Comparison of the Quality of Life between Users and Non-Users of Complementary and Alternative Medicine in Thai Women with Menopause-Related Symptoms Aged 45 Years Old and Above

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Objective: *To compare the quality of life between users and non-users of complementary and alternative medicine (CAM) in Thai women aged 45 years old and above who had menopause-related symptoms.*

Material and Method: *This cross-sectional analytical study was conducted in the Department of Obstetrics and Gynecology, Phramongkutklao Hospital. Women aged from 45 years old and experiencing menopause-related symptoms were invited. Self-administered questionnaires of patients' characteristics and the Menopause-Specific Quality of Life (MENQOL) questionnaire were used to evaluate the quality of life (score range 1 to 8 from better to worse). Main outcome measure was the difference of the quality of life between the CAM users and CAM non-users.*

Results: *A total number of 204 women were enrolled and equally grouped into CAM users and CAM non-users. Mean age was 56.45 years old. The present study revealed that there was no difference in the quality of life between the women in the two groups in all domains (mean MENQOL ± SD = 2.18±1.15 for CAM users, and mean MENQOL ± SD = 2.01±0.88 for CAM non-users, p-value = 0.593). Almost all CAM types showed associations to lower quality of life, especially the energy therapy group (p-value = 0.019). Only the women who used mind-body interventions had higher quality of life, although not significantly.*

Conclusion: *Overall, there was no statistical significant difference in quality of life between the CAM users and non-users who had menopause-related symptoms. Additional studies are needed to evaluate other specific modalities of CAM use.*

Keywords: *Menopause, menopause-related symptoms, Complementary and alternative medicine, Quality of life*

J Med Assoc Thai 2017; 100 (6): 621-9
Full text. e-Journal: *http://www.jmatonline.com*

Menopause is a natural part of the aging process in women. With increasing life expectancy, women spend almost one-third of their lives in menopause. Therefore, the overall health and well-being of the women in this age range has become a major public health concern around the world, including Thailand[1]. From several studies, a significant proportion of women experiences symptoms during the menopausal transition. Complaints, including hot flashes, night sweats, vaginal dryness, and sleep disturbances, are the results from the lack of estrogen that can affect the daily function in work, social, and sexual activities. According to the systemic review study, menopause-related symptoms can have negative impacts on the qualities of life in both menopausal and perimenopausal women[2,3]. The World Health Organization (WHO) defines quality of life as an individual's perception of his/her position in life, in relations to the culture and social values that he/she lives in, as well as to his/her goals, expectations, standards, and concerns[4]. Among the women who suffered from the menopausal symptoms, hormone replacement therapy (HRT) is an option that could alleviate the symptoms, and, therefore, improve their life qualities[5,6]. Moreover, despite the HRT effectiveness, many women seek alternative therapies to relieve the symptoms and to improve their life qualities.

Nowadays, complementary and alternative medicine (CAM) seems to become increasingly popular among not only the general population, but also the menopausal women throughout the world. CAM is a group of diverse medical and health care

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systems, practices, and products that are not presently considered to be part of conventional medicine[7]. The National Center for Complementary and Alternative Medicine (recently named National Center for Complementary and Integrative Health, NCCIH) classifies CAM therapies into five categories: 1) alternative medical systems (such as traditional Chinese medicine and Ayurveda), 2) mind-body interventions (such as patient support groups and meditation), 3) biologically-based systems (such as herbal and dietary supplements), 4) manipulative and body-based methods (such as chiropractic and massage therapy), and 5) energy therapies (such as Reiki and therapeutic touch).

According to a review conducted worldwide[8], it was estimated that 50.5% of menopausal women used CAMs as means to alleviate the symptoms. In Thailand, a study from a hospital in the northeastern region estimated that approximately 63% of menopausal women used CAM[9]. However, the information on the CAM uses among the Thai menopausal women remained limited. A few studies have examined the effectiveness of CAMs in alleviating the menopausal symptoms. Some studies reported that yoga-based and certain mind-body therapies could be beneficial for alleviating specific menopausal symptoms[10,11]. Some studies reported significant improvements (in terms of both the emotional symptoms and mental health) in menopausal women who participated in the traditional Thai exercise Rusie Dutton[12] and 24 weeks of Tai Chi exercise (3 hours/week)[13]. On the other hand, there were also reports that indicated negative effects from CAM uses, such as allergic reactions, infections, and liver damage from taking herbal products[14].

So far, there has not been a study to evaluate relationships between CAM uses and quality of life in Thai menopausal women. The goal of this initial study was to compare the quality of life between CAM users and CAM non-users, also explore the association between the use of CAM and the quality of life.

