

# اندوکرینولوژی بالینی زنان و ناباروری اسپروف

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## دوران گذار یائسگی و هورمون درمانی یائسگی

### یک مرور کلی

شروع بیماری‌ها یا معلولیت‌های عمده (و حتی مرگ) در همسر، اقوام و یا دوستان؛ بازنشسته شدن؛ ناامنی مالی؛ نیاز به مراقبت کردن از والدین یا اقوام بسیار پیر و جدایی از فرزندان. بنابراین جای تعجب نیست که یائسگی، که یکی دیگر از وقایع میانسالی است، در ایجاد این احساسات منفی دخیل باشد.

تأثیر قدرتمند باورهای اجتماعی و فرهنگی و نیز سنت‌ها، پژوهش علمی تمامی جوانب پدیده قاعدگی را دشوار کرده است. مشکلات ناشی از اتفاقاتی که در زندگی فرد می‌افتند اغلب به اشتباه به یائسگی نسبت داده می‌شوند. اما داده‌ها، به ویژه داده‌هایی که در پژوهش‌های طولی از دل جامعه به دست آمده‌اند این نکته را اثبات کرده‌اند که افزایش اغلب علائم و مشکلات در زنان میانسال بازتاب شرایط اجتماعی و فردی است و نه تغییرات هورمونی مربوط به یائسگی (۱۱-۲). تنوع تغییرات ناشی از یائسگی باعث می‌شود که پژوهش‌های مقطعی برای بررسی این پدیده مناسب نباشند. برای پی بردن به آنچه که طبیعی است و واریاسیون‌هایی که نسبت به حالت طبیعی وجود دارند، پژوهش‌های طولی بهتر هستند.

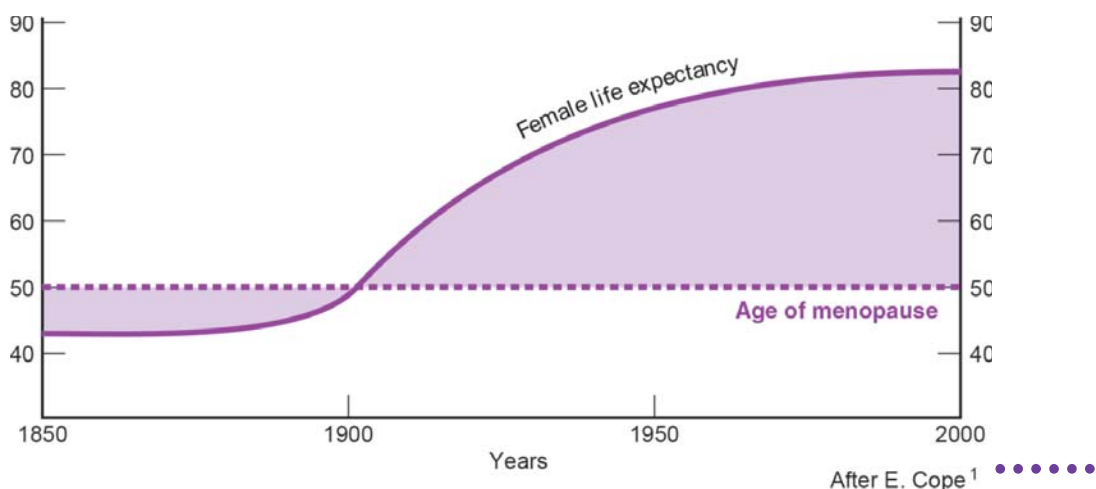
پژوهش سلامت زنان ماساچوست یک پژوهش آینده‌نگر طولی بزرگ و جامع بر روی زنان میانسال است که شواهد قدرتمندی مبنی بر این واقعیت فراهم کرده است که یائسگی یک پدیده منفی نیست و بخش اعظم زنان نباید به آن به عنوان یک تجربه منفی نگاه کنند (۱۲، ۳). زنان وارد شده به این پژوهش (و نیز زنان شرکت‌کننده در سایر پژوهش‌های طولی)، معتقد بودند قطع شدن قاعدگی‌ها تقریباً هیچ آسیبی برای سلامت جسمی و روانی آنها نداشته است، زیرا این زنان،

در طول تاریخ شرایط جسمی و روحی متعددی به یائسگی نسبت داده شده‌اند. گرچه نویسندگان حوزه پزشکی در گذشته درباره این موضوع، بسیار نوشته‌اند اما امروزه اطلاعات علمی و داده‌ها نشان داده‌اند که متأسفانه نوشته‌های آنها صحت نداشته است.

یک نمونه خوب از طرز تفکر نادرستی که طی سال‌ها در مورد این موضوع وجود داشته است را می‌توان در نوشته زیر (نوشته شده به سال ۱۸۸۷) دید (۱):

تخمندان‌ها پس از سال‌ها فعالیت، در سنین بالا از کار نمی‌افتند بلکه تحریک می‌شوند و این تحریک را به گانگلیون‌های عصبی شکم و سپس از آن راه به مغز منتقل می‌کنند. این فرایند باعث ایجاد اختلال در بافت‌های مغزی می‌شود که خود را به شکل عصبی بودن بیش از حد و یا پیدایش ناگهانی جنون نشان می‌دهد.

باور به این‌که اختلالات رفتاری مربوط به تظاهرات سیستم تولید مثل زنان هستند اعتقاد کهنی است که تا به امروز نیز ادامه دارد. این طرز نگاه به پدیده یائسگی را نمی‌توان کاملاً غیرمنطقی دانست؛ دلیلی وجود دارد که به موجب آن می‌توان سال‌های میانی عمر را با تجربیات ناخوشایند همراه دانست. وقایعی که ممکن است به ذهن بیایند وقایع اثرگذاری هستند:



شکل ۱-۱۷

After E. Cope<sup>1</sup>

نمی‌کنند (۱۴، ۱۳). بنابراین ضرورت دارد که پزشکان نه تنها با واقعیت‌های مرتبط با یائسگی آشنا باشند بلکه دید و نگرش درستی نسبت به این دوره از زندگی داشته باشند. به مداخلات پزشکی که در این دوره صورت می‌گیرد باید به عنوان فرصتی برای ارائه و تقویت یک برنامه مراقبت پیشگیرانه سلامتی نگاه کرد. برنامه‌های مراقبت پیشگیرانه برای زنان، برنامه‌های آشنایی هستند و عبارت‌اند از تنظیم خانواده، ترک سیگار، کنترل وزن بدن و مصرف الکل، پیشگیری از بیماری‌های قلبی عروقی و استئوپروز، حفظ سلامت روانی (شامل سلامت جنسی)، غربالگری برای سرطان و درمان مشکلات مربوط به دستگاه ادراری.

