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MENOPAUSAL AND PERIMENOPAUSAL DISORDERS

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Abstract: This article is written on the basis of the national standard of the Ministry of health of the Republic of Uzbekistan, which speaks about the peculiarities of the period of peri and postmenopause, the causes of origin and the elimination of the most common clinical symptoms.The average age of onset of menopause in the world is 48.8 years (95% CI 48.3-49.2), which varies significantly depending on the geographic places where female speakers live. Differences in the average age of onset of menopause in different countries are often associated with the harmony of ethnic, socio-economic and cultural factor.

Key words: perimenopousa, menopousa, urinary incontinence, postmenopausal osteoporosis, climacteric syndrome, heat casting, vasomotor disorders.

НАРУШЕНИЯ В ПЕРИОД МЕНОПАУЗЫ И ПЕРИМЕНОПАУЗЫ

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Аннотация: Данная статья основана на национальном стандарте Министерства здравоохранения Республики Узбекистан и рассматривает особенности периода пери- и постменопаузы, причины возникновения и методы устранения наиболее распространенных клинических симптомов. Средний возраст наступления менопаузы в мире составляет 48,8 лет (95% ДИ 48,3-49,2) и значительно варьируется в зависимости от географического места проживания женщин. Различия в среднем возрасте наступления менопаузы в разных странах часто связаны с сочетанием этнических, социально-экономических и культурных факторов.

Ключевые слова: перименопауза, менопауза, недержание мочи, постменопаузальный остеопороз, климактерический синдром, приливы, вазомоторные нарушения.

Introduction. The average age of onset of menopause in the world is 48.8 years (95% CI 48.3-49.2), which varies significantly depending on the geographic Mint where female speakers live. Differences in the average age of onset of menopause in different countries are often associated with the harmony of ethnic, socio-economic and cultural factoring. A woman's ethnicity may be a mystery to her age at which she eventually reaches menopause. For example,

in Asian women, the menopause process usually begins earlier in life compared to women in European ethnic groups. 60-85% of women in the Fairy - and postmenopausal period complain about the manifestation of climacteric syndrome. About 75% of women between the ages of 45 and 55 receive complaints about heat injection, while up to 25-30% of cases — expressed moderately or severely. Vasomotor symptoms often occur in the late phase of menopause o tooth, and aynygsa manifests yaggol in the early years of postmenopause. The prevalence of sleep disorders in women in perimenopause ranges from 39 to 47%, and in women in postmenopause from 35 to 60%. Symptoms of GUMS are observed in 15-20% of women in perimenopause and 80% of women in postmenopause.

Classification. Currently, the STRAW+10 scale is used for the clinical-hormonal characterization of the aging stages of the reproductive system (Stages of re-productive Aging Workshop).

The climacteric period includes the following stages:

Early transition to menopause. It begins after the age of 40, is characterized by changes in the periodicity of menstrual cycles and fsgn-ing variable values.

Late transition to menopause. Significant changes in cycle length (more than 60 days of amenorrhea), high levels of FSH (> 25me/l), are characterized by the presence of vasomotor symptoms. Includes the period up to the last menstruation.

Menopause is the last menstruation to be detected retrospectively after 1 year.
Perimenopause. Menopause includes a transition period and 12 months after the last menstruation.

Early postmenopause. Covers 3-4 years after the last menstruation, high indicators of FSG are recorded, vasomotor symptoms are most pronounced.

Late postmenopause is characterized by the rest of life, stable high rates of FSG, increased symptoms of genitourinary atrophy.

Cause of origin: natural menopause; menopause caused by bilateral ovarioectomy (surgical menopause) or chemical/light therapy. The assessment of CS severity depends on the assessment scale used (see diagnostic section).

Diagnosis. The diagnosis of the patient's condition, climacteric period and KS is made on the basis of complaints analysis, Anamnesis, physical examination and additional clinical examinations.

Anamnesis. When collecting Anamnesis and identifying complaints, the following should be asked:

- Menstrual age, the nature of the menstrual cycle and the date of the last menstruation.
- Reproductive Anamnesis, gynecological diseases and operations.
- Somatic and systemic diseases, endocrinopathies.
- Hereditary pathology (presence of cancer: breast, endometrium, ovaries, intestinal sa-Raton; diabetes mellitus; cardiovascular diseases-strokes, heart attacks under 50 years old; oste - oporosis, including fractures)

Presence of associated symptoms:

- vasomotor (redness, increased Night Sweats, tremors);
- psychoemotional - depression, irritability, excitability, sleep disorders, weakness, decreased memory and concentration;
- urogenital and sexual-itching in the vagina, aching, dryness, dyspareunia, dysuria;
- skeletal-muscular-myalgia, arthralgia.

