

Clinical Profile and Quality of Life in Climateric Women

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Abstract

BACKGROUND : Quality of life in climacteric women is intrinsically related to signs and symptoms influenced by estrogen decline, in addition to psychosocial factors linked to the natural aging process, in this context this study aims to outline a sociodemographic, clinical and quality of life profile. life of climacteric women servants of the University of the State of Rio Grande do Norte - UERN.

METHODS: this is a research with a descriptive, exploratory and quantitative approach . The population consisted of female workers from UERN, aged between 40 and 65 years. The total sample consisted of 64 women who responded to the forms and only one refused to respond.

RESULTS: the age range of the participants can be defined, so that 53.97% (n=34) are aged up to 50 years, 55.56% (n=35) are married or in a stable relationship. Regarding ethnicity, whites and browns had the same percentage of 44.44% (n=28). As for the city in which they reside, the largest number of women resides in Mossoró (RN), representing 82.53% (n=52) . The predominance of poor quality of life in the SF-36 was evidenced in the domains referring to pain, general health status and the domain referring to vitality. As for the SF-36 questionnaire, which represents the level of satisfaction with current health, 4.76% (n=3) stated that they fit the level considered excellent, 44.44% (n=28) very good, 46, 03% (n=29) were good and only 4.77% (n=3) represented a satisfaction with their current health considered bad. The intensity of symptoms related to estrogen deficiency, established by the Kupperman menopause index , was classified as: Mild 55.56% (n° =35), moderate 41.27% (n° =26) and severe 3.17% (No. =2) .

CONCLUSIONS: the occurrence of symptoms and perception of menopausal symptoms differ from woman to woman, to a greater or lesser extent. From this, it highlights the need for a qualified and individualized listening to the needs of these women in the health services and, in this way, it is possible to develop applicable solutions for solving problems based on the profile of each woman.

Background

The number of women who go through the climacteric period in Brazil is increasing, as the country is facing the beginning of a long period of population aging and epidemiological transition. According to studies carried out by the Brazilian Institute of Geography and Statistics ¹, it is estimated that in 2060 the country will have more elderly people than young people.

According to data from the Continuous National Household Sample Survey - Continuous PNAD (2019), which discusses the general characteristics of households and residents, the total resident population in Brazil is 209.5 million people, with the number of women it is higher than that of men, as it covers 51.8% (108.4 million people) of the total population of Brazil, against 48.2% (101.1 million people) in relation to men. Of these 108.4 million women, 52.9 million are in the age group between 40 and 64 years, that is, they are in the age group that corresponds to the period in which the climacteric occurs ² .

Another point worth mentioning is the fact that Brazil is going through the biggest demographic transition in history, the result of a very important factor: the arrival of population aging, which has led to a gradual reduction in young people. This point is due to the decrease in fertility and the increase in mortality, which resulted in a change in the age structure of the population, with gradual population aging ^{2,3} .

In view of this evidence, it appears not only that the life expectancy of the female population is higher in quantitative terms, but also that there is a clear tendency to increase and preponderance of this group in the general population, so that women are in greater numbers and in a growing increase in their life expectancy. Such characteristics highlight the great importance of working on health issues linked to aging, for example, the climacteric, as a progressive increase is expected in the demand for health services to deal with complaints related to the theme ⁴ .

In this transitional phase corresponding to the climacteric, usually occurring between 40 and 65 years of age, women undergo several transformations, whether psychosocial, affective, sexual, family and occupational, which can compromise, in a certain

way, their quality of life ⁵. Regarding the diagnosis of climacteric, it can be said that it is predominantly clinical, based on age group, altered menstrual pattern and climacteric signs and symptoms ⁶.

An important milestone within the climacteric is menopause, characterized as the last and definitive menstrual cycle. It can occur, mainly, between 48 and 50 years of age and is only confirmed after 12 consecutive months of amenorrhea, since the last menstrual period ⁷. Regarding this period, it is essential to note that it is divided into three main phases: pre-menopause, which, in general terms, will designate the period of time between the beginning of the decline in ovarian function until menopause itself, and can be the period of 3 to 5 years that precedes the last menstruation and in which changes in the menstrual cycle already occur ⁸.

Therefore, the perimenopause stage, which is the period of time close to menopause, sets in. Hormonal changes become more intense, generating a shortening or widening of cycles. Finally, there is the post-menopause phase, the period that begins with the last menstruation until the remaining years of a woman's life ⁸.

