Evaluation of the state of knowledge on hormone replacement therapy among climacteric women in the Lublin Voivodeship (Poland)

Ocena stanu wiedzy kobiet w okresie klimakterium na temat hormonalnej terapii zastępczej na terenie województwa lubelskiego (Polska)

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Summary

The goal of this study was to evaluate the level of knowledge on hormone replacement therapy (HRT) among climacteric women in the Lublin Voivodeship and the factors affecting this level of knowledge. HRT is a system of medical treatment offered to women experiencing a difficult period in their lives, which has become widely used in recent years. The medical literature cites many positive aspects of such therapy during the climacteric period. It should be noted, however, that the list of contraindications for HTR due to the adverse effects of the treatment is still being expanded.

Key words: climacterium, hormone replacement therapy.

Streszczenie

Celem przeprowadzonego badania była ocena poziomu wiedzy kobiet w okresie klimakterium na temat hormonalnej terapii zastępczej (HTZ) oraz czynników wpływających na poziom tej wiedzy na terenie województwa lubelskiego. Hormonalna terapia zastępcza jest propozycją nauk medycznych, skierowaną do kobiet w trudnym dla nich okresie życia, która w ostatnich latach została szeroko rozpowszechniona. Piśmiennictwo medyczne podaje wiele pozytywnych aspektów stosowania takiej terapii w okresie klimakterium. Należy jednak podkreślić, że ciągle są opracowywane przeciwwskazania do stosowania HTZ w związku z jej możliwymi działaniami niepożądanymi.

Słowa kluczowe: klimakterium, hormonalna terapia zastępcza.

Introduction

In medical terminology, climacterium is defined as a period between the fertile phase and old age in women. It is described as a set of endocrinal, somatic and psychological changes experienced by women at the end of their fertile period and usually occurs between the ages of 45 and 55 [1]. Women often use the terms "climacterium" and "menopause" interchangeably to describe the period past the last physiological menstruation. This is the period when patients report various, sometimes troublesome, discomforts interchangeably referred to as menopausal or climacteric discomforts [2].

Menopause is defined as the last physiological menstrual bleeding followed by 12 months of amenorrhea provided that no pathological reasons for this condition can be identified [3].

Climacterium and menopause are physiological, natural stages in the lives of all women. They are not conside-

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red a pathology or disease [2, 4]. Despite this fact, most women report many individual and non-uniform sets of both somatic and psychosomatic symptoms. These symptoms have a negative impact on the quality of women's lives and are known as the climacteric syndrome [4, 5].

A comparison of the results of studies on typical climacteric symptoms in different populations of women reveals that identical symptoms may differ significantly in incidence and intensity. These differences may be due to various factors, e.g. racial, geographic and climatic, socioeconomic, demographic and social, and cultural and civilizational ones [6-8].

From a medical standpoint, climacterium is caused by the decline in ovarian function over time [3]. This period is characterized by a reduction in the levels of sexual hormones that are produced and periodically secreted and a gradual cessation of ovarian cell maturation. These changes lead to menstruation disorders and less regular menstrual cycles, and eventually to complete amenorrhea [9].

Ovarian hypofunction must be confirmed before climacterium can be diagnosed. This is based on a good deal of clinical data, including a patient interview, gynaecological examination, menstrual cycle assessment, cytological assessment of vaginal swabs and determination of serum hormone levels [3, 9].

Symptoms experienced by climacteric women are mainly associated with hormonal dysfunction of the ovaries and other endocrine glands. The intensity of these symptoms is influenced by the socio-economic status, family relationships, the physiological process of aging, concurrent diseases, and the overall reduction in the quality of life that usually accompanies the above [10-12].

From a practical standpoint, climacteric symptoms are usually grouped into three categories:

- vasomotor symptoms (hot flushes, excessive perspiration);
- somatic symptoms (myalgias and arthralgias, dizziness and headaches, tingling and/or numbness of various body parts, dysaesthesias of hands and feet, shortness of breath);
- psychological symptoms (emotional lability, increased excitability, anxiety, excitation, difficulties in sleeping, difficulties in concentration, depression, loss of interest in and energy for normal activities, sadness, irritation, lachrymosity, fatigue, lower libido) [13].

