



## Menopause: Nursing Support and Health Promotion Strategies for Symptom Management-An Updated Review

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### Abstract:

**Background:** Menopause marks the permanent cessation of menstruation, primarily due to a decline in estrogen levels. It typically occurs around the age of 51 and is associated with various symptoms affecting different bodily systems, including vasomotor, urogenital, and psychogenic disturbances. Given the increasing life expectancy, many women now spend a significant portion of their lives post-menopause. This article explores both hormonal and non-hormonal treatment options and their effectiveness in symptom management.

**Aim:** The aim of this review is to evaluate various approaches for managing menopause symptoms and discuss health promotion strategies that contribute to women's overall well-being during this phase.

**Methods:** This updated review provides a comprehensive analysis of the causes, symptoms, and treatment options available for managing menopause. The article examines both pharmacological treatments, such as hormone therapy, selective estrogen receptor modulators (SERMs), and non-hormonal treatments like SSRIs and SNRIs, as well as lifestyle interventions and nursing management strategies.

**Results:** Hormonal treatments, including estrogen and progestin therapies, remain the most effective in managing vasomotor symptoms, vaginal atrophy, and preventing bone loss. Non-hormonal treatments, including SSRIs, SNRIs, and bisphosphonates, offer alternatives for symptom relief and osteoporosis management. Lifestyle modifications such as exercise, diet, and stress management are also vital in promoting health during menopause.

**Conclusion:** Menopause requires a multifaceted approach, combining medical treatments, nursing support, and health promotion strategies to enhance the quality of life. Hormonal therapies are effective but should be used cautiously, while non-hormonal options and lifestyle modifications provide significant benefits for symptom management and overall health.

**Keywords:** menopause, hormone therapy, selective estrogen receptor modulators, symptom management, health promotion, nursing support.

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## **Introduction:**

**Menopause** represents the permanent cessation of menstruation for 12 consecutive months, primarily resulting from estrogen deficiency, and is not linked to any pathological condition. The median age for menopause onset is 51. While vasomotor symptoms are commonly experienced, menopause also influences various other bodily systems, including the urogenital, psychogenic, and cardiovascular systems. This article aims to review both hormonal and non-hormonal treatment options and the associated complications of menopause. Given the increasing life expectancy, women are now spending up to one-third of their lives in the post-menopausal phase [1-3].

## **Nursing Diagnosis:**

The nursing diagnosis for women undergoing menopause includes a range of symptoms, including altered sleep patterns, irritability, mood disturbances (e.g., depression), thinning bones, decreased libido, diminished self-esteem, muscle and joint pain, excessive sweating, skin dryness, painful sexual intercourse, anxiety, hot flashes, and mood swings [4].

## **Causes:**

As women age, the number of ovarian follicles declines, leading to a reduction in granulosa cells of the ovaries, which are primarily responsible for producing estradiol and inhibin. The lack of estrogen and inhibin results in a diminished inhibitory effect on gonadotropins, thus stimulating an increase in follicle-stimulating hormone (FSH) and luteinizing hormone (LH) production. FSH levels often surpass those of LH due to the quicker clearance of LH from the bloodstream. The decline in estrogen disrupts the hypothalamic-pituitary-ovarian axis, resulting in the failure of endometrial development, which leads to irregular menstrual cycles followed by their eventual cessation. In addition to natural aging, menopause can be induced through surgical procedures such as hysterectomy with bilateral oophorectomy. Furthermore, menopause may also occur as a consequence of medical treatments for conditions like endometriosis and breast cancer, particularly those involving anti-estrogens, as well as other cancers treated with chemotherapy [5] [6] [7].

## **Risk Factors:**

In the United States, approximately 1.3 million women enter menopause each year, typically between the ages of 51 and 52. However, approximately 5% of women experience early menopause between the ages of 40 and 45, and about 1% of women experience premature menopause before the age of 40 due to permanent ovarian failure, often associated with sex chromosome abnormalities [8-9].

## **Assessment:**

The patient's medical history will focus on symptoms indicative of estrogen deficiency, with the most apparent symptom being the cessation of menstruation, which is generally preceded by changes in the menstrual cycle [1-10].