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### زیاد شدن جمعیت افراد مسن

امروزه با پدیده نسبتاً جدیدی روبرو هستیم: می‌توانیم انتظار داشته باشیم که به سن پیری برسیم. ما در مرز تبدیل به یک جامعه مستطیلی هستیم که در آن تقریباً همه افراد به سن بالا می‌رسند.

در سال ۱۰۰۰ پیش از میلاد میزان امید به زندگی فقط ۱۸ سال بود. تا سال ۱۰۰ پیش از میلاد، در زمان جولوس سزار، این میزان به ۲۵ سال رسید. در سال ۱۹۰۰، میزان امید به زندگی در ایالات متحده تنها ۴۹ سال بود (شکل ۱-۱۷). در سال ۲۰۰۵

احساساتی خنثی و یا مثبت نسبت به یائسگی داشتند. استثنای این موضوع، گروه زنانی بودند که با جراحی یائسه شده بودند. البته در این دسته از زنان نیز کاملاً معقول است که فکر کنیم علل جراحی، برای بیمار از قطع قاعدگی مهمتر بوده‌اند.

تغییراتی که در کارکرد قاعدگی رخ می‌دهند تغییرات ترسناک و تهدیدآمیزی نیستند. در پس تغییرات کارکرد قاعدگی، دلایل فیزیولوژیک موجهی وجود دارند و درک فیزیولوژی این پدیده کمک می‌کند فرد نگرش درستی نسبت به این قضیه داشته باشد. نگرش فرد و انتظارات وی از یائسگی بسیار مهم‌اند. در زنانی که مراجعات بیشتری به مراکز بهداشتی دارند و در آنها که انتظار دوران سختی را دارند علائم بیشتر هستند و افسردگی شدیدتر است (۹، ۸، ۴). علائمی که زنان گزارش می‌کنند به عوامل متعددی در زندگی آنها بستگی دارند و تغییرات هورمونی دوران یائسگی را نمی‌توان مسؤول گرفتاری‌های شایع روانی - اجتماعی و سبک زندگی دانست که همه ما تجربه می‌کنیم. نکته مهم این است که باید بر طبیعی بودن این وقایع فیزیولوژیک تأکید شود. زنان یائسه دچار بیماری (به ویژه یک بیماری ناشی از کمبود هورمونی) نیستند و به هورمون درمانی پس از یائسگی باید به چشم درمان اختصاصی علائم فرد در کوتاه‌مدت و درمان پیشگیرانه در درازمدت نگاه کرد.

نکته دیگری که باید به آن توجه شود این است که پزشکان نگرشی سوگیرانه (منفی) نسبت به این پدیده دارند چرا که اغلب زنانی که سالم و سرحال هستند اصلاً به پزشکان مراجعه

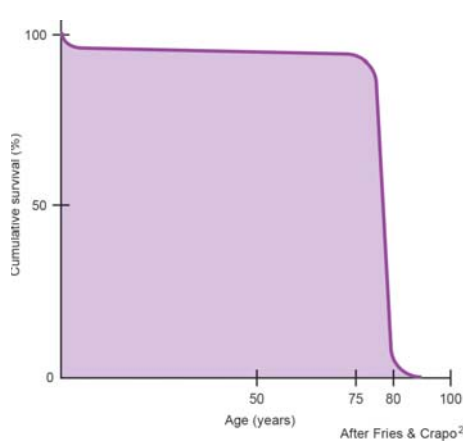


سال ۲۰۵۰ خواهد رسید (۲۰). علاوه بر رشد جمعیت، پیر شدن جمعیت را نیز باید به عنوان یکی از مشکلات اجتماعی مهم در نظر گرفت.

سرعت تغییر، تحت تأثیر دو پدیده نوین است. اولین پدیده، تولد تعداد زیادی نوزاد در سال‌های پس از جنگ جهانی دوم (۱۹۴۴-۱۹۴۶) است که پیر شدن جمعیت را موقتاً به تعویق انداخت اما امروزه باعث تسریع پیر شدن جمعیت عمومی شده است. پدیده مهم دیگر، کاهش میزان مرگ‌ومیر افراد مسن است. موفقیت ما در به تعویق انداختن مرگ باعث افزایش تعداد افراد در بخش بالایی منحنی جمعیت‌شناسی شده است (شکل ۳-۱۷). تا سال ۲۰۵۰، جوامع توسعه یافته فعلی، همگی جوامعی مستطیلی خواهند بود. تعداد افراد بالای ۶۵ سال در چین تا سال ۲۰۵۰ بیش از تعداد کل افرادی (در همهٔ سنین) خواهد بود که در حال حاضر در ایالات متحده زندگی می‌کنند (جدول ۱-۱۷).

این تغییرات، فراگیر هستند و محدود به جوامع مرفه نیستند (۲۱). جمعیت جهان تا سال ۲۱۰۰ یا ۲۱۵۰ به رشد خود ادامه خواهد داد و انتظار می‌رود که در آن هنگام به ۱۱ میلیارد نفر برسد و تثبیت شود. پس از سال ۲۰۲۰ تمام این رشد جمعیت در کشورهای در حال توسعه رخ خواهد داد (۲۰). در سال ۲۰۰۰، ۸۷٪ جمعیت جهان مربوط به فقیرترین کشورها (واقع در آفریقا و آسیا) بوده است. در سال ۱۹۵۰ تنها ۴۰٪ از افراد ۶۰ ساله و بیشتر در کشورهای در حال توسعه زندگی می‌کردند. تا سال ۲۰۵۰ در حدود ۸۰٪ از این افراد در آن کشورها زندگی خواهند کرد زیرا انتظار می‌رود میزان باروری در این کشورها از ۲/۷۳ فرزند به ازای هر زن در سال‌های ۲۰۱۰-۲۰۰۵ به ۲/۰۵ در سال ۲۰۵۰ برسد (۲۰).

در جمعیت‌های مسن یک تفاوت جنسیتی در بقا شناسایی شده است. در سال ۱۹۰۰ تعداد مردان بالای ۶۵ سال در ایالات متحده بیش از زنان بود (۱۰۲ در برابر ۱۰۰). امروزه به ازای هر ۱۰۰ زن بالای ۶۵ سال، تنها ۷۰ مرد وجود دارد (۲۲). در سن ۸۵ سالگی به ازای هر ۱۰۰ زن تنها ۳۹ مرد وجود دارد. نزدیک ۹۰٪ از زنان آمریکایی سفیدپوست می‌توانند امید داشته باشند که تا سن ۷۰ سالگی زنده بمانند. داده‌های آمار حیاتی نشان می‌دهند که این تفاوت جنسیتی در جمعیت سفیدپوستان و سیاه‌پوستان ایالات متحده، مشابه است (شکل ۴-۱۷). نزدیک ۵۵٪ از دختران آنقدر زنده می‌مانند که تولد ۸۵ سالگی‌شان را جشن بگیرند؛ این میزان برای پسران ۳۵٪ است (۲۴). از هر ۵۶۰ نفر، یک نفر می‌تواند امید داشته باشد که به ۱۰۰ سالگی برسد (۲۲).