Ailments associated with cardiovascular disorders and osteoporosis may be experienced in addition to the above symptoms [14].

Hormone replacement therapy is often used to alleviate most perimenopausal symptoms. Continuous, combined HRT does not increase the risk of endometrial or ovarian cancer, which are commonly diagnosed in the perimenopausal period [15, 16]. Clinical studies have shown that HRT reduces the incidence of colon cancer by one third and the morbidity of biliary tract and hepatic cancers [16, 17]. However, oral HRT is not always indicated as it increases the risk of cholecystolithiasis, cholecystitic and thromboembolic incidents. Women deciding to undergo HRT after being diagnosed with a risk of thromboembolism should be given transdermal preparations [17-19]. Contraindications to HRT include venous thromboembolic disease risk factors, a history of thrombosis, elective major surgeries, and/or hospitalizations [20].

Experimental procedures

The study material was collected in surveys conducted in 2006.

281 female residents of the Lublin Voivodeship were included in the study. They were recruited from the patients of family physicians and specialist outpatient clinics in Biłgoraj, Chełm, Lublin, Markuszów and Zwierzyniec. The mean age was 51.1 years with a standard deviation of 4.8 (min. 38 years, max. 66 years). Women aged 38-44 were included in the study as they had undergone radical gynaecological surgeries – including ovariectomy – and were in post-surgical menopause. The study group survey consisted of 22 questions.

The answers to some of these questions provided information on selected demographic characteristics of the study population (age; education – primary, secondary and higher; residence – village, town, Lublin).

Other questions pertained to the respondents' health and to visits made to their family physicians to have perimenopausal symptoms and/or ailments investigated.

There were questions about the general frequency of gynaecological visits, including the date of the most recent visit.

The final questions included the respondents' knowledge on climacteric symptoms and known treatment options, their opinions on the known benefits and risks of these treatments, and the sources of this knowledge.

Results and discussion

123 women (44%) were rural residents and 158 women (56%) were city dwellers. Of the latter group, 87 lived in Lublin (31% of all respondents) and 71 lived elsewhere (25% of all respondents).

Primary/occupational education was declared by 40 women (14.2%), secondary education was declared by 202 women (71.9%), while higher education was declared by 39 women (13.9%).

Regardless of their place of residence and level of education, the women were of the opinion that the climacterium affected their health. Most rural residents and women with primary/occupational education were unable to name a single adverse change that occurred in the body after the cessation of menstruation. About a third of the women, regardless of their place

of residence and level of education, noticed that they experienced climacteric symptoms. Rural residents were significantly more ignorant of the possibility of hormonal treatment of climacteric symptoms than city dwellers (26.8% and 12.7%, respectively). An analysis of the rural and towns-other-than-Lublin groups did not reveal any statistical significance in the frequency of answers. Knowledge of the possibility of hormonal treatment for climacteric symptoms was declared by most women with higher education, followed by women with secondary education and then by women of primary/occupational education (92.3%, 78.7% and 62.5%, respectively). Gynaecologists were the most frequently cited sources of information about the possibility of hormonal treatment for adverse climacteric symptoms. The least frequently mentioned sources of information were family physicians and medical staff (nurses, pharmacists). Fewer rural residents (43.9%) declared their knowledge of what HRT involves than residents from towns other than Lublin (63.4%) and Lublin residents (57.5%). HRT was more frequently proposed to city dwellers than rural residents. Women with secondary and higher education used HRT more frequently than women with primary/occupational education. The gynaecologist was the most frequent initiator of HRT in the study group. Lublin residents could properly name more climacteric symptoms than rural residents. The number and quality of properly named climacteric symptoms increased with the educational level of the respondents. About 10% of the women had consulted their gynaecologists very rarely. This was significantly more common among rural residents and least common among the residents of towns other than Lublin. About 30% of the women consulted their gynaecologists less frequently than once per year. 71.5% of the women declared having gynaecological consultations at least once a year. Rural residents were the largest group that consulted their gynaecologists less frequently than once a year. There were no statistically significant differences between the numbers of Lublin residents, residents of towns other than Lublin, and rural residents who consulted their gynaecologists either once a year or more than once a year. A significantly higher number of women with primary/occupational education consulted their gynaecologists less than once a year than women with secondary education and women with higher education (59.5%, 24.9%, 15.8%, respectively). Women with secondary and higher education consulted gynaecologists more frequently than women with primary/occupational education.