- **Vasomotor Symptoms:** Around 75% of women experience vasomotor symptoms, including hot flashes, night sweats, palpitations, and migraines. Hot flashes typically last between three to four minutes and occur at unpredictable intervals. These episodes may be exacerbated by factors such as alcohol consumption,

eating, emotional stress, or physical exertion. Migraines may also change in intensity and severity, with migraines without aura being more common than those with aura. Migraines with aura are associated with an elevated risk of stroke, particularly among women who smoke or use oral contraceptives. Other headache types, including cluster and tension headaches, may also become more prevalent due to hormonal fluctuations.

- **Urogenital Symptoms:** Approximately 60% of women experience urogenital symptoms, which include vaginal atrophy, urethral atrophy, and sexual dysfunction, particularly a decline in libido. Vaginal atrophy often results in dryness, itching, and dyspareunia (painful intercourse), while urethral atrophy can lead to stress incontinence, urinary frequency, urgency, and dysuria.
- **Psychogenic Symptoms:** Approximately 45% of women report psychogenic symptoms, such as irritability, anxiety, depression, sleep disturbances, loss of concentration, and reduced self-esteem or confidence.

#### **Physical Examination:**

The physical examination should include the measurement of blood pressure, weight, and height, as well as breast palpation, vaginal examination, and Pap smear [11-14].

- **Blood Pressure:** Elevated blood pressure may be observed, often due to arterial vasoconstriction.
- **Weight and Height:** Weight gain is common, with many women reporting some degree of weight increase during menopause. According to the North American Menopause Society, women gain an average of five pounds during the transitional menopause period. A decrease in height may also be noted, which is associated with osteoporosis and spinal fractures.
- **Breast and Vaginal Examination:** Breast palpation typically reveals a decrease in breast size, while the vaginal examination often shows signs of vaginal dryness and urogenital atrophy. Abnormal uterine bleeding necessitates a Pap smear.

#### **Evaluation**

The diagnosis of menopause is typically clinical, relying on the patient's age, symptoms, and exclusion of other potential conditions in individuals over 45 years of age. Laboratory tests are not routinely necessary for diagnosis, as symptoms often precede any significant changes in laboratory values. However, an elevated serum follicle-stimulating hormone (FSH) level, greater than 40 mIU/mL, can be suggestive of menopause due to ovarian failure, although this test is not highly sensitive. Certain medications, such as estrogens, androgens, and hormonal contraceptives, may alter laboratory results, complicating the interpretation of test findings. The United States Preventive Services Task Force (USPSTF) recommends initiating osteoporosis screening at age 65 for individuals with normal risk factors. If osteoporosis is suspected—due to factors such as falls, fractures, or certain medications—a dual-energy x-ray absorptiometry (DEXA) scan should be conducted. A T-score between 1.0 and 2.5 indicates osteopenia, while a score below 2.5 suggests osteoporosis [15].

#### **Medical Management**

The primary focus of menopause management is to alleviate disruptive symptoms and prevent long-term complications [16-19].

#### **Hormonal Treatment**

Hormone therapy (HT) is commonly employed to manage vasomotor symptoms, prevent vaginal and urogenital atrophy, preserve lipoprotein profiles, and reduce bone loss. Hormone therapy can be administered in various forms such as tablets, creams, and patches, and may be used continuously or cyclically. It can consist of systemic estrogen, estrogen-progestin combinations, estrogen-basedoxifene, progestin alone, or combined oral contraceptives. The use of unopposed estrogen, however, can lead to uterine hyperplasia and uterine cancer, making it inappropriate for women with a uterus. A cyclic regimen of combination estrogen-progestin therapy is recommended for women with an intact uterus, as it significantly reduces the severity and frequency of hot flashes, improves urogenital atrophy, and mitigates

sleep disturbances. Furthermore, it is beneficial in the prevention of osteoporosis and related fractures. Despite its advantages, hormone therapy should be used at the lowest effective dose and for the shortest duration necessary, as it is associated with increased risks of breast cancer, ovarian cancer, thromboembolism, stroke, and coronary heart disease. Notably, the risk of breast cancer increases after 3 to 5 years of estrogen-progestin use and after 7 years of estrogen-only therapy. HT is contraindicated in individuals with a history of breast cancer, endometrial cancer, venous thromboembolism, pulmonary embolism, liver disease, unexplained vaginal bleeding, and coronary heart disease. For atrophic vaginitis, systemic or vaginal estrogen can be utilized, though localized estrogen therapy at very low doses is recommended for those without other systemic symptoms. Localized estrogen therapy has been shown to improve blood flow and reverse vaginal atrophy, although it carries a small risk of venous thromboembolism [1-20].