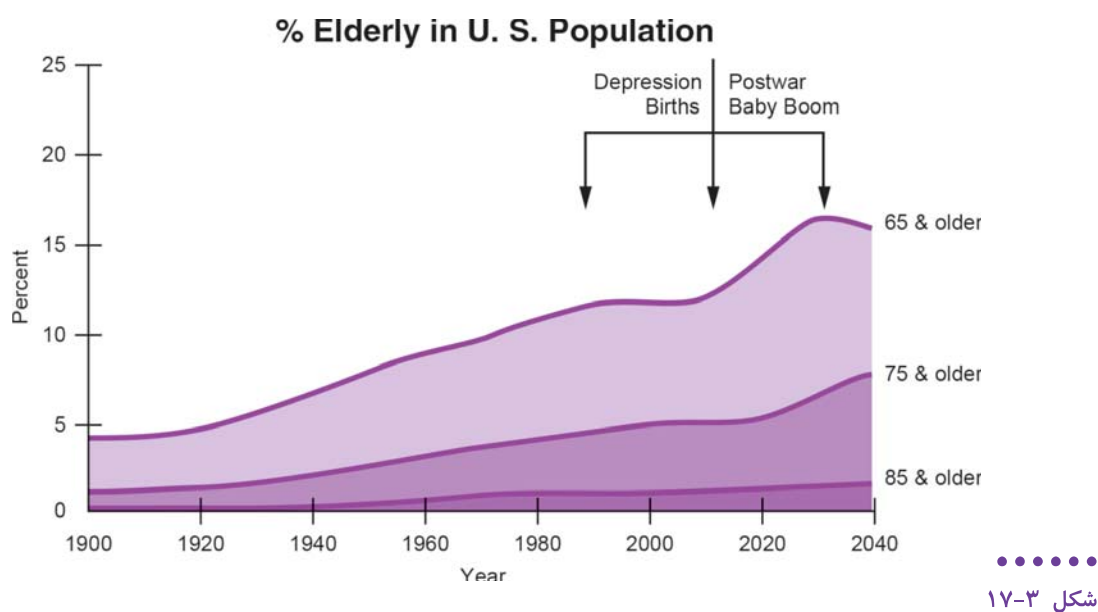


شکل ۲-۱۷

میزان امید به زندگی به طور متوسط برای زنان ۸۰/۷ سال و برای مردان ۷۵/۴ سال بود (۱۵). امروزه هنگامی که به ۶۵ سالگی برسید، اگر مرد باشید می‌توانید امید داشته باشید که به ۸۳ سالگی و اگر زن باشید می‌توانید امید داشته باشید که به ۸۵ سالگی برسید (۱۶). پیش‌بینی می‌شود که در نهایت حدود دوسوم جمعیت به سن ۸۵ یا بیشتر برسند و بیش از ۹۰٪ افراد بیش از ۶۵ سال زندگی کنند - که نزدیک صددرصد نشان‌دهنده یک جامعهٔ مستطیلی خواهد بود (شکل ۲-۱۷). هم‌اکنون سوئد و سوئیس نسبت به سایر کشورها به این ترکیب جمعیتی نزدیک‌ترینند.

یک تعریف عمومی خوب برای پیری سن ۶۵ سالگی به بالا است اگرچه درصد قابل توجهی از افراد مسن تا قبل از سن ۷۵ سالگی ضعف‌ها و مشکلات بارز پیری را نشان نمی‌دهند. امروزه، جمعیت مسن علت اصلی بیماری و نیازهای انسانی در ایالات متحده هستند و تعداد افراد مسن (و نیازهای قابل توجهشان) امروزه از هر زمان دیگری بیشتر است (۱۹). در سال ۱۹۰۰ تقریباً ۳ میلیون از آمریکایی‌ها ۶۵ سال و بیش از آن سن داشتند (در حدود ۴٪ از کل جمعیت)، و در سال ۲۰۰۰، این تعداد به ۳۵ میلیون (در حدود ۱۲٪ کل جمعیت) رسید. تا سال ۲۰۳۰ جمعیت افراد مسن در ایالات متحده تقریباً به ۷۰ میلیون نفر خواهد رسید و از هر ۵ آمریکایی، یک نفر مسن خواهد بود (۱۹). جمعیت افراد مسن دنیا از سال ۱۹۹۸ تا ۲۰۲۵ بیش از ۲ برابر خواهد شد و از ۲۶۴ میلیون در سال ۲۰۰۹ به ۴۱۶ میلیون