The respondents' declared knowledge about the health issues associated with the climacterium and HRT was not consistent with their behaviour as measured by the frequency of their gynaecological consultations. Most women (51.4%) cited their gynaecologists as the source of information on hormone replacement therapy. 10.3% of respondents were unable to tell when their last gynaecologist visit took place (mostly rural residents – 16.3% and women with secondary education – 12.4%). Of those women who could identify the date of their last gynaecological consultation (89.7%), 28.6% declared that they attend such consultations less frequently than once a year. This was significantly more frequent among women with primary/occupational education than among women with secondary or higher education, and was also more frequent among rural residents – 36.9%. Further analyses suggested that more than a year had elapsed since the last gynaecological visit of 21.6% of the women. This was most commonly the case among rural residents (27.1%) and women with primary/occupational education (50%). Similar data on the frequency of gynaecological consultation may be found in the literature [4, 21, 22].

Observations made by medical practitioners at the Gynaecology Clinic revealed that women's attitudes to, and knowledge about, the changes taking place in their bodies and the available options to prevent and treat the health disorders they experience during the climacteric period are not satisfactory.

This low level of health education – particularly among rural residents (see Fig. 1, 2) and women with a low educational level [23, 24] results in women not seeking medical help for climacteric discomforts. When this occurs, the conscious participation of women in the decision-making processes regarding treatment methods, including initiation and monitoring of HRT, is very low. The obtained results show correlations with studies on patients' knowledge and quality of life in other health-related areas, such as cancer prevention, healthy lifestyle and oral hygiene [25-28].

This lack of knowledge about the climacterium and HRT is often the reason why women erroneously attribute unrelated symptoms to it. The study results revealed that the number of correctly identified climacteric symptoms

