

A HISTORICAL PRESPECTIVE ON MENOPAUSE AND MENOPAUSAL AGE

Amarjeet Singh* Mrs. Sukhwinder Kaur
Mrs. Indarjit walia*****

ABSTRACT

Earliest known references to menopause have been very scarce. Aristotle referred to age at menopause being 40 years. A French physician coined the term menopause in 1821. Medical interest in menopause increased considerably in mid 19th century. In 1930s people started describing it as a deficiency disease. Consequently, various replenishment therapies were advocated eg. testicular juice, crushed ovaries of animals.

In 1970s medicalization of menopause was complete. Menopausal symptoms were ascribed to estrogen deficiency and estrogen (hormone) replacement therapy was exhorted as the ultimate liberation of middle aged women. Synthetic estrogen was developed in 1938. Medical industry (Pharmaceuticals) entered the scenario of menopause in a big way and dominated the center stage. In 1970s International Menopause Society was established. First International Congress on Menopause was also organized in Paris, France in 1976. Various countries have formed national societies on menopause. Symptomatology of menopause differs in different areas of the world e.g. In West - hot flush, in Japan shoulder pain and in India low vision are the hallmarks of menopause. HRT use rate is high in West while it is low or negligible in countries like India. Age at menopause is also higher in West as compared to the range of 45-47 years in developing countries like India. Historically also a lower age at menopause was range documented in earlier times. This rose to the range of 50-51 years in the present era.

Overall, women in western countries view menopause negatively. This is contrasted with a positive outlook towards menopause in a developing country like India.

* Addl. Prof. Community Medicine, ** Clinical Instructor, *** Principal, College of Nursing, P.G. Institute of Medical Education & Research, Chandigarh.

History of Menopause

Several major milestones exist in the history of menopause. Almost from the beginning, early philosophers and scientists tried to explain why a woman eventually became amenorrhoeic and sterile whereas fertility apparently continued unabated in the older male. Indeed, the first known references to menopause date back to biblical and prebiblical writings. Menopause as a life event was recognized far back in history. Aristotle (384-322 B.C.) noted menstruation to cease at the age of 40 years and references to the cessation of the age of fertility continue to pepper the literature over the next 2000 years. The term menopause is constituted by two Greek words *men*-month and *pauses*-stop. It was first utilized to describe the cessation of menstruation, although a Latin basis can also be argued. Climacteric also appears to be of Greek derivation representing the word for 'ladder' or 'steps of a ladder' (Utian, 1977).

Like rest of the world, there is hardly any reference to menopause in ancient Indian texts, treatise or epics. However, there are elaborate descriptions about menstruation, menarche and codes of conduct for men and women during menstruation. *Kautilya* described that after menarche menses of a girl should not go waste and she should be married off. *Charak Samhita* also described about disorders of menstruation. Ayurvedic texts also describe that every month '*rasa*' from food gets converted into menses and during pregnancy this *rasa* gets diverted to mammary glands to produce milk.(Bhargava,1999)

According to Hindu mythology, women started having menstrual periods, when one third to guilt (stain) of Brahminicide committed by Lord Indra (Killing of Visvarupa, son of Tvastra), was transferred to them. Visvarupa had three heads - one ate food, one drank *Sura* and the third had *Soma* (hence one third guilt). This stain (bleeding) was projected as the mark of sin, danger and impurity (Indra's curse). As a result, women were severely restricted, thereafter, in social and religious activities during menstruation (Leslie, 1991). Many taboos later got associated with menstruation which was considered a period when women were impure and emitted the colour of *Brahma-hatya*. These views have been deeply ingrained in the psyche of Indians, who, for all times to come, considered women as polluting during menses.

The term 'menopause' was evolved in 1821 by a French physician Gardanne.