The climacteric encompasses the phase of decreased production of estrogen and progesterone hormones, causing the emergence of most signs and symptoms that can cause discomfort to a greater or lesser degree for women, such as: hot flashes, sweating, irritability, headache, genital atrophy, insomnia, palpitations, dizziness, tiredness and joint pain ⁹. In addition to these, there are neuropsychic symptoms, such as depression, anxiety, fatigue and decreased libido ¹⁰.

Although there are numerous complaints and negative issues attributed to this period, it recognizes that the experience of climacteric differs from woman to woman, deserving comprehensive and differentiated care in health services ¹¹.

Studies show hypotheses that the quality of life in climacteric women is intrinsically related to signs and symptoms influenced by estrogen decline, in addition to psychosocial factors linked to the natural aging process. In addition to these indicators, there is the social and cultural stigma that characterizes the climacteric as a symbol of aging, which can favor feelings of low self-esteem and potentiate other aggravating factors ¹².

Thus, it is necessary to measure the quality of life that such indicators can interfere with, through the use of scales, which focus on subjective symptoms and global changes, which allow us to understand how they affect quality of life, well-being and relationships. daily routines of these women ¹³.

Thus, the association of specific scales can make it possible to identify the main needs of climacteric women and direct them to specific assistance for their needs and that can contribute to an improvement in the quality of life of these women ¹⁴.

Given the importance of the topic, for including as a need for holistic nursing care and based on the quality of care, also because it is a group that is little assisted by the Health System. Concomitantly, it became relevant to research on this topic, in order to know the main needs of these women. Thus, this study aims to trace the sociodemographic profile, clinical indices and quality of life of climacteric women, employees of the University of the State of Rio Grande do Norte (UERN) participating in the research.

Methodology

The present study is a research with a descriptive, exploratory and quantitative approach. The population consisted of servants from the State University of Rio Grande do Norte, aged between 40 and 65 years.

For a better characterization of the sample, some inclusion criteria were established: women who are in the pre, peri and post menopause period, aged between 40 and 65 years, and; agree to participate in the research after signing the Free and Informed Consent Form. As well as exclusion criteria: inability to respond to the interview due to any reason, such as illness and incompatibility of schedules; women with a previous history of bilateral oophorectomy; hysterectomy, and; presence of concomitant and decompensated diseases, such as diabetes mellitus and arterial hypertension.

Data collection was carried out online, with the forms built in google forms sent to the e-mail of each server, the number of 130 women was granted, among them professors, technicians and deans. Of the 130 women, 63 responded to the forms.

Four (4) questionnaires were used as data collection instruments to assess the sociodemographic, clinical and quality of life profile. The first questionnaire analyzed the profile and sociodemographic and socioeconomic characteristics, determined based on the Brazilian Economic Classification criteria of the Brazilian Association of Research Companies. In this system, each item corresponds to a score. The sum of the points gives the rating of the interviewee. Up to four points, class E; between five and nine points, class D; between ten and twenty points, class C; between twenty-one and thirty-four points, class B and thirty-five points or more, class A.

The second questionnaire, in turn, analyzed the quality of life of climacteric women and the global transformations that can occur in their lives and that compromise their quality of life. Such data were measured using the *Women's Health Questionnaire*, validated in Brazil by Silva Filho ¹⁵. The questionnaire consists of a set of 36 (thirty-six) symptoms, classified on a 4 (four) point scale, in a descending manner, and contains 9 (nine) dimensions, such as: somatic symptoms; depressed mood; cognitive difficulties; anxiety/fear; sexual functioning; vasomotor symptoms; sleep disorders; menstrual symptoms, and; whether or not you feel attractive. The higher the score obtained, the more accentuated the dysfunction and the lower the quality of life.

The third questionnaire analyzed general health, health status, physical components and mental components. These data will be obtained with the *MOS SF-36 Health Survey*, validated in Brazil by Ciconelli ¹⁶. It consists of 36 items with 8 dimensions. Such as: functional capacity; physical aspects; ache; general health status; vitality; social aspects, emotional aspects, and; mental health.

Finally, climacteric symptoms were clinically evaluated using the *Kupperman Menopausal Index* ¹⁷. It has 11 of the most common menopausal complaints. Its totalization occurs through a count that varies from 0 to 51 points. The higher the score, the more serious the level of complaints, which can be classified as: mild; moderate, and; sharp.

The database was built in EXCEL format, version 2017, for the creation of descriptive tables and application of statistical tests, the free statistical software R, version 4.2.0 was used.

