

EDITORIAL

Women, work, and menopause

The subject of the impact of menopause symptoms and related diseases on women's work warrants professional attention. In this editorial, I will briefly describe the meaning and significance of women's work at the start of the 21st century. The discussion then turns to the study of the effects of menopause symptoms on "work ability" that is published in this issue. The study is notable because it evaluates the impact of menopause on a woman's capacity to function—in this case, in the workplace. Afterward, I describe the impact of the Women's Health Initiative (WHI) reports on the use of hormone therapy (HT) for menopause symptoms and disease prevention. I express concern that failure to use HT when indicated affects work ability and absence from work due to sickness, an issue that will gain importance as the century progresses.

THE SIGNIFICANCE OF WOMEN'S WORK IN THE 21st CENTURY

In today's economy, the earnings from women's work have become a necessity.¹ Recent data show that 60% or more of women in Canada, Sweden, the Netherlands, and the United States participate in the labor force. The US Bureau of Labor Statistics reports that 68 million women, making up half the total workforce, work either full or part time.²

Most women are actively engaged in work activities outside the home when they reach age 51 years (the average age of menopause). Even after age 51 years, millions of women continue to work, and their numbers are expected to increase during the next decade. US Bureau of Labor Statistics projections indicate that more than 2,000,000 women aged 65 to 74 years will be working in 2018. Between 2008 and 2018, this age cohort will have a greater increase than any other.²

The importance of women's work should not be underestimated. Women account for 51% of all workers in high-paying management and professional and related occupations: 91.1% of registered nurses, 81.8% of elementary and middle school teachers, 80.8% of social workers, 78.8% of meeting and convention planners, and 71.1% of tax preparers are women. In addition, 66.1% of tax examiners, collectors, and revenue agents are women.²

Going to work for most women correlates with enhanced self-esteem, better health, and less psychological stress.³⁻⁵

Clearly, work should be considered a major factor contributing to quality of life, especially during the midlife years. The artist Kathe Kollwitz expressed this idea forcefully when she wrote, "For the last third of life, there remains only work.

It alone is always stimulating, rejuvenating, exciting, and satisfying."⁶

Unfortunately, age 51 years is the age when there is the highest annual decline in the rate of women's work ability.⁷ Age 51 years is an age when most women experience symptoms related to changing ovarian hormone levels. It seems reasonable to consider whether or not menopause symptoms have an impact on work ability. In addition, recognizing that millions of women continue to work long past age 51 years means that the impact on work ability and sickness absence of diseases related to ovarian hormone deficiency should be of concern.

MENOPAUSE SYMPTOMS AND WORK ABILITY

In this issue, Geukes et al⁸ raise the question of whether menopausal symptoms could be a determinant of impaired work ability. Theirs is a study of women aged 44 to 60 years working in Drachten, the Netherlands. The women were healthy working women, representative of the Dutch population. The authors used the Work Ability Index and the Greene Climacteric Scale to determine the effects of menopause symptoms on work ability. The findings are based on data from self-administered questionnaires of which only 24% were returned. There is no information about the menopause status of the women or their use of HT. The authors point out that, in other studies, the most frequently reported menopause symptoms affecting work were associated with vasomotor instability (VMI) and sleep disturbance. In contrast, the women in Drachten indicated they were experiencing a low level of VMI (hot flashes), which was not bothersome. Nevertheless, regression analysis of data drawn from the two questionnaires showed that menopause symptoms (somatic and psychological) have a detrimental effect on work ability and may also increase sickness absence.

The authors recognize the limitations of their study. They include a review of the existing literature on work and menopause.

Although the Drachten study is limited, it does add awareness of "work ability," a concept widely used in occupational health, to menopause research literature. The Work Ability Index has proved to be a reliable measuring instrument for work ability as has the Greene Climacteric Scale for menopause symptoms. This study is unique in using both of these measuring instruments and is in contrast with most studies of work and menopause in which but a single question about VMI was used to determine the significance of symptoms for work function. The protocol for the Drachten Study sets a new

standard for future studies, whereas its findings suggest an important direction for future research.