From the middle of the 19th century onwards, it gradually came into wide circulation in medical circles in Europe to describe what was known in English in daily parlance as the dodging time, i.e. the years before and after the last menstruation. The concept usually used in educated circles from medieval times onwards to express the idea of a transition at midlife, the climacteric, made no distinction between men and women, although this changed at the end of the 19th century. Thus Gardanne, in creating the idea of menopause, deliberately sought to single out the aging of women as worthy of medical attention (Lock, 1998)

Robert Barnes, another physician interested in menopause, wrote in 1873, 'physicians do, indeed, talk of the climacteric in man; but the analogy is more fanciful than real. There is nothing to compare with the almost sudden decay of the organs of reproduction, which marks the middle age of a woman. While those organs are in vigor, the whole economy of woman is subject to them. Ovulation and menstruation, gestation and lactation by turns absorb and govern almost all the energies of her system. The loss of these functions entails a complete revolution'(Lock,1998).

Each scientific advance in medicine initiated an attempt to apply those early ideas to explain the menopause. For example, elaboration of circulation led to the theory that menopause resulted from circulatory failure. The complex web of events that surround menopause has been unravelled in small steps over many years (Utian , 1990)

Systematic interest in menopause by physicians began in the middle of the 19th century (Lock, 1991).Menopause has been transformed in just over 100 years from a subject that was peripheral to medical interest into one about which there is lively and often acrimonious debate. There is now a general agreement that the term menopause should be restricted to the actual event-the end of menstruation. This is not a definition, but rather a description of the physical and psychological change that takes place at a certain time in a woman's life (Lock, 1991)

Each discipline looks at the subject of menopause from its own perspective. A physician may see the menopause as a medical problem in need of medical care; a psychologist will be interested in psychological aspects associated with this reproductive landmark, while an anthropologist may focus on how culture imposes on the biological entity called menopause. For the anthropologist, then, menopause is understood through

a culture's imposition of belief, attitudes and values, which are learnt through the life cycle.

Psychoanalysts, too, have regarded menopause as a developmental or intrapsychic task involving major personality re-organization or psychologic adaptation. Psychoanalytic writers typically regarded menopause as a critical event in the life of middle aged women that was a great threat to their adjustment and self-concept. (Avis and McKinlay, 1991). Evolutionary biologists classify theories of menopause as either:-

a) Adaptive, suggesting that female reproductive cessation results from its selective advantage, in that the increased risk of personal reproduction late in life makes it biologically more advantageous to rechannel reproductive energy into helping existing descendents or (b) Non adaptive, indicating menopause as an artifact of the relatively recent dramatic increase in human longevity. With the possible exception of pilot whales, no mammals studied to date are known to commonly exhibit reproductive cessation in nature or (c) Evolutionary models, evaluated with data from modern hunting-gathering or agricultural humans, fail to find that humans can assist their descendents sufficiently to offset the evolutionary cost of ceasing reproduction.

Menopause as a biological adaptation among monkeys

It is well established that Rhesus Macques experience menopause when approximately two thirds of their life cycle is completed, the profile of which is hormonally similar to that of human females, although the ovaries do not show much marked changes as in humans. Chimpanzee work by Jane Goodall demonstrated, that the matriline is important, and that elderly females protect not only their own daughters but also their grand children and, at times, more distantly related youngsters. These researchers conclude that the presence of post reproductive females in primitive groups is biological adaptive (Lock, 1998).

Very recent findings of early hominids in East Africa suggest that the first major adaptation from apes to humans was that of upright posture. These 'walking chimps' had a short life expectancy and lived, as far as we can tell, rather non-cooperative lives. It was not until the emergence of *Homo erectus*, 1,700,000 years ago, that shorter arms and a larger brain clearly had evolved. It is not yet established when estrus ceased.

Between 1,500,000 and 1,200,000 years ago, early hominids started to live in cooperative groups, share food, and develop technologically assisted hunting. These changes indicate very strongly that language was also evolving during this time. With an increased brain size came a dramatically lengthened time of dependency of human infants and juveniles before maturation, requiring prolonged adult attention not found in apes. Peccei (1995) has argued on the basis of mathematical modelling, that reproductive senescence permitting extended investment in dependent children from early pregnancies is biologically advantageous. Life long reproduction would probably have exposed older children to neglect while the attention was focussed on newborns, thus making survival of older siblings problematic. Peccei further argued that menopause evolved around 1.5 million years ago, the result of selective pressures in favour of females, who became prematurely infertile, and that it probably occurred somewhat earlier than 50 years of age (Lock 1998).