In the qualitative variables, a descriptive analysis was performed using absolute and relative frequency distributions (%). While in the quantitative variables evaluated in the study, descriptive statistics of measures of tendency and dispersion of the data were analyzed, such as: minimum, maximum, mean and standard deviation. To verify the reliability of the data, we will apply *Cronbach's alpha*, where authors point to data consistency classified as satisfactory for values above 0.70.

In comparing the sociodemographic profile with the instruments under study, the nonparametric statistical tests of Mann-Whitney, Friedman and Kruskal Wallis were applied. In the correlation analysis of the instruments under study, the Spearman test was used. In addition, the chi-square test of the general profile of professionals was applied with the classification of the Kupperman menopause index. For all statistical tests applied, the significance level was 5%.

The research was approved by the Research Ethics Committee (CEP) of the State University of Rio Grande do Norte, under CAAE number 38166820.6.0000.5294. The research subjects confirmed their consent to participate in this research by signing the Free and Informed Consent Term (ICF).

Results

A priori, as shown in Table 1, the age range of the participants can be defined, so that 53.97% (n = 34) are aged up to 50 years and 46.03% (n = 29) are older than of 50 years. In addition, 55.56% (n = 35) are married or in a stable relationship, 26.98% (n = 17) are single and 17.46% (n = 11) are divorced. Regarding ethnicity, whites and browns had the same percentage of 44.44% (n = 28), 9.53% (n = 6) black and 1.59% (n = 1) yellow. As for the city in which they reside, the largest number of women resides in Mossoró (RN), representing 82.53% (n = 52).

Table 1
Sociodemographic characteristic

Profile of the interviewee		absolute frequency	%
age group	up to 50 years	34	53.97
	over 50 years	29	46.03
City where you reside	Mossoró	52	82.53
	Christmas	4	6.35
	Pau dos Ferros	two	3.17
	caicó	1	1.59
	Campina Grande	1	1.59
	Strength	1	1.59
	Portalegre	1	1.59
	Lieutenant Laurentino Cruz	1	1.59
ethnicity	White	28	44.44
	brown	28	44.44
	black	6	9.53
	Yellow	1	1.59
marital status	Married/Stable union	35	55.56
	Single	17	26.98
	Divorced	11	17.46
Occupation	Teacher	38	60.31
	administrative technique	24	38.10
	Dean / Pro-rector	1	1.59
Formation	Doctorate degree	24	38.10
	Master's degree	20	31.74
	Specialization	16	25.40
	Graduated	3	4.76
economic rating	THE	15	23.81
	B	40	63.49
	Ç	7	11.11
	D	1	1.59
Concomitant diseases	Yes	27	42.86
	No	36	57.14
Medication use regularly	Yes	38	60.32
	No	25	39.68

Source: Research Data (2021)

Profile of the interviewee		absolute frequency	%
smoking	Yes	1	1.59
	No	62	98.41
Carry out regular sports activities	Yes	38	60.32
	No	25	39.68
Has a normal menstrual cycle	Yes	33	52.38
	No	30	47.62
number of pregnancies	None	10	15.87
	1 or 2	38	60.32
	3 or more	15	23.81
Total		63	100.00
Source: Research Data (2021)			

As for their occupation, 60.31% (n = 38) are professors and 38.10% (n = 24) are administrative technicians and 1.59% (n = 1) are within the dean and pro-dean category. In education: 38.10% (n = 24) have a doctorate, 31.74% (n = 20) have a master's degree, 25.40% (n = 16) have a specialization and 4.76% (n = 3) have a degree. In the economic classification, 23.81% (n = 15) are from social class A, while class B, C and D had the following percentages, respectively: 63.49% (n = 40), 11.11% (n = 7) and 1.59% (n = 1).

In addition, 42.86% (n = 27) have some concomitant disease, 60.32% (n = 38) use medication regularly, 1.59% (n = 1) smoke cigarettes and 60.32% (n = 38) engage in regular sports activities. 52.38% have a normal menstrual cycle (n = 33) and 47.62% (n = 30) do not have normal menstrual cycles. Regarding the number of pregnancies, the following result is obtained: None (15.87%), 1 or 2 times (60.32%), 3 or more times (23.81%).

Table 2
Descriptive statistics of professionals

Variable	Minimum	Maximum	25%	median	75%	IQ	Average	PD	CV	p-value
Age (in years)	40.00	63.00	44.00	49.00	55.00	11.00	49.62	6.23	12.56	0.067
amenorrhea time (in years)	0.33	23.00	2.00	3.00	10.00	8.00	6.46	6.84	105.82	<0.001
Source: Research Data (2021) IQ: Interquartile Range SD : Standard Deviation CV: Coefficient of Variation (1) Kolmogorov - Smirnov test to verify data normality										

Table 2 shows that the average time of amenorrhea was 6.46 years.