### **Selective Estrogen Receptor Modulators (SERMs)**

Selective estrogen receptor modulators (SERMs), such as raloxifene, bazedoxifene, and ospemifene, offer the benefit of modulating estrogen activity without stimulating endometrial growth or increasing the risk of cancer. These medications replicate the beneficial effects of hormone therapy on bone loss prevention and lipoprotein profiles. Raloxifene acts as an estrogen agonist on bone and lipids while functioning as an estrogen antagonist on the uterus and breast. This dual action makes it effective in preventing and treating mild osteoporosis and in lowering serum LDL cholesterol levels. Bazedoxifene, which has a similar profile to raloxifene, can be combined with estrogen without affecting the endometrium, eliminating the need for progestin in women with a uterus. When combined with estrogen, bazedoxifene is effective in treating vasomotor symptoms, such as hot flashes. Ospemifene, a newer SERM, is particularly effective in treating urogenital symptoms like vaginal dryness [12-23].

### **Non-Hormonal Treatment**

Alternative non-hormonal treatments for menopausal symptoms include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), gabapentin, and clonidine. These options are typically used for short-term management of menopause-related symptoms. SSRIs and SNRIs, such as paroxetine and venlafaxine, are antidepressants that have been shown to reduce the frequency of vasomotor symptoms like hot flashes. Paroxetine, in particular, is the only FDA-approved medication for this indication, with symptoms often diminishing within one week of treatment initiation. Though not FDA-approved for this purpose, both gabapentin and clonidine have demonstrated efficacy in reducing hot flashes in menopausal women. Gabapentin can reduce hot flashes by as much as two per day, while clonidine is most effective for mild hot flashes, though it is less effective than SSRIs, SNRIs, or gabapentin [24-25].

### **Osteoporosis-Specific Treatment**

For women experiencing osteoporosis during menopause, bisphosphonates, denosumab, and calcium and vitamin D supplementation can be utilized. Bisphosphonates work by inhibiting osteoclast activity, thereby preventing bone resorption. These medications have been proven to be both safe and effective for osteoporosis treatment. However, prolonged use at high doses may increase the risk of developing atypical bone, necessitating periodic discontinuation to maintain bone density. Denosumab, an antibody that targets RANKL, inhibits osteoclast activity, resulting in reduced bone resorption and increased bone density, which subsequently lowers fracture risk in menopausal women with osteoporosis. This treatment is typically administered via biannual subcutaneous injections [26].

### **Nonprescription Remedies**

Complementary and alternative treatments for menopausal symptoms include phytoestrogens, vitamin E, and omega-3 fatty acids. While generally considered safe, studies have shown that vitamin E and omega-3 fatty acids are no more effective than a placebo in alleviating vasomotor symptoms. Phytoestrogens, found in soy, red clover, and black cohosh, have also been used to manage menopausal

symptoms. Although evidence on black cohosh for hot flashes is mixed, soy and red clover have demonstrated effectiveness in treating osteoporosis and improving cholesterol levels [27].

### **Nursing Management**

Nursing management during menopause focuses on comprehensive assessment and supportive care. Key nursing actions include monitoring vital signs, evaluating sleep patterns, and obtaining a thorough patient history. The nurse should assess the patient's mood and mental health, particularly looking for symptoms of depression. Patient education is crucial, with emphasis on menopause, its symptoms, and effective management strategies. Nurses should promote a healthy lifestyle by encouraging balanced nutrition, regular exercise, and hydration. The intake of calcium and vitamin D supplements should be advocated to support bone health. Nurses should also educate patients on stress-relief techniques, good sleep hygiene, and the importance of maintaining physical activity. Additionally, encouraging the use of lubricants during sexual intercourse and advising the patient on Kegel exercises can help alleviate some of the physical discomforts associated with menopause [1-29].

### **Health Teaching and Health Promotion**

Health promotion during menopause involves a comprehensive approach to maintaining overall well-being. Patients should be strongly encouraged to cease smoking, particularly if they are considering hormone therapy. Women should aim for at least 150 minutes of cardiovascular exercise per week, complemented by 2 to 3 sessions of weight-bearing exercises. A healthy diet is essential to maintain a healthy weight and support overall health during this life stage. Sexual activity remains a natural part of life, and women should feel comfortable discussing any issues such as painful intercourse with their healthcare provider. Contraceptive measures should be continued for one year after the last menstrual period, especially in cases of irregular menses. If patients experience menopausal symptoms, they should be encouraged to consult with a healthcare provider due to the wide range of available treatment options [28].