In contrast to Peccei's argument, the "grandmother hypothesis" posits that post reproductive life in human females was advantageous because similar to ape communities, older members of society, unhampered by dependent infants, provided group protection. Such protection would have resulted in improved inclusive fitness of the group. On the basis of data obtained from the Ache, a hunting and gathering society in Paraguay, Hill and Hurtado (1991) argue that the grandmother hypothesis, although not proven, makes good intuitive sense. Further more, evidence from a range of contemporary hunting and gathering societies shows that women can collect more food if they leave infants in the care of older women while foraging. Moreover, freedom from dependent infants leads to better cooperation in communal endeavours other than the basic procurement of food. These hypotheses, the one in favour of direct maternal investment in living offspring, and the second arguing that the presence of post reproductive females in groups leads to greater inclusive fitness, are not mutually exclusive. Together they suggest strongly that women of post reproductive age have had a major contributory role in society that was probably biologically adaptive since the evolution of contemporary human kind. These advantages clearly remain of relatively little importance in contemporary society, but on the other hand, menopause cannot be disposed of as a biological anomaly (Lock, 1998).

Description of menopause as a deficiency disease appeared in scholarly articles

in the late 1930s and early 1940s along with recommendations for estrogen replacement therapy. There is also disagreement about whether the biological model was or is the only model of menopause. Three competing models were discerned biological, psychological, and environmental with the biological model predominating. The decline in estrogen production has become the central theme “The leit motive” in gynaecological literature (Bell, 1990). Regardless of which explanation pre-dominates, all agree that menopause has been defined as a disease.

Renewed interest in menopause started in the 1960s. Until then, menopause had been something that women simply went through - and rarely talked about. Women who have complaints or problems were told to put up with them, that they would pass. Sometimes they were handed a prescription for Valium to help them “calm down”. This seeming lack of compassion on the part of doctors stemmed from the fact that there was not much they could offer: there were no operations, no tests, and no wonder drugs. As long as menopause was a condition about which nothing could be done, the medical profession could ignore it.

Medicalisation of Menopause

Early suggestions for therapies for menopause were varied. For example, organotherapy or glandular therapy was a very ancient form of treatment for both the male and female climacteric. Egyptian men were known to eat the penis of the ass as a cure for impotence, and the Greeks and Romans prescribed the testicles of the ass for this purpose. Such treatments were to become popularised in the late nineteenth century. At the age of 72, Brown Sequard reported before the Societe’de Biologie of Paris (*June 1, 1888*) that he had rejuvenated himself by injections of “testicular juice”. The improvement in health manifested itself in greater body vigor, better vesical (sphincteric) action, and better intestinal activity. According to Brown Sequard, his wife Augusta Brown used testicular extract to combat feminine debility. At the close of the nineteenth century, ovarian therapy was limited to the administration of crude ovaries, ovarian juice (Suc Ovarian), powdered ovarian tablets. These substances were used for conditions such as physiologic and surgical menopause, dysmenorrhea, and adiposity (Utian, 1990).

Concurrent with descriptions of menopausal symptoms, suggestions for therapies to alleviate these symptoms began to appear in the medical literature of the late

eighteenth century. However, this interest in treating women in the climacteric was accompanied by the association of menopause with apparently unrelated diseases. A hallmark of the literature produced during the 1700 to 1800 centuries was the emergence of negative attitude toward menopause. Unfortunately, such negative attitudes persist even today. Menopause has been referred to as 'a tragedy and catastrophic attack', while post menopausal women have been described as 'cowlike' or 'dull and unattractive' (Utian,1990).

Around 1970s, sociologists began to examine the origins and consequences of defining and treating human experiences as medical problems - a practice that they labelled as 'medicalisation' (Fishbein, 1992). This concept forms a part of the large critique of the bio-medical model. It drew attention to the social and political elements of medicine. Menopause was defined as a psychological crisis that could cause disease under certain conditions. The most important condition was social, a woman's adherence to departure from her prescribed role. Thus, the way to prevent symptoms was to avoid being too educated, fashionable or sexually active and to provide adequate care for husbands and children. Not until the twentieth century was menopause defined as a deficiency disease and menopause attributed to estrogen deficiency. Once this connection was drawn, treatment with estrogen became not only legitimate but rather an obligation (Bell, 1990).