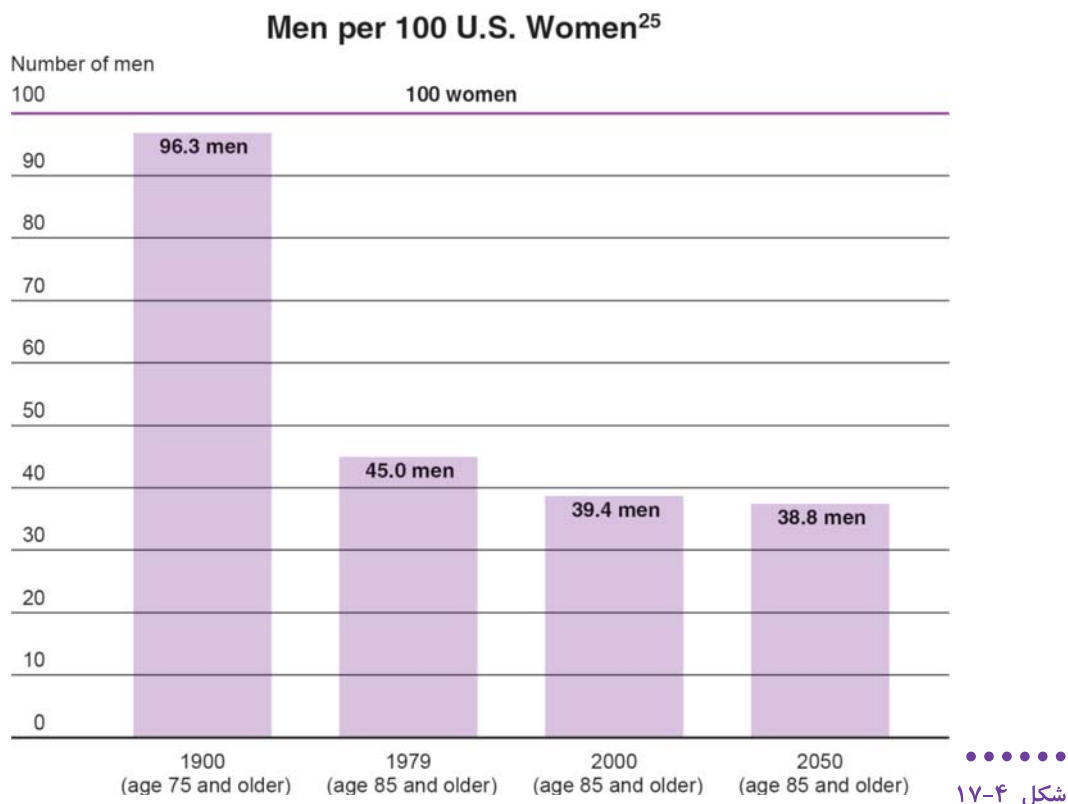


جدول ۱۷-۱ شمارگان کنونی جمعیت جهان			
رشد	مرگ	تولد	
۸۹,۴۵۸,۰۰۰	۵۱,۳۱۵,۰۰۰	۱۴۰,۷۷۲,۰۰۰	سال
۷,۴۵۴,۸۳۴	۴,۲۷۶,۲۵۰	۱۱,۷۳۱,۰۸۰	ماه
۲۴۵,۰۹۰	۱۴۰,۵۸۹	۲,۷۰۷,۱۷۳	هفته
۱۰,۲۱۲	۵,۸۵۸	۱۶,۰۷۰	ساعت
۱۷۰	۹۶	۲۶۸	دقیقه
۲/۸	۱/۶	۴/۵	ثانیه

۸. آنفلوانزا و پنومونی  
 ۹. بیماری‌های کلیوی  
 ۱۰. خودکشی
- عدد ۱۰ علت اصلی مرگ در ایالات متحده در سال ۲۰۱۶ به ترتیب زیر بوده‌اند (۱۶):

۱. بیماری قلبی
۲. سرطان
۳. آسیب‌های ناخواسته
۴. بیماری‌های مزمن دستگاه تنفسی تحتانی
۵. سکته مغزی
۶. بیماری آلزایمر
۷. دیابت ملیتوس

دورنمای سلامتی مردان و زنان در سنین بالا متفاوت است. هورمون‌های جنسی است که باعث تفاوت در نمایه کلسترول - لیپوپروتئین و سایر عوامل مرتبط با قلب و عروق می‌شوند و در نهایت به این می‌انجامد که میزان آترواسکلروز و مرگ‌های زودرس در مردان بیشتر باشد (البته همه اینها جای بحث دارد). از دیدگاه سلامت عمومی، بیشترین میزان تأثیر در این تفاوت



جدول ۱۷-۲ جمعیت زنان مسن ایالات متحده				
سن	۱۹۹۰	۲۰۰۰	۲۰۱۰	۲۰۲۰
۵۵-۶۴	۱۰/۸ (%۸/۶)	۱۲/۱ (%۹/۰)	۱۷/۱ (%۱۲/۱)	۱۹/۳ (%۱۲/۹)
۶۵-۷۴	۱۰/۱ (%۸/۱)	۹/۸ (%۷/۳)	۱۱/۰ (%۷/۸)	۱۵/۶ (%۱۰/۴)
> ۷۵	۷/۸ (%۶/۲)	۹/۳ (%۷/۰)	۹/۸ (%۶/۹)	۱۱/۰ (%۷/۳)
مجموع	۲۸/۷	۳۱/۲	۳۷/۹	۴۵/۹

سوم دیگر از این تفاوت ناشی از سرطان ریه، آمفیژم، سیروز، سوانح و خودکشی است. جالب است بدانید در جامعه آمریکا، تفاوت میزان مرگومیر در زنان و مردان بیشتر به دلیل تفاوت در شیوه زندگی است. بیشتر بودن میزان مرگومیر در سن بالای ۶۵ سال در مردان عمدتاً ناشی از کشیدن سیگار، نوشیدن الکل، رفتارهای مستعدکننده ایجاد بیماری‌های کرونر و سوانح است. برآورد می‌شود که تنها سیگار کشیدن، مسؤول دوسوم این

جنسی در میزان مرگومیر را می‌توان با تغییر سبک زندگی (به منظور کاهش میزان آترواسکلروز) اعمال کرد. این تغییرات عبارت‌اند از: رژیم کم کلسترول، ترک سیگار، حفظ وزن بدن در حد ایده‌آل و ورزش. میزان مرگومیر در تمامی سنین در مردان بیشتر است، و بنابراین زنان در جمعیت‌های مسن نمایندگان بیشتری دارند (جدول ۱۷.۲). بیماری عروق کرونر (CHD) مسؤول ۴۰٪ از تفاوت مرگومیر میان مردان و زنان است. یک

### چهارگوش شدن زندگی

طول عمر عبارت است از مرز زندگی از نظر زیست شناختی و بیشترین سنی که اعضای یک گونه خاص می‌توانند به آن برسند. باور عمومی بر این است که طول عمر انسان در حال افزایش است در حالی که واقعیت این است که طول عمر ثابت است و در واقع یک ثابت زیست شناختی برای هر گونه است (۲۹). در حقیقت تفاوت‌هایی که در میزان طول عمر گونه‌های مختلف دیده می‌شود نشان‌دهنده زمینه ژنتیکی هر کدام از آنها برای داشتن عمر طولانی است. ثابت نبودن طول عمر به این معنا خواهد بود که جمعیت افراد مسن به صورت نامحدود در حال افزایش است، در حالی که تجزیه و تحلیل درست میزان بقاء نشان می‌دهد که بیشینه سنی که مرگ در آن رخ می‌دهد ثابت است. در حقیقت آنچه که افزایش یافته است امید به زندگی است که نشانگر تعداد سال‌هایی است که انتظار می‌رود فرد از زمان تولد زندگی کند. امید به زندگی نمی‌تواند بیشتر از طول عمر باشد اما می‌تواند تا حد زیادی به آن نزدیک شود. بنا بر آنچه گفته شد تعداد افراد مسن در نهایت از یک حد ثابت فراتر نخواهد رفت اما درصد سال‌هایی از زندگی که در دوران پیری سپری می‌شوند افزایش خواهد یافت (شکل ۲-۱۷).

در جامعه آمریکا مرگ‌های پیش از موعد تقریباً دیگر دیده نمی‌شوند. بیماری‌های قلبی عروقی و سرطان‌ها در حال حاضر علل اصلی مرگ‌ومیر هستند. علت این پدیده، افزایش شیوع این بیماری‌ها و یا اپیدمی شدن آنها نیست بلکه در واقع ناشی از موفقیت کامل در از بین بردن بیماری‌های عفونی است. امروزه علل اصلی مرگ‌ومیر بیماری‌های مزمن (که خود تحت تأثیر ژنتیک، سبک زندگی و محیط قرار دارند) و خودکهورت هستند. با این حال حتی اگر بتوان سرطان، دیابت و تمامی بیماری‌های عروقی را به طور کامل از میان برداشت، باز هم امید به زندگی بیش از ۹۰ سال نخواهد بود (۱۷).