As the authors indicate, most studies of work and the effects of menopause symptoms are limited by the use of a single question to identify effects. One exception is the Yale Midlife Study, which was carried out during the mid-1980s to late 1980s.⁹ In that study, hormone levels documented that each of the women was postmenopausal. Function at work outside as well as inside the home and frequency and severity of menopausal symptoms were measured using the Symptom Checklist-90 (SCL-90), the Menopause Symptom Index (MENSI), and daily diaries. Data were collected at each of seven visits to compare baseline findings with the effects of HT versus placebo. Two thirds of the women were affected by symptoms, the most common of which were sleep disturbance and VMI. Work function outside the home was negatively affected by these symptoms. In these women, VMI and sleep disturbance developed at menopause, responded to HT, and did not respond to placebo.¹⁰ The Yale study supports the observations of Kronenberg,¹¹ which found that symptoms associated with hot flashes such as anxiety, depression, chest pressure, and memory impairment were clinically significant, seemed to be manifestations of a “catecholamine disorder,” and affected work function. These symptoms also responded to HT and not to placebo.¹⁰

I believe that something is missing in a discussion of women, work, and menopause if one's understanding is confined to numbers and data analysis. An additional understanding comes from consideration of individuals and the pain of their experiences. In the Yale study, findings were cited of women who quit work because of menopause symptoms. These included a banker who could no longer conduct business meetings because she was so disturbed by severe hot flashes and palpitations, an opera singer whose anxiety attacks made her unable to perform, and a sleep-deprived head nurse of a neonatal nursery who found herself taking too many “sick days.” It was also reported that each of these women responded to HT and returned to work.¹⁰ The Yale Study supports the earlier findings of Collins et al¹² in Sweden indicating the importance of ovarian hormones in modulating the effects of stress.

In their study of women who are corporate executives, Simon and Reape¹³ reported that 95% of the participants were experiencing physical symptoms, whereas 79% experienced emotional symptoms related to menopause. Forty percent found their symptoms to be problematic. The most common problematic symptoms were insomnia, night sweats, and hot flashes. At the time of this study (2008-2009), 39% of women had stopped using HT because of the WHI reports.

IMPACT OF THE WHI

The impact on women and healthcare providers of the WHI findings should be considered when thinking about the current situation facing working women with menopause symptoms. The adverse effects reported for the use of conjugated estrogens with medroxyprogesterone acetate immedi-

ately led to a decline in HT use.¹⁴ New prescriptions and renewal of ongoing prescriptions have continued to decline. Before the WHI initial report in 2002, about 35% to 40% of postmenopausal women were using HT. Current estimates are that less than 15% of postmenopausal women are current users.¹⁵

In addition to the effects of menopause symptoms on work function, consideration should be given to diseases that have been related to menopause. Loss of ovarian function is a contributing factor to the development of atherosclerosis and heart disease, osteoporosis and fracture, and clinical depression. Keep in mind that the work projections for women in the United States work force include a major increase in women workers older than 65 years by 2018. By this age, diseases become manifest.

At particular risk of menopause-related diseases are women who have had a surgical menopause at an age before the age of natural menopause. These women show the highest rates of severe VMI and an increased risk of severe depression, osteoporosis-related fracture, and cardiovascular disease. Before the WHI, most of these women would have used estrogen-only therapy. However, a recent Canadian study of women in their 40s undergoing surgical menopause showed that two thirds of the women were not using estrogen therapy at 10 months postoperatively despite continuing symptoms.¹⁶

Women without a uterus and their healthcare providers should have been reassured by the initial findings of the WHI conjugated estrogens-only treatment arm and especially by the more recent April 2011 report on long-term follow-up results.¹⁷ These WHI results show that treatment with estrogen-only versus placebo led to a number of positive findings for surgically menopausal women aged 50 to 59 years. These women showed a long-term decrease in risk of myocardial infarction and overall mortality. Women of all ages using estrogen only compared with women using a placebo showed a decrease in the risk of breast cancer.¹⁷ The WHI positive findings for estrogen-only therapy do not seem to have affected use of HT; at least, not yet. Recent data for HT prescriptions, accessed in November, 2011, show continued decline in the number of women using HT. By the end of 2011, there will be a million fewer women using HT than at the end of 2010 despite the increased number of women from the “baby boomer” generation who are experiencing menopause symptoms.¹⁸

Millions of symptomatic women who would have used estrogen-only treatment in the past no longer consider HT. Significant increases in the incidence of osteoporosis-related fractures and clinical depression have already been reported.¹⁹⁻²¹ There is also growing professional concern on the potential for increased cardiovascular disease in untreated symptomatic women.^{22,23}

CONCLUSIONS

It seems that women and their healthcare providers remain confused and apprehensive about the use of HT. For too many of today's working women, menopause symptoms go largely untreated or inadequately treated.

The declining rate in women's work ability is bound to get worse, and it is also probable that rates of sickness absence will increase. The need for studying these parameters of work function has never been greater. The Drachten Study should motivate others to include their measures of work ability in future menopause research. However, even beyond this, the Drachten Study is to be applauded for focusing on menopause and its effect on a woman's capacity to function in her world.

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