The use of tranquilizers in the pre-estrogen era paved the way for menopause's change in status from a normal biologic process to a treatable disease. The early work of Freud, which described menopause as a crisis period during which a woman mourned the end of her feminine attractiveness and child bearing capacity, did lend some credence to the notion of menopause as a mental illness. Indeed, to some psychiatrists, menopause spelled the loss of meaning in a woman's life. Terms such as 'middle crisis' and 'empty nest syndrome' were used to explain the emotions women were supposed to suffer from, at this time. Tranquilizers dulled these emotions and quelled anxiety; they provided a Band-Aid solution to the so called problems of menopause. The introduction of synthetic estrogen (Premarin) in the early 1960s changed all that.

In early 1960s, gynaecologist Robert Wilson introduced the concept of "feminine forever": the 'tragedy of menopause' he said, could be avoided by the use of estrogen

'from puberty to grave'. His epiphany coincided with the discovery of a cheap estrogen drug: Premarin. Once Premarin hit the market, tranquilizers were no longer necessary, because all of a woman's emotional complaints would now be abolished right along with her menopause, making her 'feminine forever'. The drug companies, of course, supported Wilson's efforts to promote the use of estrogen. The media, too, touted Wilson's ideas, and organized medicine was forced to handle this. Barraged with requests from women patients, physicians began prescribing estrogen widely. Wilson and his cohorts described a huge range of (HRT) rapidly became a widely touted 'treatment' for menopause - and menopausal women became a prime target for drug manufacturers. Some people wonder if the pharmaceutical industry turned menopause into a disease to create a market for new products (Cherry & Runowicz, 1994).

Although menopause is clearly a natural biological phenomenon, many medical researchers and practitioners view menopause as a disease. Evidence of conceptual medicalisation of menopause can be found in medical text books. This medicalisation is a social construct that has been adapted and changed over the years. This view is that menopause is the cause of disease. By conceptualising menopause this way, medical researchers are in search of an intervention-hormonal or otherwise to prevent or cure a health problem. After synthetic estrogen developed in 1938, it was added to a variety of menopausal medical treatments. (Mac Pherson, 1990).

Access to estrogen treatment in U.S. was controlled by the Food and Drug Administration and legally prescribed only by physicians. By 1975, estrogen was the first most frequent prescribed drug in the United States. In the same year a survey in Washington state found that 51% of all post-menopausal women had used estrogens for at least three months, with a median duration of over 10 years (Bell, 1990).

Menopause was medicalised when ageing women began to seek medical advice, information and help when they thought they were entering menopause and when physicians began to attribute their complaints to estrogen deficiency and prescribed estrogen for them (Bell, 1990).

Increasingly in recent years, menopause has been implicated in the etiology of some major age-related diseases in women, such as cancer, cardio-vascular diseases, osteoporosis and depression. To date, most of the information on menopause has been

based on data from a relatively small proportion of self-selecting women who experience and report problems, utilize health facilities, and are therefore conveniently available as research subjects. What has emerged from these studies of predominantly patient populations in a clinical stereotype of the 'typical' menopause woman, who presents a broad range of often diffuse symptoms and consequently consumes a disproportionate share of health resources. The stereotype is reinforced by pharmaceutical advertisements in professional journals (Mc Kinlay et al, 1987) However, cross cultural differences in menopausal symptoms have been reported e.g. hot flush dominate the scene in west, shoulder pain in Japan and diminished vision in India (Kaur, 2001).