جی.اف. فرایز<sup>۱</sup> سه دوره تاریخی را در سلامت و بیماری توصیف کرده است (۳۰). دوره اول تا سال‌های اولیه دهه ۱۹۰۰ ادامه داشته و ویژگی آن بیماری‌های عفونی حاد بوده است. دوره دوم هم‌اکنون است که ویژگی‌اش بیماری‌های قلبی عروقی و سرطان است. این دوره در حال اتمام است و دوره سوم در حال شروع شدن است که ویژگی آن مشکلات پیری (کاهش دید و شنوایی، اختلال در حافظه و کارکردهای شناختی، کاهش توان و

اختلاف در میزان مرگ‌ومیر است، چرا که شیوع کشیدن سیگار در مردان بیشتر است. در زنانی که الگوی سیگار کشیدنشان مشابه مردان است، میزان افزایش خطر مرگ‌ومیر و بیمارمندی همانند مردان است (۲۵).

میزان تفاوت جنسیتی در میزان مرگ‌ومیر از سال ۱۹۷۹ رو به کاهش نهاده است. اداره سرشماری ایالات متحده نشان داده است که میزان تفاوت در امید به زندگی بین زنان و مردان تا سال ۲۰۵۰ افزایش خواهد یافت و سپس به حد ثابتی خواهد رسید. در سال ۲۰۵۰، امید به زندگی در زنان ۸۲ سال و در مردان ۷۶/۷ سال خواهد بود (۲۶). همچنین تعداد زنان ۶۵ ساله و بالاتر ۳۳/۴ میلیون نفر و تعداد مردان ۶۵ ساله و بالاتر ۲۲/۱ میلیون نفر خواهد بود.

علاوه بر افزایش تعداد افراد مسن، خود جمعیت افراد مسن نیز در حال پیرتر شدن است. در سال ۱۹۸۴، جمعیت گروه سنی ۶۵-۷۴ سال در ایالات متحده، ۷ برابر سال ۱۹۰۰ بوده است، اما جمعیت گروه سنی ۸۴-۷۵ سال نسبت به سال ۱۹۰۰، ۱۱ برابر و جمعیت گروه سنی ۸۵ ساله و بالاتر، ۲۱ برابر بیشتر شده است. در دهه ۱۹۹۰ جمعیت افراد ۸۵ ساله و بالاتر تا ۳۸٪ افزایش یافت (۲۲). انتظار می‌رود سریعترین افزایش بین سال‌های ۲۰۱۰ و ۲۰۳۰ اتفاق بیفتد چرا که در این سال‌ها، نوزادانی که در انفجار جمعیتی پس از جنگ جهانی دوم به دنیا آمده‌اند، به سنین ۶۵ و بالاتر خواهند رسید. تنها گروه سنی در ایالات متحده که انتظار می‌رود در قرن آینده رشد قابل توجهی داشته باشد گروه سنی بالای ۵۵ سال است. در این گروه سنی، نسبت زنان به مردان، ۲/۶ به ۱ خواهد بود. تا سال ۲۰۴۰ در ایالات متحده ۱۳-۸ میلیون فرد ۸۵ ساله و پیرتر وجود خواهد داشت. تفاوت بین ۸ و ۱۳ اختلاف پیش‌بینی منفی‌نگرانه با خوش‌بینانه درباره پیشگیری و درمان بیماری‌ها است.

در میان جمعیت سالمند، نسبت زنان مجرد افزایش خواهد یافت. احتمال بیوه شدن در زنان مسن بیشتر از مردان مسن است (۵۹٪ در برابر ۲۲٪) (۲۷). نیمی از مردان ۸۵ ساله و مسن‌تر با همسرانشان زندگی می‌کنند در حالی که تنها ۱۰٪ از زنان مسن با شوهرانشان زندگی می‌کنند (۲۸). چون افراد مجرد بیشتر آسیب‌پذیر هستند نیاز به خدمات برای این بخش از جمعیت پیر بیشتر خواهد بود. افراد مسن مجرد آسیب‌پذیرتر هستند، میزان مرگ‌ومیر در آنها بیشتر و میزان رضایت از زندگی کمتر است.

مقعد مشاهده شده است. از اواسط دهه ۱۹۷۰ تا اوایل دهه ۱۹۹۰، میزان سیگار کشیدن در پزشکان ایالات متحده از ۱۸/۸٪ به ۳/۳٪ رسیده است. متأسفانه همین میزان اندک نیز نمایانگر نزدیک ۱۸۰۰۰ پزشک سیگاری است. از میان آن دسته از جمعیت ایالات متحده که دیپلم دبیرستان ندارند، نزدیک ۳۵ درصد سیگاری هستند. این در حالی است که شیوع مصرف سیگار در میان دارندگان تحصیلات بالاتر ۱۲٪ و در میان دارندگان مدرک دانشگاهی تنها ۵/۷٪ است. در حال حاضر نزدیک ۱۷/۵٪ از مردان و ۱۳/۵٪ از زنان سیگار می‌کشند (۱۶). کشیدن سیگار در میان دانش‌آموزان دبیرستانی در سال ۱۹۹۷ به اوج خود رسید و سپس به حد کنونی خود (۱۵/۵٪) رسید (۱۶). علاوه بر این، ۱۴٪ از دانش‌آموزان دبیرستانی از سیگار برگ و ۸٪ از آنها از تنباکوی جویدنی استفاده می‌کنند. استفاده از تنباکوی جویدنی، پپ و سیگار برگ به میزان چشمگیری با بیمارمندی و مرگومیر مرتبط است. به همین دلیل تنباکو یگانه و قابل پیشگیری‌ترین علت بیماری‌های زودهنگام و مرگ در ایالات متحده است. نکته قابل توجه اینجا است که آسیب‌های سیگار کشیدن بر روی زنان بیشتر از مردان است (۳۳). خطر بیماری‌های کشندهٔ عروق کرونر قلب در زنانی که روزانه فقط ۴-۱ نخ سیگار می‌کشند ۲/۵ برابر افزایش می‌یابد (۱۴).

