MENOPAUSE AND ANDROPAUSE – THE SOCIO-MEDICAL VIEWPOINT

A. Rieder, M. Kunze

DEMOGRAPHIC ASPECTS

Demographic development is giving rise to demands to change the focus with regard to requirements in health policy towards measures which promote good health. In many instances the causes of illness and the reasons for care dependency are linked to life style. The promotion of good health aims to change life style, i.e.: the living, working and environmental conditions of the population. All in all there is no doubt that extensive prevention leads to a reduction in dependency and need for care in old age. Women and men are equally affected, with regards to risks resulting from the menopause and andropause during the third phase of life.

Life expectancy is defined as the number of years, which an individual of particular age still has to live, if the current mortality rate continues; statistical figures are based on existing age-specific death rates [1].

In 1998 life expectancy in Austria was 74.6 years for men and 80.9 years for women. At the beginning of the 19th century people scarcely reached the age of 35. If the current death rate continues, 86% of men and 93% of women can assume to at least reach the age of 60 and the majority (57% of men and 77% of women) will live at least until the age of 75. A quarter of all men and 44% of women can expect to reach the age of 85. Based on current mortality risks only women can reach extremely old age both now and in future. Nearly a quarter of women who are currently aged 60 can assume to live to 90 or beyond (in 1970 this was only the case for 9%). It is still a small proportion of men (11%), who will live to the age of 90 and beyond compared with 4% in 1970, although an increase has also been registered [2] (Table 1).

Defining the state of health of the population it is no longer sufficient simply to state the life expectancy as an indicator. An indication of the expected state of health also is needed. These indicators provide information about the populations’ functional status, vitality, as well as subjective and objective quality of life (disability-free life expectancy, DFLE). In Austria the percentage of disability-free life expectancy for the total life expectancy for women is 91.3% and for men 94.7% [3].

The debate, to which extent the gender specific differences in life expectancy are determined by biological factors (hormonal and immunological gender difference) or behavioural factors (risk factors, life style) is diverse. Increases regarding gender specific differences observed over recent decades allow the conclusion that behavioural and risk factors are significant, even when the interaction of biological and social factors is largely assumed [4].

Due to the high potential of preventing male morbidity and mortality the
Table 1. Life expectancy at birth and later at the age of 1, 60 and 75 years, Austria from 1870 to 1998 (source: death records for the alpine regions of the monarchy: demographic indicators of the ÖSTAT)

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<th>Year</th>
<th>Men</th>
<th>Women</th>
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<td></td>
<td>At birth 1 Year 60 Years 75 Years</td>
<td>At birth 1 Year 60 Years 75 Years</td>
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<tr>
<td>1868/71</td>
<td>32.7 45.5 11.9 5.2</td>
<td>36.2 47.2 12.1 5.2</td>
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<td>1899/1902</td>
<td>40.6 51.7 12.8 5.8</td>
<td>43.4 52.7 13.5 6.0</td>
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<td>1930/33</td>
<td>54.5 60.5 14.2 6.3</td>
<td>58.5 63.5 15.4 6.8</td>
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<tr>
<td>1949/51</td>
<td>61.9 65.9 15.1 6.9</td>
<td>67.0 70.1 17.3 7.7</td>
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<tr>
<td>1960</td>
<td>65.4 67.3 15.0 7.0</td>
<td>71.9 73.4 18.6 8.3</td>
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<td>1970</td>
<td>66.5 67.5 14.9 7.0</td>
<td>73.4 74.1 18.8 8.5</td>
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<td>1975</td>
<td>67.7 68.3 15.6 7.0</td>
<td>74.7 75.0 19.6 8.8</td>
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<td>1980</td>
<td>69.0 69.2 16.3 7.4</td>
<td>76.1 76.0 20.3 9.2</td>
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<td>1985</td>
<td>70.4 70.3 17.0 7.8</td>
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<td>1998</td>
<td>74.7 74.1 19.4 9.5</td>
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life- and health expectancy of men probably contains a disproportional further increase in comparison with the female population [5–7].

**Menopause and Andropause**

With increasing life expectancy after the menopause, the menopausal and postmenopausal phase in the life of a woman and the andropause in men is becoming more important. Increased life expectancy of women has resulted in the postmenopausal phase covering one third of the total life expectancy.

Women have a higher life expectancy than men, however, their share of disability free life expectancy is smaller than that of men. The risks of old age in women are mainly associated with the menopause (osteoporosis, cardiovascular disease, dementia etc.) and are to date better researched than that of men.

The question regarding the andropause was already posed in 1965 in a paper by Vignalou and Bouchon: “Is there an andropause?” [8]. However only in recent years more attention has been given to the andropause. Andropause is a syndrome affecting the ageing male, manifested by a number of symptoms such as: fatigue, tiredness, reduced muscle mass and bone density, diminished haematopoiesis, oligospermia, sexual dysfunction, anxiety, irritability, sleeping disorders, diminished memory and cognitive function. Although the causal link between reduced testosterone levels and the disorders of the andropause have not yet been totally analysed, the substitution of hormones has resulted in an improvement of these disorders [9].
If testosterone is substituted improvements in muscle mass and bone density as well as in the haematopoetic system are registered. Data concerning lipid profiles and brain function are contradictory. The absolute contraindication of testosterone supplementation – existing prostate cancer – is a problem due to its high frequency in the population [10]. Preliminary indicators already exist with regard to risk factors for premature onset of the andropause. It has already been established that smoking causes premature onset of the menopause in women and it is now clear that the same is true for the premature onset of the andropause in men [11].

