What Midlife Women Want from Gynecologists: A Survey of Patients in Specialty and Private Practices

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Abstract

Background: This study characterized the self-reported reason for a gynecology visit among midlife women in three different practice settings. We hypothesized that women seeking specialty care were more likely to report nonvasomotor symptoms potentially related to the menopausal transition.

Methods: Participants were 625 women aged 40–60 seen by gynecologists at three sites: an urban, academic, gynecologic menopause practice (Midlife Practice, or MLP) and urban (site A) and suburban (site B) locations of a general, nonacademic obstetrics and gynecology practice. Participants completed a self-report questionnaire asking them to choose and weigh the reason for their visit as “very much,” “somewhat,” or “not at all” for 15 common gynecologic and menopausal concerns. Demographic questions included age, self-rated health status, race/ethnicity, difficulty of paying for basics, and education. Comparisons between the three groups were made using parametric and nonparametric tests as appropriate. The main outcome measure was the response to the reason for participants’ visit compared across the three sites.

Results: Women presenting to the MLP were significantly older and more likely to report vasomotor symptoms (VMS), moodiness, sexual problems, sleep problems, and weight and to learn more about menopause. When “very much” and “somewhat” reasons were combined, nearly 80% of the MLP responses listed sleep problems, 60% listed vaginal dryness or low desire, 34% listed weight gain, and 30.7% listed mood.

Conclusions: Midlife women seeking care in a menopause gynecology practice had significantly more visits for vasomotor and nonvasomotor concerns than did women seeing general gynecologists. Women sought care for a broad range of concerns that are not typically in gynecologists’ scope of practice, including sleep disturbances, moodiness, and weight management.

Introduction

MIDLIFE WOMEN REPORT a wide variety of symptoms across the menopausal transition. These symptoms extend beyond vasomotor symptoms (VMS) and menstrual irregularities to sexual problems, mood disturbances, and sleep disorders.^{1–4} Which of these nonvasomotor symptoms are directly attributable to the hormonal changes of the menopausal transition and how best to address them have not been elucidated.

In a prospective nine-year community-based study of perimenopausal women in Australia, Guthrie et al. noted that

86% of women consulted a physician for menopause-related symptoms, with an annual incidence of 30%.⁴ In another study, 36% of women aged 45–60 received most of their information from their primary gynecologic doctor,⁵ and healthcare providers remain the most trusted source of information⁶ about menopause. Studies to date have not clearly characterized the subset of midlife women who seek more specialized gynecologic care. Morse et al. reported findings from the Melbourne Women’s Health Study comparing menopausal women who sought healthcare for menopausal-related symptoms to women who did not.⁷ Women who sought care did not differ in age or education but had more

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stressful lives and more nonvasomotor symptoms; however, the presence of VMS was not a significant predictor of healthcare seeking. DiDonato et al. reported that nearly half of the women seeking care in their menopause clinics in Italy complained of moderate to severe VMS, depression, difficulty sleeping, irritability and forgetfulness.⁸ Women who seek specialty care may experience a broader range of menopause-related symptoms or may be more bothered by them.

In this study, we aimed to determine the reason for a single-office visit among women aged 40–60 seeking gynecologic care in three settings: an urban, academic menopause specialty practice and the urban and suburban locations of a single private, nonacademic practice. We hypothesized that women who present to the specialty menopause practice would be more likely to have nonvasomotor symptom concerns, including sleep disruption and mood problems, compared to patients presenting to a generalist practice.

Materials and Methods

The study was deemed exempt by the institutional review board at the University of Pittsburgh, so written informed consent was not required of participants. All gynecology patients presenting for care at each of three gynecology practices were offered the opportunity to voluntarily complete the survey. Participating practices were an urban academic specialty menopause practice (the Midlife Practice, or MLP) of four female gynecologists; a private, nonacademic general obstetrics and gynecology practice (site A) of five female and three male practitioners across the hallway from the MLP; and the suburban office of the same private practice (site B) with a subset of four of the same practitioners (two female and two male). The MLP sees female patients with issues or concerns related to perimenopausal and menopausal symptoms. MLP patients are primarily self-referred, but internal medicine, family medicine, general gynecology, medical oncology, and gynecologic oncology refer women to the MLP for consultation and management of complex and difficult menopausal symptoms. Although the MLP specializes in menopause, the term *midlife* is used publicly, as women seem to prefer and better identify with this description than with *menopause*. Surveys were offered to all non-obstetric patients at the practices, and the research staff determined eligibility prior to data entry and analysis. Eligible women were between 40 and 60 years old, were not seeking obstetric care, and could read and write in English.