Material and Method

The present project was approved by the Institutional Review Board Royal Thai Army. The data came from a cross-sectional survey of 204 individuals from the Department of Obstetrics and Gynecology, Phramongkutklao Hospital, Thailand. The survey was taking from the period between July and August 2016. The inclusion criteria were perimenopausal or menopausal women (both naturally occurred and surgically-induced menopause) who: had at least two menopause-related symptoms (based on the Modified Greene Climacteric Scale, MGCS), were at least 45 years old, and competent in writing/speaking Thai and able to consent to the study participation. Incomplete data and confounding factors that would affect the quality of life such as uncontrolled chronic diseases (i.e., hypertension, diabetes mellitus), current use of hormone therapy, and cancer were excluded. The patients who declined to participate in the study were also excluded.

From the pilot study, a total sample size was 204. When patients visited our outpatient clinic for the routine follow-up, our research staff provided them with a brief description of the study. The patients were invited, and their informed consents were obtained. The 204 women were categorized equally into 2 groups: CAM users and non-CAM users. The CAM users were defined as women who used CAM for at least three months in the last one year.

This survey was conducted using validated self-administered questionnaires developed by the research staff. They contain items that assess the patients' personal and clinical data, and the uses of CAM. The questionnaires required 15 to 20 minutes to complete. The survey instructions were clearly informed. The personal and clinical related questionnaire included the patients': age, weight, height, marital status, religion, coexisting illness, history of surgery, and history associated with the obstetrics and gynecology. The questionnaires related to the CAM uses included the histories, types, durations, and reasons for the uses.

The quality of life was evaluated based on the Thai version of Menopause-Specific Quality of Life (MENQOL) which was validated, and obtained the Cronbach's alpha equal to 0.894[15]. The MENQOL questionnaire consisted of questions on 29 menopausal symptoms. The questions were grouped into 4 domains: vasomotor, psychosocial, physical, and sexual domains. For analysis, the item scores were converted to the score ranging from 1 to 8; score 1 rated as the subject did not experience the problems, and score 8 rated as extremely bothered. Therefore, the higher MENQOL score refers to lower quality of life. For the sexual domain questionnaire, only data from the sexually active women were evaluated.

All data were analyzed using Statistical Package for the Social Science (SPSS) version 17.0. Descriptive statistics (means, median, and percentages) were used to show the distributions of the patients' personal data, clinical data, and quality of life. The

univariate analysis was used to compare the personal and clinical data of the CAM users to those of the CAM non-users. We used Chi-square test or Fisher's exact test for the categorical data analysis and Mann-Whitney U test for the continuous data analysis. Mann-Whitney U test was used to associate the quality of life and CAM uses. For all statistical analysis, a two-sided *p*-value of less than 0.05 was considered to be statistical significant.

Results

Of the CAM survey participants, 204 were divided equally into CAM users and non-users. Table 1 summarized the personal and clinical data of all participants. The results showed that the participants' mean age was 56.45±7.74 years old (range 45 to 88 years old) and 68.1% were married. Almost all of the participants were Buddhist. Approximately, half of these women were obese (54.4%). At the CAM user

Table 1. Characteristics of complementary and alternative medicine (CAM) users and non-users

Characteristics	Total (n = 204) n (%)	CAM users (n = 102) n (%)	CAM non-users (n = 102) n (%)	*p*-value
Age (years)				0.774
45-54	87 (42.6)	41 (40.2)	46 (45.1)	
55-64	83 (40.7)	43 (42.2)	40 (39.2)	
≥65	34 (16.7)	18 (17.6)	16 (15.7)	
Mean ± SD	56.45±7.74	56.94±7.85	55.96±7.63	0.905[T]
Min to max	45 to 88	45 to 88	45 to 73	
BMI				0.269[F]
Underweight (<18.5)	4 (2.0)	3 (2.9)	1 (1.0)	
Normal (18.5-22.9)	44 (21.6)	26 (25.5)	18 (17.6)	
Overweight (23-24.9	45 (22.1)	24 (23.5)	21 (20.6)	
Obese (≥25)	111 (54.4)	49 (48.0)	62 (60.8)	
Mean ± SD	26.12±4.37	25.29±3.82	26.93±4.73	0.007*[T]
Min to max	17.58 to 42.97	17.58 to 35.56	18.37 to 42.97	
Religion				-
Buddhist	202 (99.0)	101 (99.0)	101 (99.0)	
Islam	2 (1.0)	1 (1.0)	1 (1.0)	
Marital status				0.322
Single	31 (15.2)	15 (14.7)	16 (15.7)	
Married	139 (68.1)	66 (64.7)	73 (71.6)	
Divorced	34 (16.7)	21 (20.6)	13 (12.7)	
Co-existing diseases				0.260
No	112 (54.9)	60 (58.8)	52 (51.0)	
Yes	92 (45.1)	42 (41.2)	50 (49.0)	
- Diabetes mellitus	18 (8.8)	8 (7.8)	10 (9.8)	0.622
- Hypertension	50 (24.5)	19 (18.6)	31 (30.4)	0.051
- Dyslipidemia	19 (9.3)	7 (6.9)	12 (11.8)	0.228
- Allergy	9 (4.4)	7 (6.9)	2 (2.0)	0.170[F]
- Thyroid disease	6 (2.9)	3 (2.9)	3 (2.9)	1.000[F]
- Others	16 (7.8)	8 (7.8)	8 (7.8)	1.000[F]
Surgical history				0.087
No	64 (31.4)	37 (36.6)	27 (26.5)	
Yes	140 (68.6)	65 (63.7)	75 (73.5)	
- Hysterectomy	9 (4.4)	4 (3.9)	5 (4.9)	1.000[F]
- Hysterectomy with BSO	5 (2.5)	4 (3.9)	1 (1.0)	0.369[F]
- BSO	6 (2.9)	4 (3.9)	2 (2.0)	0.683[F]
- Others	46 (22.5)	26 (25.5)	20 (19.6)	0.315
Last menstruation				1.000[F]
≥12 months	160 (78.4)	80 (78.4)	80 (78.4)	
<12 months	44 (21.6)	22 (21.6)	22 (21.6)	