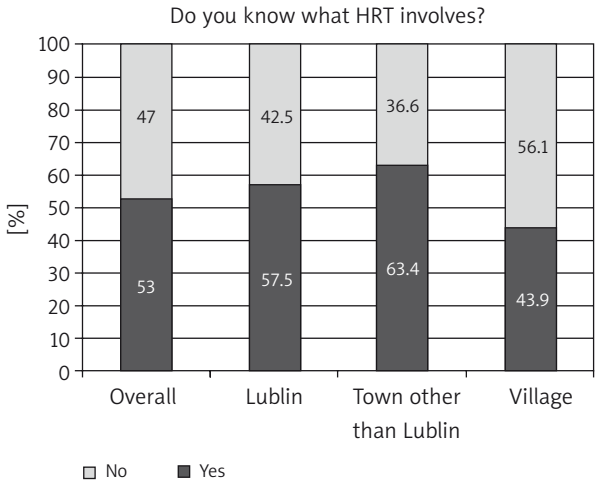

Fig. 1. Declared general knowledge of HRT by place of residence

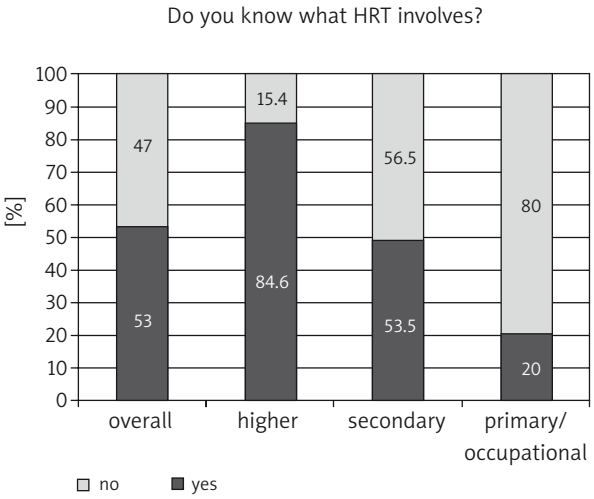

Fig. 2. Declared general knowledge of HRT by educational level

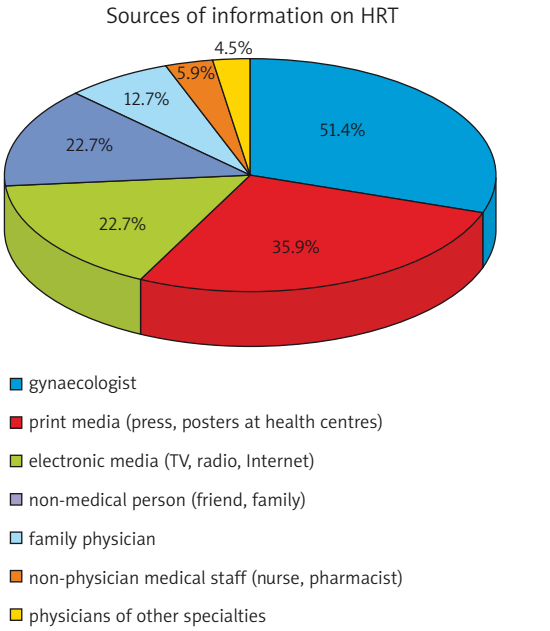

Fig. 3. Respondents' sources of information about the possibilities of hormonal treatment for adverse climacteric symptoms

varied significantly with the educational level. Women with higher education had more correct answers than women with secondary and primary/occupational education. The analysis of place of residence revealed a significant difference in the number of correctly identified symptoms between the residents of Lublin, who identified the most, and rural residents. Similar results, suggesting better health education among urban patients and patients with a higher general education, have been reported by other authors [4, 22-24].

As for health information sources, gynaecologists were most frequently cited as the sources of knowledge on HRT (51.4%). The second most frequent source was the media, with the printed media being the most frequently cited (35.9%). The electronic media were identified as health information sources equally frequently as non-medical persons (22.7%). The respondents did not cite family physicians, nurses or pharmacists as their primary sources of health information (see Fig. 3). The obtained results were similar to those presented in other works on health knowledge sources identified by gynaecological patients, as in studies analysing ways of gaining health knowledge in cardiological patients [22, 25, 29]. As has been noted by other authors, apart from the availability of medical information sources, there is the ability to make use of these sources, and this most commonly depends on the educational level [30].

Only a few years ago, hormone replacement therapy was considered to be the best, most beneficial and safest way to alleviate climacteric symptoms in women. Late 20th-century reports on natural estrogen substitution therapy revealed that such treatment lowered the risk of cardiovascular diseases. It was also assumed that by eliminating hot flushes, HRT reduced the probability of contracting Alzheimer's disease through the effect of estrogens on the metabolism of β-amyloid precursor proteins [31, 32]. However, a growing number of studies have been published in medical journals over recent years showing that hormone replacement therapy may be associated not only with benefits, but also with risks, and that these risks may be more serious than previously thought [33].

Opinions of growing – albeit still unsatisfactory – health awareness in climacteric patients, particularly those with higher education or professionally associated with biology or medicine, can be found in the literature [23]. This observation is consistent with the results of our own research presented in this study.

Conclusions

The results obtained in a group of female Lublin Voivodeship residents revealed an unsatisfactory level of knowledge about the climacteric stage of life and hormonal replacement therapy, and demonstrated that this correlated with the level of education and place of residence of the respondents. Further confirmation of this state of health-related knowledge were the health behaviour of the studied women, as measured by the inadequate frequency of gynaecological consultations. This likewise correlated with the level of education and place of residence of the respondents. Nonetheless, gynaecologists – and not family physicians and other health care professionals – were identified as the main source of HRT knowledge.

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