Table 3
Satisfaction with current health - SF - 36

Response	absolute frequency	%
Great	3	4.76
very good	28	44.44
Good	29	46.03
Bad	3	4.77
Total	63	100.00
Data: Survey 2021		

As for the SF-36 questionnaire represented in Table 3, which represents the level of satisfaction with current health, 4.76% (n = 3) stated that they fit into the level considered excellent, 44.44% (n = 28) very good, 46.03% (n = 29) good and only 4.77% (n = 3) represent satisfaction with their current health considered bad.

Table 4
Frequency distribution of items related to the WHQ instrument

Item	Frequency	No way	Rarely	Yes sometimes	Yes, no doubt	Total
I wake up at dawn and then I sleep badly for the rest of the night.	no	13	25	18	7	63
	%	20.63	39.69	28.57	11.11	100.00
I get very scared or terrified for no apparent reason.	no	42	14	6	—	62
	%	67.74	22.58	9.68	—	100.00
I feel sad and unhappy.	no	33	16	13	—	62
	%	53.22	25.81	20.97	—	100.00
I get distressed when I leave the house alone.	no	47	10	5	—	62
	%	75.81	16.13	8.06	—	100.00
I lost interest in things.	no	46	8	7	two	63
	%	73.02	12.70	11.11	3.17	100.00
I feel churning (palpitations) or a cold feeling in my stomach or chest.	no	34	13	15	1	63
	%	53.97	20.63	23.81	1.59	100.00
I still like the things I liked before.	no	two	1	16	44	63
	%	3.17	1.59	25.40	69.84	100.00
I think life is not worth living.	no	49	3	5	4	61
	%	80.32	4.92	8.20	6.56	100.00
I feel nervous or agitated.	no	21	21	16	4	62
	%	33.87	33.87	25.81	6.45	100.00
I have a good appetite.	no	1	1	14	47	63
	%	1.59	1.59	22.22	74.60	100.00
I feel restless and can't stay still.	no	29	12	15	6	62
	%	46.77	19.35	24.20	9.68	100.00
I'm angrier than usual.	no	15	21	17	9	62
	%	24.19	33.87	27.42	14.52	100.00
Getting old worries me.	no	29	10	14	9	62
	%	46.77	16.13	22.58	14.52	100.00
I have headaches.	no	16	23	20	4	63
	%	25.40	36.50	31.75	6.35	100.00
I feel more tired than usual.	no	12	11	26	14	63
	%	19.05	17.46	41.27	22.22	100.00
I have dizziness.	no	30	16	15	1	62
	%	48.39	25.81	24.20	1.61	100.00

Source: Survey 2021

Item	Frequency	No way	Rarely	Yes sometimes	Yes, no doubt	Total
	%	48.39	25.81	24.19	1.61	100.00
My breasts are sore or bother me	no	31	17	12	two	62
	%	50.00	27.42	19.35	3.23	100.00
I have pain in my back or arms and legs.	no	7	10	39	7	63
	%	11.11	15.88	61.90	11.11	100.00
I have hot flashes.	no	29	15	10	9	63
	%	46.03	23.81	15.87	14.29	100.00
I'm more clumsy (clumsy) than usual.	no	28	13	13	7	61
	%	45.90	21.31	21.31	11.48	100.00
I feel very excited and excited.	no	7	11	30	13	61
	%	11.48	18.03	49.18	21.31	100.00
I have discomfort or cramps in my belly.	no	27	21	11	3	62
	%	43.55	33.87	17.74	4.84	100.00
I feel sick or want to vomit.	no	43	10	8	—	61
	%	70.50	16.39	13.11	—	100.00
I lost interest in sex life.	no	21	14	21	5	61
	%	34.43	22.95	34.42	8.20	100.00
I have a feeling of well being.	no	two	5	25	30	62
	%	3.23	8.06	40.32	48.39	100.00
I bleed a lot during my periods.	no	32	8	12	8	60
	%	53.34	13.33	20.00	13.33	100.00
I have sweats at night.	no	34	13	9	6	62
	%	54.84	20.96	14.52	9.68	100.00
I feel my stomach bloated (stuffy).	no	18	15	18	10	61
	%	29.51	24.59	29.51	16.39	100.00
I have difficulties falling asleep.	no	21	17	16	9	63
	%	33.33	26.98	25.40	14.29	100.00
I feel tingling and prickling in my feet and hands	no	26	9	22	6	63
	%	41.27	14.29	34.92	9.52	100.00
I am satisfied with my sex life (Please do not respond if you do not have a sex life).	no	4	8	21	17	50
	%	8.00	16.00	42.00	34.00	100.00
I feel physically attractive.	no	4	8	32	18	62
	%	6.45	12.90	51.62	29.03	100.00