Physical examination. In a physical examination, standard basic examinations should be carried out, which include an assessment of the general condition, a general examination with anthropometry, measurement of the heart rate, measurement of blood pressure.

All patients are advised to determine height and weight by calculating the body weight index (TVI) to diagnose excess body weight and obesity

All patients are advised to measure the waist circumference (BA) to determine abdominal/visceral obesity.

All patients are advised to perform a visual examination and palpation of the mammary glands in order to diagnose the pathology of the mammary gland.

To assess the condition of the Vulva, vagina, cervix and small groin organs and diagnose possible pathology, a gynecological examination should be carried out.

All patients are advised to perform a visual examination of the external genitals, vagina, cervix and bimanual vaginal examination

Laboratory and instrumental examination methods. Women over 45 years of age, in which menopause symptoms are observed, are advised to make the diagnosis of" perimenopause "or" menopause " only on the basis of these signs, without confirmation laboratory tests.

It is recommended to check serum FSG levels up to 45 years of age:

- in women with menopausal symptoms such as amenorrhea or irregular menstruation,

- ovarian polycystosis syndrome, in women with endometrial ablation or in women who need differential diagnosis of amenorrhea,

- in women who have undergone hysterectomy without excess of the uterus.

Confirmation of a pre-term menopause diagnosis C FSG high level (25 ME / l) is recommended with an interval of at least 4-6 weeks only after at least two results have been obtained

AMG in serum, ingibin A, ingibin B, estradiol for the diagnosis of menopause in women over 45 years of age is also not recommended to determine the size of the ovaries on ultrasound

In people who use combined estrogen-progestagen contraception or high doses of progestagens It is not recommended to detect FSH in serum to detect menopause

It is recommended to check serum TTH levels for a comparative diagnosis of atypical vasomotor symptoms, weight changes, sleep disorders and the causes of rapid fatigue

A postmenopausal women are advised to assess the individual 10-year probability of fractures (using the FRAX algorithm). Osteoporosis it is recommended to check the level of 25-OH vitamin D in the blood in the presence of risk factors. Peri-and postmenopausal women are advised to undergo a screen-ing of cervical cancer and breast cancer

In order to determine the mineral density of bones, it is recommended to carry out bienergetic X-ray absorbency (IERA) in the lumbar part of the spinal cord and proximal part of the thigh bone in the presence of fractures, osteoporosis risk factors or an average (intermediate) individual 10-year risk of a detected osteoporotic fracture (according to the FRAX algorithm . All prematurely menopausal women are advised to perform two-energy X-ray absorbciometry (IERA) on the lumbar part of the spine and proximal part of the thigh bone in order to assess the mineral density of the bones

Treatment. *Lifestyle, nutrition and exercise.*

Management of menopausal symptoms includes drug-free exposure methods, non-hormonal, and hormonal sweat-Apia. First of all, it is necessary to follow a general strategy, which includes recommendations for nutrition, normalization of physical activity. Discuss the principles of STT with the patient and his relatives, give specific recommendations. It should be noted that changes in lifestyle include communication and mental activity.

Women with symptoms of a KS should first be given recommendations for lifestyle changes, including stress reduction, regular exercise, optimal weight control, appropriate diet, smoking cessation and excessive consumption of alcohol and caffeine

Regular exercise is recommended to improve the quality of life and reduce cardiovascular and total mortality. At least 150 minutes of moderate intensity exercise per week is recommended. Additional strength training twice a week can bring additional benefits. It is necessary to explain to a woman who is experiencing menopause the importance of maintaining muscle mass and bone health with the help of physical activity.

Drug treatment. The use of an individual approach to each patient when choosing a CS treatment tactic is considered to be superior-vor

Systemic MGT:

- MGT is the most effective therapy in vasomotor symptoms and genitourinary atrophy

- MGT should not be recommended for use without specific indications, i.e., symptoms or physical consequences of estrogen deficiency. Recommend MGT to a woman with vasomotor symptoms and GUMS in the absence of contraindications as first line therapy.