The sample size of 200 from each site was calculated for a *t*-test with a 0.05 two-sided significance level and an 80% power to detect a 20% difference between two groups. Surveys were administered until the sample size for each site had been achieved between February 2011 and June 2011. Patients identified as obstetric patients by the registration desk at the private offices were not offered surveys. No obstetric patients are seen at the MLP.

The survey was designed to be completed in about 5 minutes and consisted of 24 questions: 16 defining the reason for the gynecology office visit, 1 about current use of hormone therapy, 1 regarding use of other providers, and 5 demographic questions. One question confirmed that the woman was not seeking obstetric care. Instructions for the first 16 questions were, “As you think about TODAY’S appointment, please circle Not At All a Reason, Somewhat a Reason,

or Very Much a Reason for today’s appointment for each question.” Demographic questions included age, self-rated health status, race/ethnicity, difficulty of paying for basics, and education. The survey was designed by the research team for this study, piloted in small groups, and refined. The survey had a Flesch Reading Ease score of 62.6 and a Flesch-Kincaid grade level of 7.8, both in the target range for surveys.

We conducted univariable comparisons of baseline characteristics between sites, using the chi-squared test for categorical data and analysis of variance (ANOVA) or Student *t*-test for continuous data. For the continuous variables with highly skewed distribution, nonparametric tests, such as the Kruskal–Wallis test or the Wilcoxon rank-sum test, were considered. To investigate the association between each response and sites, we used chi-squared or Fisher’s exact test. We first evaluated differences across all three groups, followed by tests for pairwise differences if the overall comparison was significant. Continuous data were compared using ANOVA or Student’s *t*-test and their nonparametric counterparts when necessary. Categorical data were expressed as proportions and compared, using the chi-squared or Fisher’s exact test. We fitted logistic regression models to examine the association between each of the questions and sites, adjusting for other factors.

Results

Response rates for eligible women at the MLP, site A, and site B were 68% (221/325 eligible), 92% (201/219), and 42.5% (203/478), respectively, for a total of 625 completed surveys across all three sites. Table 1 summarizes the characteristics of the sample at each of the three sites. Women seeking care at the MLP were significantly older than the women at the other two practices (mean age of 51.7 years versus 49.5 (site A) and 47.7 (site B), $p < 0.001$). The groups did not differ in educational attainment or ability to pay for basics, but site A had significantly more African American women than either of the two other sites (23.6% versus 3.7% (site B) and 5.1% (MLP), $p < 0.001$). There was no difference between the two urban sites in self-rated health status, but the suburban site B had significantly higher self-rated health than the MLP ($p = 0.005$). Significantly more women presented to the MLP for menopause-related symptoms (Table 2), including VMS, learning more about menopause, weight gain, moodiness, sexual problems, and sleep problems, and more women presented to the other sites for annual exams (81.7%, site A, and 86.6%, site B) versus 65.9%, $p < 0.001$). The three sites had no differences for visits for vaginal discharge, breast problems, or irregular periods. Significantly more women in the MLP sample were on hormone therapy: 21.2% compared to 6.7% (site A) and 5.5% (site B) ($p < 0.001$). Very few women reported vaginal estrogen use only: 6% of the MLP respondents and 1.5% and 1% of sites A and B, respectively. When answers “very much” and “somewhat” as reason for the visit were pooled into a single category, results did not change significantly in the group comparisons. However, in the pooled category, the percentages of women at the MLP who were seeking care for weight gain, VMS, sexual problems, moodiness, or sleep problems greatly increased (see Table 3). Twenty-three MLP participants, 18 at site A, and 8 at site B listed “other” as their primary reason for their visit. These answers represented unique responses that did not fit

TABLE 1. SAMPLE CHARACTERISTICS (N=625)

Characteristic	Practice n (%) or mean (SD)		
	MLP	Site A	Site B
Age (years) ^a	51.7 (5.3)	49.5 (6.3)	47.7 (5.6)
Ethnicity ^b			
White	201 (93.1)	145 (74.4)	178 (92.7)
African American	11 (5.1)	46 (23.6)	7 (3.7)
Other	4 (1.9)	4 (2.1)	7 (3.7)
Education			
Less than high school	1 (0.5)	1 (0.5)	2 (1.0)
High school	52 (24.2)	41 (21.2)	42 (21.9)
College	89 (41.4)	91 (47.2)	93 (48.4)
Postgraduate	73 (34.0)	60 (31.1)	55 (28.7)
Ability to pay for basics			
Somewhat hard	47 (22.0)	47 (24.5)	38 (20.1)
Not at all hard	165 (77.1)	145 (75.5)	150 (79.4)
Don't know	2 (0.9)	0	1 (0.5)
Any HT use (yes) ^c	46 (21.2)	13 (6.7)	11 (5.5)
Only vaginal estrogen use (yes) ^d	13 (6.0)	3 (1.5)	2 (1.0)
Health status ^e			
Very good/Excellent	117 (53.4)	126 (62.7)	139 (68.5)
Good	78 (35.6)	55 (27.4)	52 (25.6)
Poor/Fair	24 (11.0)	20 (10.0)	12 (5.9)

Proportions do not sum to 100% where data are missing.