Thus whereas a grossly negative attitude predominates among Western women the menopause is viewed positively in developed countries like India. Moreover, medicalization of menopause is high in West as compared to India where HRT use rate is very low and even nil in rural areas. Most of the rural Indian women considered attainment of menopause a welcome relief after going through an almost 30 years of monthly, monotonous routine of managing menstruation. They felt free of the self-imposed social, dietary, physical and religious restrictions because of menses. Cessation of menses was welcomed as it relieved them off dealing with the 'filth' and the dirty blood. They were able to devote time to religious activity - an important past time for elders in India. Going to temple requires cleanliness, which is a sort of obsession among Indians. Since menses are considered as polluting - menopause implied cleanliness for women, many of whom said, 'I feel clean & tidy' at menopause (Sing and Arora, 2000, Kaur, 2001) .

Menopausal Societies

By the early 1970s, clinics had been established in some of the western countries to further the study of menopause and to provide symptomatic relief to women at the climacteric (Utian, 1990). A 'menopause club' was originally proposed by Van Keep and Utian at a meeting in Geneva in 1973. This resulted in the first International Congress on Menopause in France in 1976, the launch of the International Menopause Society (IMS) in 1978 and intimation of *Maturitas*, the international journal for the study of the climacteric in 1978. At this time nearly all European and several Latin American and Australian countries had developed national societies on menopause of their own (Utian, 1990). Recently, another journal on menopause viz. 'climacteric' has also been launched. Tenth

World Congress on menopause was organized in Berlin in 2002.

The Age at Menopause

Since the early 19th century, a downward trend for age at menarche has been documented. The age at menopause is not nearly so well documented. Some researchers have documented that the age at menopause is increasing all over the world. Others, however, report that there is no conclusive evidence for such an increase. Several factors contribute to the relative lack of data on the age at menopause as compared to that on the age at menarche. The difference in significance of the two events, the death rate, the difficulty of recalling when an event no longer occurs (menopause) compared to remembering when that event first occurred (menarche), and inappropriate statistical analysis are some of the reasons for uncertainty regarding the age at menopause (Amundsen and Diers, 1973).

The age at menopause in the classical period has previously been reported as probably between 40-45, menopause began about the age of 40 in ancient times, and at the age of about 45 in the middle ages and beyond until the 19th century. Aetius, Physician to Justinian, in 6th century Byzantium wrote in *Tetrabiblos*;; “The menses do not cease before the 35th year nor appear after the 50th , rarely some menstruate until the sixtieth year (table 1). Those who are very fat cease early.”

Data concerning the age of menopause during the classical era are not quite as plentiful as those dealing with menarche. As with menarche, the earliest noted references to the age of menopause appear in the Aristotelean writings and in the Hippocratic Corpus. Aristotle (384-322B.C.) wrote in *Historia Animalium*, (VII,5, 585a):- “The menses cease in most women around the fortieth year and in those in whom it goes on longer the menses continue until the fiftieth year, and at this time some women of that age have borne children; but none beyond that age. For the most part - ‘Fifty marks the limit of the capacity of reproduction in women’ Pliny the Elder (1st cent.A.D.) briefly mentions the age of menopause in his *Historia Naturalis*, (VII,XIV,61): “A woman does not bear children after the age of fifty, and with the majority menstruation cease at Forty” (Amundsen and Diers, 1970).

The age of the last menstrual period appears to be fixed more rigidly than that

at which the menarche occurs- a woman’s first menstruation. According to historic literature, the average menopausal age has not changed for the last 2000 years. This contrasts with the marked downward shift of the age at menarche, which is thought to be caused by nutritional factors. Menopause before 48 years has been found in only a few modern-day, non-caucasian populations (e.g. Philippines, New Guinea, Mexico). External factors such as nutrition or high altitude may cause this early menopause.(Hollihn,1997).

In industrialized societies the average age at menopause is about 51 years. In most reports, women from developing countries are found to be older at menarche and younger at menopause than women in industrialized countries. Similar studies, some restricted to isolated populations in Papua, New Guinea and the Philippines, or in various parts of Africa, India, Pakistan and Thailand have reported younger ages at menopause, i.e. late forties. (Okonofua et al, 1990,Sukwatana et al, 1991; Singh and Arora, 2000; Kaur, 2001)

Table 1

Summary of the Age at Menopause According to Medieval Sources

(Amundsen and Diers, 1970)