ترک سیگار پس از دهه‌ها سیگار کشیدن سودمند است، و آثار سودمند آن با گذشت یک ماه از ترک پدیدار می‌شوند (۳۵). در پژوهش سلامت پرستاران، با گذشت ۵ سال از ترک سیگار، ۶۱٪ از افزایش خطر مرگومیر ناشی از بیماری‌های کرونری قلب و ۴۲٪ از میزان مرگومیر ناشی از سکنه‌های مغزی از بین رفته بود (۳۶). از بین رفتن تأثیر سیگار کشیدن بر مرگومیر ناشی از بیماری‌های تنفسی کندتر است و حتی پس از ۳۰ سال نیز افزایش خطر اندکی در میزان مرگومیر ناشی از سرطان ریه وجود خواهد داشت. با این حال ۲۰ سال پس از ترک سیگار، میزان خطر مرگومیر ناشی از بیماری‌های عروقی و مرگ ناشی از بیماری‌های تنفسی (به غیر از سرطان ریه) به حد افراد غیرسیگاری خواهد رسید. حتی در بیماران مسن‌تری که دچار بیماری‌های عروق کرونر هستند در صورت ترک سیگار میزان بقاء افزایش خواهد یافت (۳۷). جدا از این‌که فرد چقدر سن دارد، ادامهٔ سیگار کشیدن باعث افزایش خطر نسبی مرگ خواهد شد. همچنین صرف‌نظر از سن فرد، ترک سیگار خطر مرگ را کاهش خواهد داد. با این حال حتی در افرادی که قبلاً به مدت

اندوخته) است. اغلب رویکردهای پزشکی ما هنوز بر پایه دوره اول است (پیدا کردن بیماری و درمان آن)، اما شرایط کنونی به گونه‌ای است که باید علاوه بر رویکرد پزشکی، رویکردهای روان‌شناختی و اجتماعی را نیز وارد میدان کرد. تمرکز ما بر روی بیماری‌های مزمن و کشندهٔ وابسته به سن بوده است، اما آنچه چالش‌های جدیدی برانگیخته است مشکلات غیرکشنده و وابسته به پیری مانند بیماری آلزایمر، استئوآرتریت، استئوپروز، چاقی و بی‌اختیاری است. می‌توان گفت که ارزیابی برنامه‌های بهداشتی در سال‌های آینده به جای تأثیر آنها بر میزان مرگومیر، باید بر پایه توانایی آنها را در ایجاد سال‌هایی بدون معلولیت باشد.

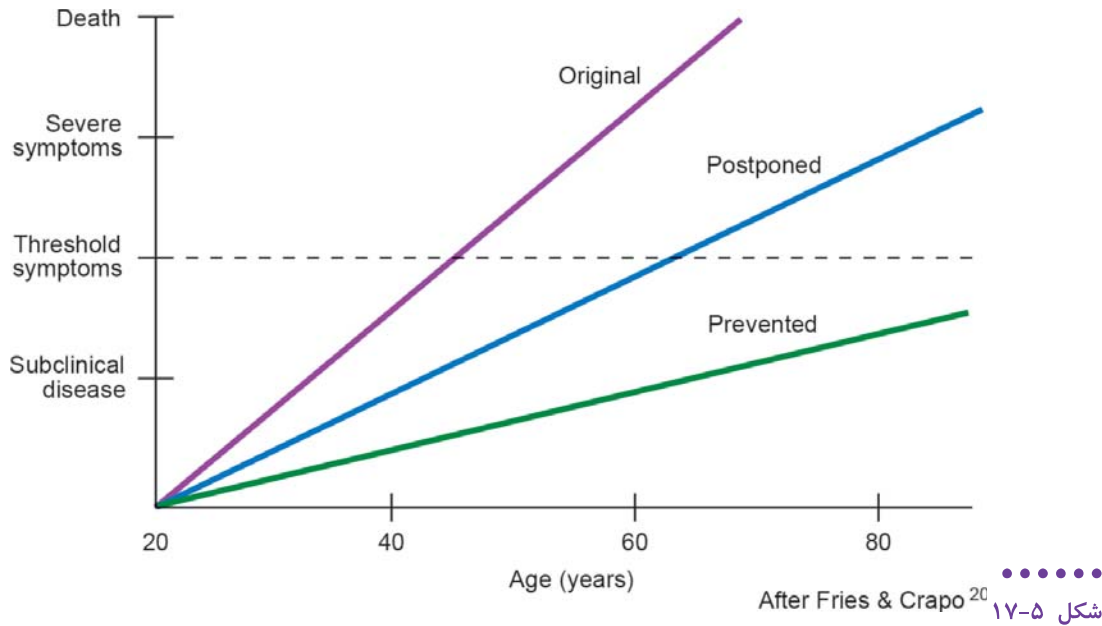
### مفهوم کوتاه کردن بیمارمندی

بیماری‌های مزمن، رشد فزاینده‌ای دارند. بهترین راهکار سیستم‌های بهداشتی در برخورد با این بیماری‌ها سعی در تغییر شیب منحنی رشد آنها، کاهش سرعت پیشرفت بیماری و در نتیجه به تعویق انداختن نمود بیماری از لحاظ بالینی و در صورتی که بیماری به حد کافی به تعویق افتاد، پیشگیری مؤثر از آن است. آگاهی عمومی جوامع نسبت به بیماری‌ها به طرز چشمگیری تغییر کرده است. به طور روزافزون به بیماری به چشم مشکلی که بهترین روش برخورد با آن درمان دارویی یا جراحی است نگاه نمی‌شود بلکه بهترین درمان را پیشگیری می‌دانند.

جی.اف. فرایز پیشگیری از بیماری را **کوتاه کردن**

**بیمارمندی** می‌نامد (۳۱ و ۲۹). در صورت پیشگیری از بیماری، انسان‌ها زندگی نسبتاً سالمی خواهند داشت و دوران بیمار بودن آنها به یک دوره کوتاه قبل از مرگ محدود خواهد بود. اما آیا این تغییر واقعاً امکان‌پذیر است؟ مثال خوبی که این مورد را تأیید می‌کند کاهش آنرواسکلروز در ایالات متحده است. علل این کاهش عبارت‌اند از کاهش مصرف چربی‌های اشباع شده، کارآمدتر شدن روش‌های تشخیص و درمان پرفشاری خون، افزایش فعالیت بدنی و کاهش میزان سیگار کشیدن (شکل ۱۷-۵).

میزان پزشکان سیگاری از ۷۹٪ به اقلیت ناچیزی رسیده است (۳۲). نکته جالب و قابل تأمل این است که بیشترین میزان کاهش در مصرف سیگار در میان جراحان ریه بوده (که البته جای شگفتی نیست) و کمترین میزان آن در میان متخصصان رکتوم و



### یائسگی به عنوان یک فرصت

یائسگی یک دوره طبیعی از زندگی است؛ نباید آن را غیرطبیعی انگاشت. برای بسیاری از زنان، این تغییر خوشایند است - دیگر قاعدگی یا سندرم پیش قاعدگی (PMS) رخ نمی‌دهد و نیاز به جلوگیری از بارداری / نگرانی از بارداری نیست.