Source: Survey 2021

Item	Frequency	No way	Rarely	Yes sometimes	Yes, no doubt	Total
I have difficulty concentrating.	no	13	16	25	9	63
	%	20.63	25.40	39.68	14.29	100.00
My sex is uncomfortable because my vagina is dry. (Please don't answer if you don't have a sex life).	no	26	8	9	7	50
	%	52.00	16.00	18.00	14.00	100.00
I have to urinate more often than usual.	no	29	10	16	7	62
	%	46.77	16.13	25.81	11.29	100.00
My memory is bad.	no	17	18	17	11	63
	%	26.98	28.57	26.98	17.47	100.00
Source: Survey 2021						

With the analysis of the variables provided by the women's health questionnaire (Table 4), greater changes were found in "yes, sometimes" and "yes, without a doubt" in questions related to body pain (n = 39) and (n = 7), feeling tired (n = 26) and (n = 14), difficulty concentrating (n = 25) and (n = 9), tingling (n = 22) and (n = 6), loss of of sexual interest (n = 21) and (n = 5), headache (n = 20) and (n = 4). In addition, other alterations that deserve to be highlighted are poor memory, impaired sleep, feeling of a bloated stomach, irritability, restlessness and nervousness.

Table 5
Frequency distribution of items related to the Kupperman menopause instrument

Items	Freq.	no symptoms	light	moderates	accentuated	Total
Vasomotors	no	21	33	6	3	63
	%	33.33	52.39	9.52	4.76	100.00
paresthesias	no	20	28	11	4	63
	%	31.75	44.44	17.46	6.35	100.00
Insomnia	no	18	22	12	11	63
	%	28.57	34.92	19.05	17.46	100.00
nervousness	no	13	31	17	two	63
	%	20.63	49.22	26.98	3.17	100.00
Melancholy	no	22	27	13	1	63
	%	34.92	42.86	20.63	1.59	100.00
Vertigo	no	20	30	12	1	63
	%	31.75	47.61	19.05	1.59	100.00
Weakness	no	23	29	10	1	63
	%	36.51	46.03	15.87	1.59	100.00
Arthralgia and/or myal .	no	12	22	23	6	63
	%	19.05	34.92	36.51	9.52	100.00
headache	no	13	24	21	5	63
	%	20.63	38.10	33.33	7.94	100.00
Palpitation	no	24	28	11	—	63
	%	38.10	44.44	17.46	—	100.00
Tingling	no	18	27	12	6	63
	%	28.57	42.86	19.05	9.52	100.00
Source: Survey 2021						

According to Table 5, of the clinical signs evaluated as “severe”, the greatest predominance of responses refers to clinical signs of insomnia, with values of 17.46% (n = 11). Of the symptoms considered “moderate”, there is a predominance of signs of arthralgia/myalgia, with 36.51% (n = 23), followed by signs of headache, with 33.33% (n = 21). Of the mild symptoms, the greatest predominance refers to vasomotor symptoms 52.39% (n = 33) and signs of nervousness, representing 49.22% (n = 31).

Table 6
Comparison of the dimensions of the instruments under study in relation to the age of the professionals