If the patient has clinical symptoms (arthralgia, muscle pain, memory loss, sleep disorders and psycho-emotional disorders) that can be associated with estrogen deficiency, which significantly reduces the quality of life, the issue of MGT appointment should be resolved by discussing it with other specialists. MGT should be recommended in accordance with the principles of personal choice, including the need for symptoms and prevention, as well as taking into account the personal and family history of a woman, the results of relevant studies, advantages and expectations

The principles of the concept of modern personalization (individual selection) of MGT:

• The onset of systemic MGT should be considered in women under 60 years of age and with a postmenopausal duration of less than 10 years (therapeutic opportunity window).

• Age-specific checlots are not present when prescribing topical therapy of GUMS symptoms with estrogens (estriol).

• In accordance with treatment goals, the minimum effective doses of MGT should be used.

• Individualization of MGT (selection of the dosage, form of the drug, its composition, mode of use) is carried out taking into account the age of the patient-ing, the stage of reproductive aging, gynecological diseases, comorbid conditions, the preferences of the woman.

• The use of MGT requires periodic changes in dosages depending on the stage of reproductive aging, age, treatment effectiveness and durability. With an increase in the age of the patient and the duration of postmenopause, it is advisable to reduce the dose of MGT.

Women with spontaneous or yatrogenic menopause under the age of 45 and especially under the age of 40 may have a higher risk of cardiovascular disease and osteoporosis, as well as an increased risk of Affective Disorders and mental retardation. Treatment with sex steroids for such patients should be started as early as possible and carried out at least until the age of physiological menopause (when there are no contraindications).

For women who have undergone hysterectomy, there is no need for combined therapy, since there is no need for the use of gestagens: monotherapy with estrogens is associated with

uncontrolled hyperplasia and potential malignancy of the endometrium. It is recommended to use preparations containing estradiol. Routes of administration: peroral (tablets) or parenteral (on the skin - gels, sprays, plasters).

When prescribing Estrogen-gestagen therapy, either didrogesterone or micronized progesterone is preferred, which may have a more favorable profile for the risk of KBS compared to synthetic progestagens.

• In perimenopause, it is recommended to use estrogen-gestagen preparations in a cyclic mode: continuous estrogen with proges-tagen is introduced cyclically).

• Standard and low doses of estrogens are used (estradiol 2-1 mg/day). In this case, the dosage of gestagens is 200 mg of micronized progesterone/10 mg of didrogesterone during the 12-14 continuous days of the month of kalen-dar.

• In postmenopausal, it is recommended to use estrogen-gestagen drugs in a combined continuous mode. Estrogens should be reduced to low and extremely low doses (estradiol 1-0.5 mg/day). The dose of gestagens is 100 mg progesterone/5-2.5 mg didrogesterone.

• Women who experience prematurely or early menopause should receive higher doses of estrogens than women with natural menopause.. The recommended doses of estrogens in this case are: estradiol per os 2 mg/day or transdermal estradiol 75-150 mcg/day. In this case, the dosage of gestagens is 200 mg of micronized progesterone/10 mg of didrogesterone.

• LNG-BIV is another possible option and can be used in combination with estrogen if combined therapy is required.

Switching to monophase combined mode-I of MGT is possible when cyclic combined MGT is applied in the following cases:

• After 1-2 years of taking low-dose MGT in cyclic mode in women over 50 years of age at the time of starting treatment.

• When the patient reaches the middle age of menopause (51-52 years old), up to 50 years old when he begins to use MGT.

• When the nature of the menstrual-like reaction changes: a small amount of Grease is completely absent during separation/more than 2 consecutive cycles.

Prevention. No special preventive measures have been developed in relation to patients with Peri - and postmenopause. Non-specific prevention implies physical activity, proper nutrition and leading a healthy lifestyle.

All women in Peri - and aostmenopause are advised to eat a balanced diet with adequate protein intake, excluding magnesium and zinc deficiency. The obvious benefits of taking vitamin D at a dose of 800 XB per day and 1,200 mg of calcium per day have been proven for women in

postmenopause in an attempt to reduce bone mass loss. Side effects associated with prolonged calcium supplementation prefer to consume sufficient amounts of calcium with food.

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