^aMLP significantly older, $p < 0.001$ compared to either site A or site B.

^bSite A has significantly more African American participants, $p < 0.001$ compared to either MLP or site B.

^cMLP has significantly more HT users, $p < 0.001$ compared to either site A or site B.

^dMLP has significantly more vaginal estrogen users, $p < 0.02$ compared to either site A or site B.

^eSite B was significantly healthier than MLP, $p \leq 0.005$.

HT, hormone therapy; MLP, Midlife Practice; SD, standard deviation.

well into any larger categories for reporting and included concerns about a variety of vulvar “growths,” specific concerns about family history (colon or ovarian cancers), and second opinions for surgical decision making. When women answered “other” but wrote in something that was addressed by another category (for example, “to review mammogram results” was recategorized as a “breast problem”), those answers were not categorized as “other” in the analysis. The single item “I just don’t feel like myself” was added based on our clinical experience, where we have anecdotally noted that this is a common chief complaint. Significantly more MLP respondents listed this item as “very much” a reason for the visit: 10.8% versus 4.7% (site A) and 4% (site B), $p = 0.023$, 0.009, respectively.

Previous unpublished data from our group suggested that many symptomatic peri- and early postmenopausal women presented with the triad of issues of depressed mood or moodiness, sleep disturbances, and sexual problems. We analyzed “very much” and “somewhat” answers for moodiness, tiredness and trouble sleeping, and decreased desire for and pain with sex or vaginal dryness in each of the three groups. Consistent with the overall results, significantly more MLP women listed concerns in all three of those domains, with 20% of the MLP respondents citing concerns in all three areas versus 8.3% and 10.5% for sites A and B, respectively (overall $p < 0.001$). There were no significant differences between women with concerns in all three domains and those without either between or within the three survey sites, with the exception of age. MLP respondents with all three concerns were significantly older than those from the other two sites, with a mean age of 51.8 versus 46.5 (site A) and 46.2 (site B) (overall $p < 0.0001$).

Discussion

Consistent with our hypothesis, women aged 40–60 presenting to an academic specialty menopause gynecology

TABLE 2. RESULTS: COMPARISON OF “VERY MUCH A REASON” BETWEEN THREE SITES

Reason for visit	Practice n (%)			p value	
	MLP (n=221)	Site A (n=201)	Site B (n=203)	MLP vs. site A	MLP vs. site B
Routine annual exam	143 (65.9)	161 (81.7)	175 (86.6)	0.001	<0.001
Desire	23 (11.2)	8 (4.3)	9 (4.6)	0.011	0.014
Trouble sleeping	38 (18.5)	15 (7.9)	11 (5.6)	0.002	<0.001
Weight gain	26 (12.5)	13 (6.9)	12 (6.1)	NS	0.026
Tiredness	40 (19.1)	13 (6.9)	9 (4.6)	<0.001	<0.001
Pain/dryness	30 (14.6)	19 (10.2)	16 (8.1)	NS	0.039
Moodiness	19 (9.3)	7 (3.7)	9 (4.5)	0.026	NS
VMS	41 (19.8)	24 (12.6)	22 (11.2)	NS	0.017
Heavy periods	10 (4.9)	25 (13.2)	19 (9.6)	0.004	NS
Irregular periods	22 (10.7)	20 (10.6)	24 (12.1)	NS	NS
Breast problem	15 (7.4)	18 (9.5)	13 (6.6)	NS	NS
Vaginal discharge	19 (9.2)	24 (12.6)	14 (7.1)	NS	NS
Learn about menopause	46 (22.2)	18 (9.5)	27 (13.6)	<0.001	0.025
Don't feel like self	22 (10.8)	9 (4.7)	8 (4.0)	0.023	0.009
Contraception	8 (3.9)	28 (14.7)	17 (8.5)	<0.001	NS
Other (yes)	23 (10.4)	18 (9.0)	8 (3.9)	NS	0.011

NS, non-significant; VMS, vasomotor symptoms, including hot flashes and night sweats.