Medical research in the male population has largely been limited, however, new areas of research have to be defined for men, such as the fields of andropause and ageing. This does not only affect clinical research, but also to a large extent the study of health and preventive medicine. Various studies show that health awareness and preventive measures are less strongly evident in men than in women. Men have to be specifically targeted through characterised health and preventive measure campaigns in order for them to benefit from the existing good health potential of the population as a whole [5–7].

A number of significant age related changes in the male body such as the change of fat distribution, muscle fatigue, incontinence, cognitive function, reduced well-being, depression, sexual dysfunction, could be diagnosed and treated earlier [12]. The increased scientific and public interest in the andropause as the male climacteric may be the reason that men are increasingly taking advantage of preventive medicine and that early diagnosis of illnesses and problems is facilitated. The treatment of climacteric problems in women also has opened the door to greater preventive awareness and involved more women in postmenopausal preventive programmes.

Education, social environment as well as the attitude towards ageing are influencing the level to which health facilities and preventive measures are being used. Furthermore social factors play a major role in the consciousness towards good health, frequency of sickness and mortality. These factors are even more relevant to men than women [5–7].

Numerous studies about women’s health have revealed the factors contributing to the use of hormone replacement therapy (HRT). There is an evident close relationship between the acceptance of hormone replacement, social status and education [13]. According to Avis, the use of HRT in women is closely associated with a healthier lifestyle, post operative menopause, better socio-economic status, more frequent use of preventive medicine (mammography, well-woman examination etc.) and climacteric symptoms (e.g. hot flushes) [14]. Medical advice, advice from trusted friends, and personal risk profiles also have an influence.

In a study carried out at a female menopause clinic with the aim to investigate personal characteristics between HRT users and non-users, no significant difference was found with the exception that women without HRT were less anxious about their future. These women were more satisfied with their lifes and did not expect major changes in their personal life. The decision against HRT was therefore not related to HRT as such, they simply did not expect that it would further enhance their future personal life-style [15].

A variety of studies in different cultural environments showed no evidence that
women generally view the menopause as negative. In fact the women’s attitude to the menopause emerged more positive than expected. Postmenopausal women do not see themselves as less attractive or less feminine.

Several studies have also focused on whether the attitude towards the menopause changes if the women questioned are pre- or postmenopausal. Postmenopausal women have a much more positive attitude to the menopause than premenopausal women. The attitude towards menopause is also age-related. In retrospect, the majority of women regarded the time of the menopause to be positive [16].

A representative survey of women between the age of 50–64 by the North American Menopause Society showed changes of the post menopausal women since the menopause as follows: 24% noted improved physical health, 26% experienced deterioration in physical health, three quarters of women had made a change in their lifestyle (e.g., healthier eating, more exercise, stress reduction, more holidays, reduction in alcohol consumption, stop smoking). The situation at the workplace only deteriorated for 3% of women, however, 22% reported improvements and conditions remained the same for 47%. Improvements in social life had been cited in the areas of family life, personal fulfilment, relationships, friendships and the take-up of hobbies. Approximately half of the women in the survey (51%) felt happier than when they were 20, 30 or 40 years old [17].

Much information still has to be compiled with respect to andropause, especially regarding the male attitude to the andropause and to hormone replacement, motivation regarding health care and factors influencing this.

**Conclusion**

Further promotion regarding gender specific research and its conversion into healthcare is necessary. The areas of research encompass epidemiological, socio-medical research as well as basic research and clinical medicine.

In order to achieve these aims, there has to be a reduction in risk factors for the most frequent causes of death today (e.g., cardiovascular disease and cancer) with determined strategies for prevention. On the other hand, due to the increased life expectancy a large number of deaths will occur as a result of old age disorders (osteoporosis, dementia, stroke, incontinence etc). These are becoming more important for the health care and preventive health care of the population. These disorders gain increasing importance with regard to health and social care, since the ageing population will be increasing, measured in absolute numbers.

Neither for women nor men is it simply a question of compensating for hormonal deficit. It is more a matter of developing a concept of lifestyle medicine, a sensible combination of drug-free and drug-including measures, and close co-operation of doctors and patients as a “lifestyle team”. The use of lifestyle medicine means, therefore, preventive and curative intervention, which is particularly important with regard to andropause and menopause.

Increasing life expectancy should also lead to an increase in the years of good health. Preventive management of the menopause and andropause will be of importance here.

In order to achieve this, not only gender specific aspects, but also socio-economic factors will need to be taken
into account. These extraordinarily influence the preventive measures. Women and men will need to be continually informed about the risks of ageing and the related preventive and therapeutic possibilities. The information has to be given specifically to the target groups with consideration to the educational and age differences.

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Editor:
Franz H. Fischl

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