### **Discharge Planning**

Although menopause is a natural physiological process rather than a disease, it carries significant implications for women's health, including an increased risk of osteoporosis, fractures, and cardiovascular disease. The symptoms of menopause can be difficult to tolerate, leading to a diminished quality of life. Consequently, many women seek care from nurse practitioners, primary care providers, or internists. Healthcare professionals, including nurses and pharmacists, have an important role in educating patients about the physiology of menopause. Treatment should be reserved for those who are unable to manage their symptoms, with a cautious approach to prescribing medications. It has been noted that some clinicians may over-prescribe interventions without solid evidence, particularly for osteoporosis, where bisphosphonates represent a more effective option. Hormonal therapies should be used only for short durations and at the lowest effective doses to mitigate potential risks. Nurses should also emphasize the heightened risk of heart disease following menopause and prioritize preventative measures. Regular physical activity, a nutritious diet, smoking cessation, and weight management should be encouraged to mitigate cardiovascular risks. Given that menopause can also lead to mood disturbances, women may benefit from counseling provided by a mental health specialist. Clinicians should ensure that women are regularly screened for bone health, including bone density scans, and that they adhere to a diet rich in calcium and vitamin D. Pharmacists should advise against the use of untested products, encouraging patients to seek professional guidance. Only through a coordinated, interprofessional team approach can the long-term morbidity associated with menopause be effectively reduced [29].

### **Long-Term Care of Menopause:**

Menopause, a natural biological process marking the cessation of menstrual cycles, typically occurs in women between the ages of 45 and 55. It is associated with a series of physical, emotional, and psychological changes that can significantly impact a woman's long-term health. While menopause itself is not a disease, the accompanying symptoms and the associated increase in risk for various health conditions

necessitate a comprehensive long-term care approach. This approach involves the management of menopausal symptoms, prevention of chronic diseases, and the promotion of overall well-being.

### **Menopausal Symptoms and Their Management**

One of the central components of long-term care for menopause is the management of symptoms, which can include vasomotor symptoms such as hot flashes, night sweats, and insomnia, as well as urogenital changes like vaginal dryness and urinary incontinence. These symptoms often persist for several years, making effective management crucial for maintaining quality of life.

Hormone Replacement Therapy (HRT) remains one of the most common and effective treatments for managing menopausal symptoms. Systemic HRT, which typically includes a combination of estrogen and progestin, is used to treat vasomotor symptoms and prevent vaginal and urogenital atrophy. It is also beneficial for maintaining a favorable lipid profile and preventing bone loss, particularly in postmenopausal women. However, the use of HRT must be carefully managed, as it carries potential risks such as an increased incidence of breast cancer, cardiovascular disease, and thromboembolic events, especially when used for extended periods. Consequently, it is recommended that HRT be prescribed for the shortest duration and at the lowest effective dose, with ongoing monitoring of the patient's health status [1-12].

For women who are contraindicated for HRT or prefer non-hormonal treatments, Selective Estrogen Receptor Modulators (SERMs), such as raloxifene and ospemifene, provide alternative options. These medications modulate estrogenic activity selectively on tissues like bones and the vagina, without stimulating endometrial growth, thus offering a safer alternative to traditional hormone therapy. SERMs are effective in treating osteoporosis and alleviating vaginal dryness while minimizing the risks associated with systemic hormone use. For symptomatic relief from hot flashes and mood disturbances, Non-Hormonal Medications such as SSRIs and SNRIs can be used. These medications, including paroxetine, venlafaxine, and gabapentin, have been shown to reduce vasomotor symptoms. Paroxetine, in particular, is the only FDA-approved non-hormonal treatment for hot flashes. Gabapentin, originally developed as an anticonvulsant, has also been found effective in reducing the frequency of hot flashes, making it a valuable option for women who are not suitable candidates for hormone therapy [4].