TABLE 3. RESULTS: COMPARISON OF COMBINED “VERY MUCH” AND “SOMEWHAT A REASON” BETWEEN THREE SITES

Reason for visit	Practice n (%)			p value	
	MLP (n=221)	Site A (n=201)	Site B (n=203)	MLP vs. site A	MLP vs. site B
Routine annual exam	166 (76.5)	170 (86.3)	184 (91.1)	0.011	<0.001
Desire	67 (32.5)	38 (20.3)	43 (21.8)	0.006	0.016
Trouble sleeping	78 (37.9)	41 (21.7)	39 (19.8)	<0.001	<0.001
Weight gain	71 (34.1)	40 (21.2)	40 (20.2)	0.004	0.002
Tiredness	84 (40.0)	43 (22.9)	40 (20.2)	<0.001	<0.001
Pain/dryness	59 (28.8)	32 (17.1)	41 (20.7)	0.006	NS
Moodiness	63 (30.7)	33 (17.5)	39 (19.6)	0.002	0.010
VMS	91 (44.0)	56 (29.5)	46 (23.4)	0.003	<0.001
Heavy periods	24 (11.8)	34 (18.0)	33 (16.7)	NS	NS
Irregular periods	39 (19.0)	33 (17.5)	35 (17.7)	NS	NS
Breast problem	29 (14.3)	25 (13.2)	18 (9.1)	NS	NS
Vaginal discharge	31 (15.1)	33 (17.3)	26 (13.2)	NS	NS
Learn about menopause	101 (48.8)	50 (26.3)	64 (32.3)	<0.001	<0.001
Don't feel like self	57 (28.1)	28 (14.6)	33 (16.5)	0.001	0.005
Contraception	14 (6.9)	41 (21.5)	25 (12.5)	<0.001	NS
Other (yes)	23 (10.4)	18 (9.0)	8 (3.9)	NS	0.011
Combined sex, mood, and sleep	43 (20.1)	16 (8.3)	21 (10.5)	<0.001	0.007

practice cited nonvasomotor menopause-related symptoms as the reason for their visit significantly more often than did midlife women presenting to a general private gynecology practice. In addition to issues a midlife gynecologist may be expected to manage, such as VMS and patient education about menopause, women coming to the MLP were also significantly more likely to cite symptoms not considered traditionally gynecologic in nature as the reason for their visit. Nongynecologic issues included weight gain, trouble sleeping and tiredness, moodiness, and “not feeling like myself.” These differences were not explained by differences in educational attainment or ability to pay for basics between the groups. However, women seeking care at the MLP were significantly older than the women at the other two sites, with a mean age of almost 52 compared to 50 and 48 years of age ($p < 0.001$). This age difference may represent more complaints based on aging (e.g., subjective sleep quality worsens with age) or a more symptomatic late perimenopausal- or early menopausal-stage population. Alternatively, the older age could be a proxy for duration of symptoms, indicating that women came to the MLP as a “last resort” after either having lived with significant symptoms for years or having had unsuccessful interventions in the past. Significantly more women in the MLP sample were taking hormone therapy, potentially also representing more baseline symptoms, more bothersome symptoms, or symptoms more difficult to treat.

Of the MLP respondents, 32.5% cited low sexual desire and 28.8% pain with sex or vaginal dryness as either being very much or somewhat a reason for their visit, significantly more than at either of the comparator practices. Sexual problems are prevalent among American women⁹ and highly prevalent at midlife.^{10–12} Vaginal dryness leading to dyspareunia and sexual pain problems has been shown to increase across the menopausal transition, with highest rates in postmenopausal women, who are also presumed to have the highest degree and prevalence of vaginal atrophy secondary to hypoestrogenic urogenital tissues.^{11,12} Few women in the MLP sample were using vaginal estrogen (6%), which may

represent an opportunity for treatment for these symptomatic women.

Women seeking care in the MLP were significantly more likely to choose sleep concerns as the reason for their appointment than were women at the other two sites. Studies have consistently shown increased complaints of sleep disturbances during midlife,^{13–15} but data are conflicting regarding both the etiology and the prevalence of sleep disturbances in midlife women. These sleep concerns are clearly problematic in this population, as nearly 30% of women coming to the menopausal gynecologist's office in this study cited them as their primary reason for the visit.

In our study, twice as many women in the MLP as in the other two sites reported weight changes as an important reason for their visit. The relationship of hormonal changes to weight change is unclear. The most important determinant of weight gain is individual diet and lifestyle; however, a trend toward increasing weight through midlife has been reported in both men and women.¹⁶ Weight management, beyond assessment of body mass index (BMI) and referral, is not in the scope of the typical gynecologist and not an integral part of residency training for gynecologists.