پزشکانی که با زنان در دوران یائسگی سروکار دارند، فرصت جالب توجه و در نتیجه مسؤولیت مهمی دارند. ارائه خدمات پزشکی در این دوره از زندگی می‌تواند از لحاظ پیشگیری از بیماری‌ها بسیار مفید باشد. به همین دلیل این دوران فرصتی است که نباید آن را از دست داد.

با آن‌که اهمیت عادت‌های سالم رفتاری در جوانان را نباید دست‌کم گرفت، اثر آموزش مراقبت‌های پیشگیرانه در سنین میان‌سالی بیشتر است. در این سنین افراد به کاهش میزان مرگ‌ومیر و بیمارمندی بیماری‌های مزمن با دیدی سرشار از باور، درک و علاقه نگاه می‌کنند. در این سنین احتمال پیدایش بیماری بیشتر است اما اثر تغییر در سبک زندگی نیز بیشتر است.

طولانی سیگار می‌کشیدند ولی مصرف آن را ترک کرده‌اند، خطر سرطان ریه، بالا باقی خواهد ماند (۳۸).

از سال ۱۹۷۰ تاکنون، میزان مرگ ناشی از بیماری‌های کرونری قلب در ایالات متحده، نزدیک ۵۰٪ کاهش یافته است. بین سال‌های ۱۹۷۳ تا ۱۹۸۷ در ایالات متحده میزان مرگ‌ومیر ناشی از بیماری‌های قلبی عروقی تقریباً در تمامی گروه‌های سنی کاهش یافت. مقدار این کاهش در افراد زیر ۵۴ سال، ۴۲٪ و در افراد ۵۵-۸۴ ساله، ۳۳٪ بود (۳۳). علیرغم پیشرفت‌هایی که مشاهده می‌شود، تلاش‌های پیشگیرانه در زمینه عوامل خطر ساز بیماری‌های قلبی عروقی، به ویژه چاقی، افزایش فشارخون و کمبود فعالیت جسمی باید افزایش یابد.

تلاش برای بهبود کیفیت زندگی، ارزش ویژه‌ای برای جوامع دارد. این کار باعث کاهش میانگین تعداد سال‌های ناتوانی فرد، که یک مشکل مهم بهداشتی و اجتماعی است، خواهد شد. نکته مهم‌تر این است که این مشکلات چالش‌های مالی بزرگی برای نظام مراقبت‌های بهداشتی و برنامه‌های اجتماعی ایجاد می‌کنند. با مستطیلی شدن جوامع، نسبت افراد مستمری بگير به افرادی که مالیات می‌پردازند به سرعت افزایش می‌یابد و این مسئله، حمایت‌های مالی برنامه‌های بهداشتی و اجتماعی را به خطر می‌اندازد. کاهش دوره بیمارمندی دست‌کم یک راه‌حل مناسب برای این مسئله است.

### مرحله دیررس باروری (مرحله ۳- STRAW)

کاهش آشکار توانایی باروری زودرس‌ترین شاه علامت دوران گذار است که در پی آن گستره‌ای از یک پدیده آشکار بالینی، مانند تغییرات الگوی قاعدگی رخ می‌دهد. چون تغییرات غدد درون‌ریز درست پیش از نمودهای آشکار و چشمگیر بالینی رخ می‌دهند (مانند تغییرات در دوره قاعدگی)، STRAW+ 10 پیشنهاد کرد که مرحله دیررس باروری به دو زیرمرحله 3b- و 3a- تقسیم شود. در مرحله 3b- چرخه‌های قاعدگی به نسبت به بدون تغییر هستند، سطوح سرمی FSH دوره زودرس فولیکولی به نسبت پایین اما در بازه طبیعی پیش از یائسگی هستند، اما AMH و AFC (و شاید اینهپین B) کاهش می‌یابند (۴۱). در مرحله 3a- چرخه‌های قاعدگی کوتاه‌تر می‌شوند و FSH زودرس فولیکولی افزایش می‌یابد، اما AMH، AFC، و اینهپین B کاهش می‌یابند (۴۱).

### دوره گذار زودرس یائسگی (مرحله ۲- STRAW)

ویژگی این مرحله افزایش بی‌نظمی در طول چرخه قاعدگی است. این بی‌نظمی با تکرار تفاوت ۷ روزه چرخه قاعدگی که در بیش از ۱۰ چرخه رخ دهد، شناخته می‌شود. ویژگی دیگر این مرحله افزایش متغیر در سطوح FSH دوره زودرس فولیکولی همراه با سطوح پایدار اندک AMH و کاهش AFC است (۴۱).

### دوره گذار دیررس یائسگی (مرحله ۱- STRAW)

ویژگی این مرحله از دست رفتن برخی قاعدگی‌ها همراه با دوره‌هایی از آمنوره است که ۶۰ روز یا بیشتر طول می‌کشند. طول چرخه‌های قاعدگی نامنظم‌تر می‌شود، سطوح هورمون‌های باروری متغیر است و عدم تخمک‌گذاری بیشتر رخ می‌دهد. سطوح FSH به طور معمول افزایش یافته و در اندازه یائسگی هستند، اگرچه گاهی ممکن است در اندازه پیش از یائسگی و همراه با سطوح بالای استرادیول باشند. سطح سرمی FSH بیشتر از ۲۵ IU/L به طور معمول در این مرحله دیررس گذار دیده می‌شود. این مرحله ۱-۳ سال طول می‌کشد و آغاز علامت‌های وازوموتور مانند گرگرفتگی در آن رخ می‌دهد (۴۱).

### مرحله‌های پیر شدن باروری: از سال‌های باروری تا آستانه یائسگی (واژه‌شناسی کهنه‌تر) یا از دوران گذار یائسگی (واژه‌شناسی تازه‌تر) تا یائسگی

