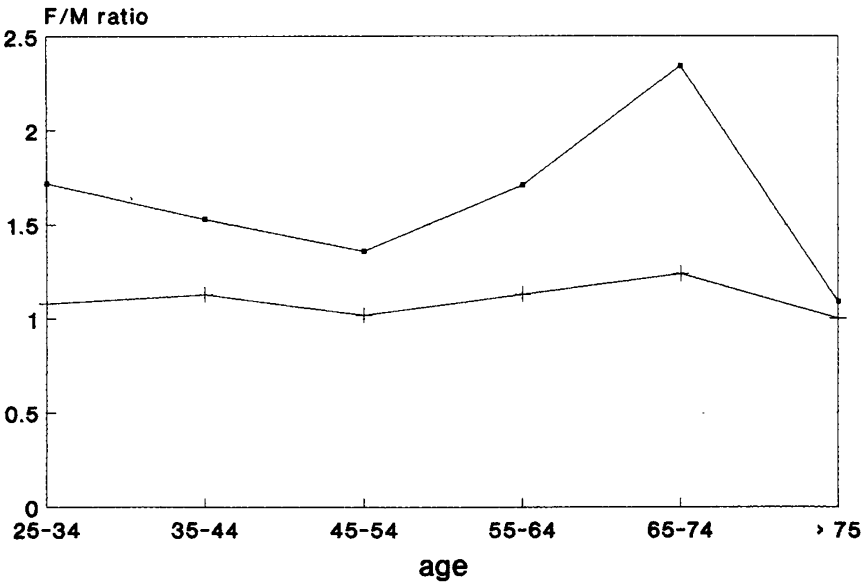

FIG. 4. Mental health: female/male (FM) ratio according to age. GHQ (•—•); BIOPRO (+—+).

flushes and, consequently, give no information on a direct dependence of mood on estrogens.

Despite the fact that the majority of women (approximately 70%) go through menopause with minimal or no complaints,[20] this period of life is still associated with ill health. As Ballinger[11] points out, "Negative expectations of the menopause and the conviction that it presages a marked deterioration in mental health still persist. It is a tribute to the power of culturally determined attitudes, media pressure and the promotion of oestrogen sales that this menopause myth persists, despite all the evidence to the contrary."

The tendency to attribute all sorts of aspecific complaints (also occurring in men of the same age) to climacteric hormonal changes and to consequently prescribe HRT is not based on sound scientific data, and it makes women unnecessarily dependent on medical care and deprives them of the responsibility to find their own solutions.

In our opinion, future research on the relation between perimenopausal complaints and hormonal changes should include control data on men.

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