Cited age at Menopause

Author	Century	Minimum	Average	Maximum
Aristotle	4 th cent.B.C.	—	40	50
Diocles	4 th cent.B.C.	—	—	60
Hippocratic Corpus	4 th cent.B.C.	—	42	—
Pliny	1 st cent.A.D.	—	40	50
Soranus	1 st /2 nd cent.A.D.	—	40-50	60
Oribasius	4 th cent.A.D.	35	50	60
Aetius	6 th	35	50	60
Paulus Aegineta	7 th	35	50	60
Trotula	11 th /12 th	35	50	75

Hildegard	12 th	-	50	60-80
Thoumas of Cantiumpre	13 th	-	50	-
Gilberus Anglicus	13 th	-	50	-
John of Gaddesden	14 th	35	50	-
Ortolff the Bavarian	15 th	-	40-50	-

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सारांश

रजोनिवृत्ति एवं रजोनिवृत्त आयु की एक ऐतिहासिक स्वरूप

अमरजीत सिंह, सुखबिन्दर कौर एवं श्रीमति इन्दरजीत वालिया

रजोनिवृत्ति का संदर्भ प्राचीन ग्रंथों में कम ही मिलता है। हां अरस्तू ने रजोनिवृत्ति की आयु 40 वर्ष होने का प्रस्ताव अवश्य किया है। सर्वप्रथम एक फ्रांसीसी डाक्टर ने 'मैनोपॉज' शब्द का प्रयोग 1821 में किया था। 19 वीं शताब्दी के मध्य में रजोनिवृत्ति में चिकित्सीय क्षेत्र का रुझान काफी बढ़ गया। लोगों ने 1930 के दशक में मैनोपॉज को एक तरह की कमी की बीमारी कहना शुरू कर दिया। फलश्वरूप, तरह तरह की औषधियों का प्रयोग परीक्षण के तौर पर किया गया, जैसे जानवरों के अंडकोष / अंडाशय का सत्व।

1970 के दशक में मैनोपॉज का पूर्ण रूप से औषधीकरण / चिकित्सीकरण हो गया। रजोनिवृत्ति के लक्षणों का कारण ईस्ट्रोजन की कमी बताया गया तथा प्रौढ़ महिलाओं के जीर्णोद्धार / उत्थान के लिए एच. आर. टी. राम बाण की तरह उभर कर सामने आयी। 1938 में कृत्रिम ईस्ट्रोजन बना लिया गया। औषधी निर्माण में लगी कम्पनियाँ बृहत् रूप से इस क्षेत्र में प्रवेश कर पूरी तरह से छा गईं। 1970 दशक के मध्य में अंतर्राष्ट्रीय मैनोपॉज सोसाइटी की नींव रखी गई। 1976 में पेरिस, फ्रांस में पहली अंतर्राष्ट्रीय मैनोपॉज कांफ्रेंस आयोजित हुई। कई देशों ने राष्ट्रीय स्तर पर निजी मैनोपॉज सोसाइटियां बनाईं। रजोनिवृत्ति के प्रमुख लक्षण अलग-अलग देशों में अलग - अलग पाए गए- जैसे पश्चिमी देशों में हॉट फ्लश (चेहरे / गर्दन पर लाली / पसीना), जापान में कंधों का दर्द और भारत में नजर कमजोर होना। एच. आर. टी. का प्रचलन पश्चिमी देशों में बहुत है। जबकि भारत जैसे देश में यह बहुत कम या बिल्कुल नहीं है। रजोनिवृत्ति की आयु पश्चिमी देशों में 50 के आसपास है जबकि भारत में यह 45-47 वर्ष के बीच है। प्राचीन काल में सारे संसार में रजोनिवृत्ति कम उम्र (40 वर्ष) तक हो जाती थी। अब पश्चिमी देशों में यह धीरे-धीरे 50-51 वर्ष तक पहुंच गई है। पश्चिमी देशों की महिलाओं का मैनोपॉज के प्रति दृष्टिकोण वस्तुतः नकारात्मक है। इसके विपरीत भारत जैसे विकासशील देश में महिलाओं का रजोनिवृत्ति के प्रति सकारात्मक रवैया है।