dimensions	Age	Minimum	Maximum	25%	median	75%	I Q	Average	PD	CV	p-value
Functional capacity	≤ 50 years	30.00	100.00	70.00	90.00	100.00	30.00	82.79	18.76	22.65	0.052
	> 50 years	35.00	100.00	55.00	75.00	95.00	40.00	73.28	21.22	28.97	
Limitation by physical aspects	≤ 50 years	0.00	100.00	50.00	100.00	100.00	50.00	75.74	33.98	44.87	0.217
	> 50 years	0.00	100.00	25.00	75.00	100.00	75.00	64.66	38.68	59.83	
Ache	≤ 50 years	31.00	100.00	62.00	72.00	84.00	22.00	70.79	19.66	27.77	0.028
	> 50 years	0.00	100.00	41.00	62.00	72.00	31.00	57.69	24.09	41.76	
general health status	≤ 50 years	12.00	80.00	42.00	47.00	57.00	15.00	48.91	12.25	25.04	0.300
	> 50 years	22.00	82.00	42.00	52.00	62.00	20.00	52.45	14.56	27.75	
Vitality	≤ 50 years	20.00	75.00	55.00	60.00	65.00	10.00	55.59	13.86	24.93	0.397
	> 50 years	30.00	80.00	55.00	60.00	65.00	10.00	58.79	10.91	18.56	
Social aspects	≤ 50 years	25.00	100.00	50.00	75.00	87.50	37.50	71.69	22.04	30.75	0.669
	> 50 years	25.00	100.00	50.00	75.00	100.00	50.00	72.84	25.68	35.25	
Limitation by emotional aspects	≤ 50 years	0.00	100.00	33.33	100.00	100.00	66.67	67.65	40.61	60.03	0.982
	> 50 years	0.00	100.00	33.33	100.00	100.00	66.67	67.82	39.32	57.98	
Mental health	≤ 50 years	36.00	92.00	64.00	74.00	84.00	20.00	73.29	13.95	19.03	0.814
	> 50 years	44.00	96.00	56.00	76.00	88.00	32.00	71.31	17.63	24.73	
Somatic Symptoms	≤ 50 years	28.57	89.29	39.29	50.00	60.71	21.43	50.53	13.68	27.08	0.186
	> 50 years	25.00	82.14	46.43	53.57	67.86	21.43	55.91	16.62	29.73	
depressed mood	≤ 50 years	25.00	66.67	29.17	39.58	50.00	20.83	41.30	11.93	28.90	0.536
	> 50 years	20.83	66.67	29.17	37.50	45.83	16.67	39.37	11.76	29.88	
Cognitive Difficulties	≤ 50 years	25.00	100.00	41.67	50.00	75.00	33.33	56.13	23.78	42.36	0.808
	> 50 years										

Source: Survey Data (2021) IQ: Interquartile Range SD : Standard Deviation CV: Coefficient of Variation

dimensions	Age	Minimum	Maximum	25%	median	75%	I Q	Average	PD	CV	p-value
	> 50 years	16.67	100.00	41.67	58.33	66.67	25.00	56.32	22.01	39.08	
Anxiety	≤ 50 years	25.00	81.25	25.00	37.50	43.75	18.75	39.52	14.33	36.25	0.695
	> 50 years	18.75	75.00	25.00	37.50	50.00	25.00	41.16	15.45	37.53	
sexual functioning	≤ 50 years	8.33	100.00	25.00	37.50	58.33	33.33	42.65	21.00	49.24	0.427
	> 50 years	8.33	83.33	25.00	50.00	66.67	41.67	47.53	24.22	50.96	
Vasomotor Symptoms	≤ 50 years	12.50	100.00	25.00	25.00	37.50	12.50	36.76	20.63	56.11	< 0.001
	> 50 years	25.00	100.00	37.50	50.00	75.00	37.50	58.62	25.68	43.81	
Problems with Sleep	≤ 50 years	25.00	100.00	33.33	50.00	58.33	25.00	50.00	19.03	38.05	0.081
	> 50 years	25.00	100.00	50.00	50.00	75.00	25.00	58.05	20.35	35.06	
Menstrual Problems	≤ 50 years	25.00	100.00	37.50	53.13	68.75	31.25	53.49	18.09	33.81	0.006
	> 50 years	12.50	87.50	25.00	37.50	50.00	25.00	40.95	17.80	43.48	
Attraction	≤ 50 years	25.00	83.33	41.67	41.67	58.33	16.67	49.26	15.40	31.26	0.368
	> 50 years	33.33	83.33	41.67	50.00	58.33	16.67	52.30	13.34	25.51	
WHQ	≤ 50 years	31.94	69.44	37.50	45.83	55.56	18.06	46.43	10.67	22.99	0.460
	> 50 years	26.39	77.78	41.67	46.53	56.25	14.58	48.47	12.21	25.19	
Kupperman Menopause Index	≤ 50 years	0.00	35.00	5.00	13.50	21.00	16.00	14.21	10.30	72.49	0.012
	> 50 years	4.00	39.00	15.00	20.00	29.00	14.00	20.97	9.82	46.85	

Source: Survey Data (2021) IQ: Interquartile Range SD : Standard Deviation CV: Coefficient of Variation

In an analysis of Table 6, women aged up to 50 years had higher SF36 scores for pain and higher WHQ scores for menstrual problems, in addition to lower WHQ scores for vasomotor symptoms and a lower Kupperman menopausal index . Married professionals or those in a stable relationship had higher WHQ scores on somatic symptoms, sexual and global functioning on the WHQ, in addition to lower SF36 scores on vitality.