Women transitioning through the menopause are at increased risk of clinically diagnosed depression, symptoms of depressed mood,^{17–20} and a subgroup of women is at increased risk of new onset depression during the transition.^{21–24} Longitudinal data suggest that the highest risk time for depression is in the perimenopause. Results from the Study of Women's Health Across the Nation (SWAN) and the Penn Ovarian Aging study^{20,25} have shown a two- to fourfold increase in increasing depressive symptoms across the menopausal transition. The Harvard Study of Moods and Cycles found major mood disorders in 9.5% of premenopausal women and in 16.6% of perimenopausal women.²⁶ Our survey did not ask directly about depression, because, based on our clinical experience, many women seeking care from gynecologists do not identify their symptoms as being consistent with depression. However, 9% of the MLP respondents listed moodiness as very much a reason for the

visit, and 30.7% named moodiness as either very much or somewhat a reason for the visit, indicating a high prevalence of concern for mood symptoms in our patients. The addition of a question specifically about self-concept ("I don't feel like myself") reflected our clinical experience, and 28% of patients in the MLP reported this as a reason for their visit. Both self-concept and mood symptoms were significantly different from the patients in the other practices surveyed. This finding may be related to the fact that the MLP patients were more likely to have other nongynecologic concerns, such as sleep problems or sexual problems, or to have more or more bothersome VMS and may be at increased risk for perimenopausal depression as a result.

Other studies have looked at how menopausal symptoms cluster in women.^{27,28} We have noticed in our clinical practice, and this is consistent with these survey results, that many women present for moodiness or depressed mood, sexual problems, and sleep concerns. This may be due to the high prevalence of all three symptoms in our patient population, or it may be due to underlying dysthymia or depression, which in turn produces sexual problems and poor sleep. However, it remains possible that these women are presenting with a unique symptom cluster related to the menopausal transition specifically, which cannot be explained merely by depression. To explore this further, we analyzed this sample to evaluate whether we saw more women with symptoms in all three of these domains. This study confirmed that we see a large number of women with all three concerns, 20%, versus less than 10% for the other two practices.

The strengths of this study include the large sample size: more than 600 women from three practices. The urban practice (site A) is located directly across the hall from the MLP, making them excellent comparators. The same practitioners go to both site A and site B, which decreases bias from provider preference. Our survey assessed concerns across multiple domains simultaneously, allowing women to choose their most important concern. Participants were able to choose their reason for coming anonymously, which may represent a more accurate reflection of patient concerns than a review of diagnostic codes or a chart.

The study has several limitations. Selection bias may have affected our results, since there may have been unmeasured differences between women who completed the survey and those who did not. The response rates were lower at the suburban site than at either of the two urban sites, which also may introduce selection bias. The research team developed and pilot tested its own survey, as no previously validated surveys were appropriate for the aim. There may have been more African American women at site A because an African American provider is at that site. Because the MLP patients were older, differences between them and patients at the other practices may be partially attributed to later menopausal stage, which was not assessed.

Conclusions

The study demonstrated that women presenting to a specialty academic menopausal practice are more likely to cite VMS, mood symptoms, sleep problems, weight concerns, and sexual problems as the reason for their visit than are women of the same age presenting to general private gynecologists. Women presenting to the MCP were also more

likely to cite a symptom group of sleep problems, sexual problems, and mood concerns as reasons for their visit. Of the problems midlife women cited as reasons for their visit, 22% of all respondents across three sites answered with sleep concerns, and 14.6% of all respondents answered with mood concerns, neither of which is an area of gynecologic expertise. Most gynecologists do not receive specialized training in these areas, as they are considered outside the scope of practice of most gynecologists. Additional education for ob/gyn residents and practitioners, as well as for internists, could improve care for midlife women. We cannot conclude from these data why women chose our practice and whether this is due primarily to referral patterns or community perceptions and personal choice.

Many factors contribute to how women perceive their health, including social support, relationships, chronic medical conditions, sexuality, diet, and exercise. Nonvasomotor symptoms occurring during the menopausal transition, such as those explored in this study, are likely related to this complex set of biopsychosocial factors. Even the relatively young women included in this midlife study may have substantial functional limitations related to their menopausal status.²⁹

We, as providers for these women, need to focus research on understanding and ultimately alleviating the broad range of symptoms experienced by women during the menopause transition. Less traditional models of care provision, including interdisciplinary teams (incorporating behavioral medicine, sleep, weight management, health coaches, and behavioral health experts), should be explored to improve care and quality of life for women around the time of the menopause.

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