### **Osteoporosis Prevention and Bone Health**

One of the most significant long-term health risks following menopause is the development of osteoporosis. This condition is characterized by reduced bone mass and an increased risk of fractures, particularly in postmenopausal women due to the decline in estrogen levels, which accelerates bone resorption. Preventive measures are critical to mitigate this risk and enhance long-term health outcomes. Calcium and Vitamin D supplementation play a central role in bone health management. Postmenopausal women should aim to consume adequate amounts of calcium (1,200 mg daily) and vitamin D (800-1,000 IU daily), as these nutrients support bone strength and calcium absorption. In addition to dietary intake, weight-bearing exercises such as walking, jogging, and strength training can improve bone density and reduce the risk of falls and fractures. For women diagnosed with osteoporosis, bisphosphonates and denosumab are commonly prescribed to reduce bone loss and fracture risk. Bisphosphonates, such as alendronate and risedronate, inhibit osteoclast-mediated bone resorption, while denosumab, a monoclonal antibody targeting RANKL, prevents osteoclast activation. These treatments can significantly reduce the risk of vertebral, hip, and other fractures. However, long-term use of bisphosphonates may lead to complications such as osteonecrosis of the jaw or atypical femur fractures, necessitating careful monitoring [12-16].

### **Cardiovascular Health**

The risk of cardiovascular disease (CVD) also increases after menopause, primarily due to the reduction in estrogen, which has protective effects on the cardiovascular system. Postmenopausal women are at a heightened risk for conditions such as coronary artery disease, stroke, and hypertension. Regular physical activity, including aerobic exercise and resistance training, is crucial for cardiovascular health. Women should aim for at least 150 minutes of moderate-intensity exercise per week to maintain heart

health, along with activities that enhance muscle strength and bone health. A heart-healthy diet, emphasizing whole grains, fruits, vegetables, lean proteins, and healthy fats, can further reduce the risk of CVD. Additionally, regular monitoring of blood pressure, cholesterol levels, and blood sugar is recommended to detect and address any emerging cardiovascular risk factors. Smoking cessation is also an essential part of long-term care for postmenopausal women. Smoking accelerates the onset of cardiovascular disease and osteoporosis and exacerbates menopausal symptoms such as hot flashes and sleep disturbances. Women who smoke should be counseled and supported in their efforts to quit.

### **Mental Health and Well-Being**

Menopause can have a profound impact on mental health, with many women experiencing mood swings, anxiety, and depression. The hormonal fluctuations that occur during menopause, along with the physical and psychological stress associated with aging, can contribute to these emotional challenges. Therefore, mental health support is a critical component of long-term care. Women experiencing mood disorders should be encouraged to seek counseling and psychotherapy. Cognitive behavioral therapy (CBT) and other forms of psychological support have been shown to be effective in managing anxiety and depression during menopause. Additionally, stress management techniques, including mindfulness meditation, relaxation exercises, and yoga, can help alleviate emotional stress and improve overall well-being [19-20].

### **Lifestyle Modifications and Patient Education**

Long-term care for menopause also includes education and lifestyle modifications that support overall health. Women should be encouraged to maintain a healthy weight, as excess weight can exacerbate menopausal symptoms and increase the risk of chronic diseases such as diabetes, CVD, and joint problems. A balanced, nutrient-dense diet rich in antioxidants and phytonutrients, alongside regular physical activity, can enhance both physical and mental health. Additionally, hydration and proper sleep hygiene should be emphasized. Menopausal women often experience sleep disturbances due to hot flashes, night sweats, and mood changes. Maintaining a cool, quiet sleep environment, establishing a consistent sleep routine, and avoiding stimulants before bedtime can help improve sleep quality. Long-term care for menopause is multidimensional, encompassing symptom management, prevention of chronic diseases, and the promotion of overall well-being. By addressing the physical, emotional, and psychological changes associated with menopause, healthcare providers can help women navigate this life stage with a greater sense of empowerment and improved quality of life. Through a combination of lifestyle modifications, pharmacologic interventions, and ongoing health monitoring, women can manage the long-term effects of menopause and continue to lead active, healthy lives [22].