Professionals with a regular menstrual cycle had a higher SF-36 score for functional capacity and a higher WHQ score for menstrual problems, and a lower WHQ score for vasomotor symptoms. Women with a concomitant disease had higher scores in the respective dimensions mentioned. Professionals who practice regular physical activity had higher scores in the mentioned dimension.

It was found that professionals who had 3 or more pregnancies scored higher on sleep problems, somatic symptoms and the Kupperman menopause index . While professionals with 1 or 2 pregnancies had higher pain scores.

Table 7
Kupperman Menopause Index Classification

Assessment	absolute frequency	%
Light	35	55.56
Moderate	26	41.27
accentuated	two	3.17
Total	63	100.00
Source: Survey 2021		

In Table 7, using the general Kupperman score, there is the following classification for the situation of the occurrence of clinical signs in the climacteric: Mild 55.56% (n = 35), moderate 41.27% (n = 26) and severe 3.17% (n = 2).

Discussion

In this study, the predominance of poor quality of life in the SF-36 was evidenced in the domains referring to pain, general health status and the domain referring to vitality. In this sense, it is important to highlight that studies have identified a compromise in the vitality dimension, which can be explained by the double working hours that women perform inside and outside their homes¹⁸.

For the most part, when asked about the level of satisfaction with their health, women responded that they were classified as good and very good, so that only a small portion referred to their health as poor. However, this finding can be justified, in part, by the economic classification and levels of education they belong to, which, being more favorable, provide opportunities for better dietary practices, awareness for the practice of physical activities and other measures that promote the performance of physical activities. healthy habits¹⁹. On this issue, a study carried out in Brazil that showed that schooling was one of the predominant factors for better coping with the climacteric period, since it provides greater knowledge about its difficulties, symptoms and, mainly, forms of treatment and treatment. alleviation of symptoms²⁰.

In addition, the economic level is another fundamental factor for the improvement of the quality of life of these women, because, given the social and health situation in the country, it provides access to specialized services for the care of their climacteric complaints, with a more professional service. qualified and multi-professional. Thus, having a humanized, prepared and informative service has a greater positive effect on the perception of these women's quality of life⁶.

Furthermore, studies carried out with climacteric women have shown that regular physical activity is another factor that positively contributes to a lower manifestation of climacteric symptoms and improved quality of life²¹. Practices are responsible, for example, for improving mood and relieving hot flashes and, therefore, contributing to a better perception of quality of life²². Predominant factor in this study, in which the large portion of women who participated in this research perform physical activities regularly, representing a value of 60.32%.

Pain was one of the domains that also changed from the SF-36, which may be associated with the work performed, physical exertion and issues related to non-ergonomics in the work environment²³. In addition, other studies relate pain to hormonal changes, especially hypoestrogenism, which is associated with bone cartilage wear²⁴. Furthermore, musculoskeletal pain was characterized as one of the most frequent complaints, affecting approximately 93% of the population studied, among them, most of them classified the pain as intense²⁵.

In the WHQ, the dimensions that showed the greatest impairments are the dimensions focused on depressed mood, anxiety, sexual functioning, vasomotor symptoms and menstrual problems. About 50 to 70% of women who go through the climacteric

period can trigger emotional problems, loss of libido, anxiety and even depression. Furthermore, this author also points to the relationship between depression, mainly associated with the fear of aging and the feeling of uselessness and affective lack²⁶.

In addition, studies indicate that between 25% and 35% of women between 35 and 59 years old tend to have sexual dysfunctions, which can reach up to 75% among women aged 60 to 65 years. This dysfunction can be evidenced by the urogenital atrophy mechanism, but above all, by the physical changes that occur with aging, which impact on self-esteem and influence libido²⁰. In line with these findings, studies carried out in Sweden showed that most women reported sexual dysfunctions, such as decreased libido, sexual activity, satisfaction, and especially symptoms associated with vaginal dryness²⁷.