در سال ۲۰۰۱، کارگاه مرحله‌های پیر شدن باروری<sup>۱</sup> (STRAW) نام‌گذاری مرحله‌های دوران گذار یائسگی را استانداردسازی کرد (۳۹). پیش از این کارگاه هیچ روش پذیرفته شده‌ای برای تعریف مرحله‌های پیر شدن باروری منجر به یائسگی وجود نداشت. در سال ۲۰۱۰ در یک کارگاه پیگیری (STRAW + 10)، این معیار به روزرسانی شد تا نشانگر پیشرفت در شناسایی تغییرات کارکرد هیپوتالاموس - هیپوفیز که در سراسر پیر شدن باروری رخ می‌دهند، باشد (۴۰). نظام مرحله‌بندی STRAW طول عمر زنان را به سه دوره گسترده تقسیم می‌کند: دوره باروری، دوره گذار به یائسگی، و دوره پس از یائسگی. هر کدام از این سه دوره بر پایه یافته‌های بالینی (الگوی دوره قاعدگی، علائم) و داده‌های پژوهشی (سطوح سرمی هورمون تحریک‌کننده فولیکول [FSH] و هورمون آنتی مولرین [AMH] و شمارش فولیکول آنتروم تخمدان [AFC] با سونوگرافی) به چند مرحله تقسیم می‌شوند. دوران گذار یائسگی یک دوره محدود از تغییرات فیزیولوژی است که در پایان به پیر شدن باروری می‌انجامد. این دوره از زندگی می‌تواند با تغییرات بی‌مانندی همراه باشد که ممکن است اثرهای چشمگیری بر تندرستی جمعیت و بر کیفیت زندگی داشته باشند (۳۹). به یک زن یائسه گفته می‌شود، اگر او یک بازه ۱۲ ماهه بی‌بایی را بدون قاعدگی سپری کرده باشد و دارای مدرک بیوشیمیایی هیپوگنادیسم (سطوح پایین استرادیول) هیپرگنادوتروپیک (سطوح بالای FSH و هورمون لوتئینیزه‌کننده [LH]) باشد. دوره قاعدگی نهایی یا پایانی<sup>۲</sup> (FMP) مرحله «صفر» نامیده می‌شود که نشانگر یک نقطه عطف بین دوره‌های باروری و پس از باروری است. دوره باروری خود به سه مرحله (زودرس [-5]، اوج [-4]، و دیررس [-3]) تقسیم می‌شود. دوران گذار یائسگی به دو مرحله (زودرس [-2] و دیررس [-1]) تقسیم می‌شود. دوره پس از یائسگی نیز به دو مرحله (زودرس [+1] و دیررس [+2]) تقسیم می‌شود (۴۰). بنابراین FMP یک نقطه مرجع برای گزارش باقی مرحله‌ها از میان این سه دوره ویژه پیری باروری است (شکل ۶-۱۷).

1. Stages of Reproductive Aging Workshop  
2. final menstrual period



Stages	-5	-4	-3b	-3a	-2	01	0	+1	+2a	+2b
Phase	Reproductive			Transition			FMP	Post Menopause		
Clinical profile	Fertile	Fertility problems for some	• Fertility problems • Menstrual irregularity • Occasional VMS		• Fertility problems • Menstrual irregularity • VMS are common			• VMS are common • Declining bone density	• Improving VMS in many • Worsening GUSM symptoms • Worsening risk for osteoporosis, cardiovascular disease	
Biochemical finding	• Normal AMH & inhibin • Low FSH	• Normal AMH & inhibin • Low FSH	• Declining AMH • Declining inhibin • Rising FSH		• Low or undetectable AMH & inhibin levels • High FSH			• High FSH • AMH & inhibin undetectable	• Stable FSH • AMH & inhibin undetectable	• Slight decline in FSH • AMH & inhibin undetectable
Ultrasound findings	Adequate AFC >>8		Decline in AFC		Few antral follicles			Occasional antral follicle		

AMH: Antimüllerian hormone  
FSH: Follicle stimulating hormone  
AFC (Antral follicle count)  
AMS: Vasomotor symptoms  
GUSM: Genitourinary Syndrome of Menopause  
FMP: Final menstrual period

•••••  
شکل ۶-۱۷

بسیاری کاهش می‌یابد، علائم بالینی همراه با کاهش استروژن، مانند خشکی مهبل و علائم ادراری تناسلی برجسته‌تر می‌شوند. جالب این‌که ممکن است سطوح FSH دچار کاهش بیشتری شوند، هر چند پژوهش‌های بیشتری برای تأیید این مشاهده لازم است (۴۱).

### دوران گذار یائسگی

برای تعریف عینی آنچه که دوران گذار یائسگی خوانده می‌شود تنها یک نشانه وجود دارد و آن نامنظم شدن قاعدگی است. بیمار این بی‌نظمی را به صورت جا افتادن قاعدگی‌ها و یا طولانی شدن فواصل بین قاعدگی‌ها (در حدود ۶۰-۴۰ روز) تجربه می‌کند (۴۲). در عین حال هیچ الگوی جامعی وجود ندارد و هر زن این تغییرات را به صورت تغییر در ویژگی‌های خاص قاعدگی خودش تجربه می‌کند.

**یائسگی** مقطعی از زمان است که در پی از دست رفتن فعالیت تخمدان‌ها، قاعدگی‌ها برای همیشه قطع می‌شوند. واژه "menopause" از واژه‌های یونانی "men" (به معنی ماه) و "pausis" (به معنی قطع) می‌آید. "climacteric" واژه‌ای

### دوره زودرس پس از یائسگی (مرحله ۱ STRAW زیرمرحله‌های 1a، 1b، 1c +)

در دوره زودرس پس از یائسگی افزایش سطوح FSH ادامه می‌یابد، اما کاهش سطوح استرادیول تا ۲ سال پس از FMP ادامه دارد تا به سطوح پایدار برسد. هر یک از زیرمرحله‌های 1a و 2b + در دوره زودرس پس از یائسگی یک سال طول می‌کشند و با پایدار شدن نوسان‌های سطوح FSH به پایان می‌رسند. مرحله 1a + نشانگر تکمیل فاصله ۱۲ ماهه‌ای است که برای تعریف FMP لازم است. این زیرمرحله همچنین نشان‌دهنده پایان دوران آستانه یائسگی (زمان نزدیک یائسگی که با مرحله 2- آغاز می‌شود و ۱۲ ماه پس از FMP پایان می‌یابد) است (۴۱). مرحله 1b + دربرگیرنده افزایش تغییرات در سطوح FSH و استرادیول است؛ علائم وازوموتور در مرحله‌های 1a + و 1b + بسیار شایع هستند. در مرحله 1c +، FSH که افزایش یافته و کاهش سطوح استرادیول اکنون طبیعی شناخته می‌شوند. این زیرمرحله ۳۶ سال به درازا می‌کشد. بدین ترتیب، گستردگی مرحله زودرس پس از یائسگی ۵۸ سال است (۴۱).

### دوره دیررس پس از یائسگی (مرحله ۲ +)

در این مرحله، سطوح هورمون‌های باروری به طور الزامی پایدار و یکنواخت است. با آن که در این مرحله بار علائم وازوموتور در



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# Chapter seventeen

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# Chapter twenty

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# Chapter twenty one

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# Chapter twenty two

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# Chapter twenty three

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# Chapter twenty four

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# Chapter twenty five

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# Chapter twenty six

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# Chapter twenty seven

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# Chapter twenty eight



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# Chapter twenty nine

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# Chapter thirty one

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# Chapter thirty two

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# Chapter thirty three

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