### **Conclusion:**

Menopause is a natural biological process with wide-ranging effects on women's physical and emotional health. As women experience the transition to menopause, they may face various symptoms such as vasomotor issues, urogenital disturbances, and psychogenic changes. Given the substantial time women spend in the post-menopausal phase, it is critical to address these symptoms comprehensively to improve quality of life. Hormonal treatments, including estrogen and progestin therapy, remain the gold standard for managing vasomotor symptoms such as hot flashes and night sweats. These treatments also help manage vaginal atrophy, prevent bone loss, and improve cardiovascular health. However, their use is not without risks. Extended use of hormone therapy can increase the likelihood of developing conditions like breast cancer, stroke, and thromboembolism, which necessitates a cautious, short-term approach. For women who cannot use hormone therapy or prefer alternatives, non-hormonal treatments, including selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and gabapentin, provide effective relief from hot flashes and mood disturbances. Additionally, selective estrogen receptor modulators (SERMs) are promising in reducing osteoporosis risk without the adverse effects associated with traditional hormone therapy. Beyond pharmacological treatments, lifestyle changes play a pivotal role in managing menopause symptoms and promoting long-term health. Regular physical activity,

especially weight-bearing exercises, helps mitigate osteoporosis, improve cardiovascular health, and alleviate mood disturbances. A balanced diet rich in calcium and vitamin D is essential for bone health. Nurses and healthcare providers must educate women on the benefits of these lifestyle modifications to prevent further complications. In conclusion, menopause management requires a holistic approach that includes personalized medical treatments, regular monitoring, and ongoing education. Nurses play a crucial role in supporting women through this transition by offering guidance on treatment options and lifestyle changes. The combination of pharmacological therapies, non-hormonal options, and health promotion strategies can significantly improve the well-being of women during menopause, helping them navigate this natural life stage with better outcomes.

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سن اليأس: دعم التمريض واستراتيجيات تعزيز الصحة لإدارة الأعراض - مراجعة محدثة

## الملخص:

**الخلفية:** يشير سن اليأس إلى التوقف الدائم عن الدورة الشهرية، ويحدث عادة بسبب انخفاض مستويات الإستروجين. ويحدث عادة حول سن 51 عامًا ويرتبط بمجموعة من الأعراض التي تؤثر على أنظمة الجسم المختلفة، بما في ذلك اضطرابات الأوعية الدموية، والجهاز البولي التناسلي، والاضطرابات النفسية. نظرًا لزيادة متوسط العمر المتوقع، فإن العديد من النساء يقضين الآن جزءًا كبيرًا من حياتهن بعد سن اليأس. يستعرض هذا المقال خيارات العلاج الهرموني وغير الهرموني وفعالتهما في إدارة الأعراض.

**الهدف:** من هذه المراجعة هو تقييم الأساليب المختلفة لإدارة أعراض سن اليأس ومناقشة استراتيجيات تعزيز الصحة التي تساهم في رفاهية المرأة بشكل عام خلال هذه المرحلة.

**الأساليب:** توفر هذه المراجعة المحدثة تحليلًا شاملاً للأسباب والأعراض وخيارات العلاج المتاحة لإدارة سن اليأس. يتناول المقال العلاجات الدوائية مثل العلاج الهرموني، والمعدلات الانتقائية لمستقبلات الإستروجين (SERM)، والعلاجات غير الهرمونية مثل مثبطات امتصاص السيروتونين الانتقائية (SSRIs) ومثبطات السيروتونين والنورإبينفرين (SNRIs)، بالإضافة إلى التدخلات المتعلقة بنمط الحياة واستراتيجيات إدارة التمريض.

**النتائج:** تظل العلاجات الهرمونية، بما في ذلك العلاجات بالإستروجين والبروجستين، الأكثر فعالية في إدارة الأعراض الوعائية، ضمور المهبل، والوقاية من فقدان العظام. تقدم العلاجات غير الهرمونية، بما في ذلك SSRIs، وSNRIs، والبيسفوسفونات، بدائل لتخفيف الأعراض وإدارة هشاشة العظام. كما أن التعديلات في نمط الحياة مثل ممارسة الرياضة، النظام الغذائي، وإدارة التوتر ضرورية أيضًا لتعزيز الصحة خلال سن اليأس.

**الختام:** يتطلب سن اليأس نهجًا متعدد الأبعاد، يجمع بين العلاجات الطبية، ودعم التمريض، واستراتيجيات تعزيز الصحة لتحسين جودة الحياة. العلاجات الهرمونية فعالة، ولكن يجب استخدامها بحذر، في حين أن الخيارات غير الهرمونية وتعديلات نمط الحياة توفر فوائد كبيرة لإدارة الأعراض والصحة العامة.

**المفتاحية:** سن اليأس، العلاج الهرموني، المعدلات الانتقائية لمستقبلات الإستروجين، إدارة الأعراض، تعزيز الصحة، دعم التمريض.