Still in the WHQ, another problem that compromises the quality of life of the analyzed women was in the dimension of somatic symptoms, characterized by hot flashes (hot flashes) and sweating. Hot flashes are felt in approximately 75% of menopausal women²⁸. Such symptoms tend to compromise the quality of life of these women. In studies developed, they showed a small incidence of hot flashes in pre - menopause, with an increase in these symptoms in early perimenopause and a higher incidence in late perimenopause, however, after menopause, especially in older women, there is a decline in the intensity of these symptoms.²⁹

As mentioned through the Kruskal -Wallis test, there is evidence of a statistical difference in the number of pregnancies with the SF-36 pain dimension, sleep problems and WHQ somatic symptoms. This finding was mentioned in studies in which the association of a greater number of pregnancies with the intensity of climacteric symptoms, which shows that women with three children or more, had greater menopausal symptoms³⁰.

In this study, no statistical differences were found in relation to quality of life with smoking, which can be explained by the low number of female smokers. However, studies show an association between a poor quality of life and the habit of smoking³¹.

However, there is evidence of statistical difference between marital status and the vitality dimension of the SF-36, and the dimensions of somatic symptoms and sexual and global functioning of the WHQ. Where married professionals or those in a stable relationship had a higher WHQ score on somatic symptoms, sexual and global functioning on the WHQ, in addition to a lower SF-36 score on vitality. This corroborates with other studies, which point to a correlation between a better quality of life in women who had a partner to the detriment of those who declare themselves single or divorced³².

Furthermore, for this study, there was evidence of statistical difference of the existence of concomitant disease with the dimension of anxiety in the WHQ and in the Kupperman Menopause Index, where professionals with a concomitant disease had higher scores in the respective dimensions mentioned. The chance of professionals with a concomitant disease to present moderate or severe Kupperman classification increases 5.20 times, compared to professionals without concomitant disease³³.

Finally, the chance of professionals using regular medication, presenting moderate or severe Kupperman classification, increases 4.35 times, compared to professionals without regular medication use. This corroborates the studies carried out in the city of Ouro Preto, where approximately 113 climacteric women were analyzed and the results indicate that the presence of chronic diseases and the use of medications concomitantly with the climacteric was associated with a worse quality of life³³.

The intensity of symptoms related to estrogen deficiency, established by the Kupperman menopause index, was classified as: Mild 55.56% (n° =35), moderate 41.27% (n° =26) and severe 3.17% (No. =2). Insomnia symptoms were perceived as the most marked change, while symptoms related to arthralgia/myalgia and headache were classified as moderate.

Insomnia problems are common in the climacteric period, however, there are no studies that correlate insomnia with estrogenic drop, being, therefore, more associated with the occurrence of hot flashes and emotional difficulties²⁶. Furthermore, studies show a positive relationship between the scores on the sleep scale and the score related to menopause, which highlights a worse quality of sleep in women who were experiencing this period³⁴. Thus, insomnia, along with hot flashes, are the main complaints of women during menopause²⁸. Furthermore, studies show that the use of sleeping pills increases from 5.8–11.22% in the female population who are going through menopause³⁵.

Therefore, the results found in this research corroborate with several authors who work on the climacteric theme and who mention that the arrival of this period in a woman's life is marked by several changes, whether physical, hormonal or emotional. The occurrence of symptoms and perception of these symptoms differs from woman to woman, to a greater or lesser extent. This highlights the need for qualified and individualized listening to the needs of these women in health services.

Conclusions

This study showed that the occurrence of climacteric signs and symptoms are associated, especially, with basal hormone levels, but, above all, with the way women experience this stage of life, with all the physical and emotional changes. The adoption of measures that promote a better quality of life, such as healthy habits, adequate nutrition, awareness of the practice of regular physical activities, the promotion of self-esteem and moments of leisure can provide better health and a significant improvement in the quality of life. .

Thus, it corroborates with several authors, when stating that quality of life is not only associated with the occurrence of signs and symptoms, but as a way of seeing and facing life, reality and adversities ⁶. With this, health professionals, especially nurses, should develop actions that promote the quality of life of women who go through the climacteric period, by focusing on well-being, self-care, self-esteem, as well as the promotion and prevention of complications.

Declarations

Ethical approval and consent to participate

The research was approved by the Research Ethics Committee (CEP) of the State University of Rio Grande do Norte, under CAAE number 38166820.6.0000.5294. The research subjects confirmed their consent to participate in this research by signing the Free and Informed Consent Term (ICF).

Consent for publication

Not applicable.

Availability of data and materials

Datasets used and/or analyzed during the current study are available from the corresponding author upon reasonable request.

Competitive interests

The Authors declare that they have no competing interest.

Financing

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Author contributions

All authors contributed in equal part to the structuring of this manuscript. All reviewed and approved the final version of the manuscript.

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