BMI = body mass index; BSO = bilateral salpingo-oophorectomy

p-value from Chi-square test, [T] = *p*-value from independent t-test, [F] = *p*-value from Fisher's exact test, * significant at the 0.05 level

vs. CAM non-user level, the women in the non-user group (mean BMI ± SD = 26.93±4.73) were more obese than those in the user group (mean BMI ± SD = 25.29±3.82). The results also showed that 45.1% of the 204 women had coexisting diseases that included hypertension (24.5%), dyslipidemia (9.3%), and diabetes (8.8%). More than half of the women had no prior history of surgery (68.6%). There were no significant differences in the ages, marital status, religions, coexisting diseases, and history of gynecologic surgery between CAM users and non-users. Lastly, the results showed that most of the participated women (78.4%) were in the menopausal state, whereas only 21.6% were in the perimenopausal state.

In terms of CAM uses, 20.6% (n = 42) of the 204 participants reported that they were using CAMs, and 74.5% (n = 76) of the 102 CAM users used more than two types of CAMs. Three most common forms of CAM used in our participants were massage (39.7%), followed by traditional Chinese medicine (36.8%), and vitamins (27.9%), respectively (Table 2). The main reasons for the CAM uses were to promote health (35.3%), alleviate the menopause-related symptoms (10.8%), and treat any disease (9.3%). A substantial number of the CAM users (87.7%) indicated that CAMs were effective. Of the 29 assessed menopause-related symptoms, the three mostly reported symptoms by the CAM users were: weight gain (92.2%), accomplishing less (87.3%), and feeling depressed or wanting to be alone (86.3%) with the MENQOL score of 3 (Table 3). Nevertheless, none of these symptoms were significantly different between the users and non-users.

Table 4 showed the mean MENQOL scores in the vasomotor, psychosocial, physical, and sexual domains. The overall CAM user (mean MENQOL score ± SD = 2.18±1.15) and non-user (mean MENQOL score ± SD = 2.01±0.88) the mean scores did not show a significant difference (p-value = 0.593) from one another. The present study revealed that almost all specific types of CAM have trend to have poorer quality of life when compared with CAM non-users. When classified in type of CAM, CAM users had poorer quality of life in all types of CAM with the exception of mind-body interventions group. Women who used mind-body interventions reported higher quality of life but not significant (MENQOL score (mean ± SD) 1.87±0.82 in CAM users and 2.01±1.88 in non-users, p = 0.298). However, there was only women who used energy therapy group demonstrated significant poorer quality of life (MENQOL score (mean ± SD) 3.09±1.54 in CAM users and 2.01±1.88 in non-users, p = 0.019).

Table 2. Types and patterns of CAM use

	Total (n = 204) n (%)
Group 1: alternative medical systems	75 (36.8)
Traditional Chinese medicine	75 (36.8)
Ayurvedic medicine of India	2 (1.0)
Group 2: mind-body interventions	57 (27.9)
Meditation	22 (10.8)
Yoga	31 (15.2)
Qigong	6 (2.9)
Group 3: biologically based therapies	92 (45.1)
Herbs	54 (26.5)
Vitamins	57 (27.9)
Ozone therapy	1 (0.5)
Group 4: manipulative and body-based methods	82 (40.2)
Massage	81 (39.7)
Osteopathy	1 (0.5)
Chiropractic	2 (1.0)
Group 5: energy therapies	12 (5.9)
Pray	9 (4.4)
Universal energy	1 (0.5)
Others	2 (1.0)
Duration of CAM use	
Current use	42 (20.6)
Within the last 1 year	60 (29.4)
Reasons of CAM use	
To treat any disease	19 (9.3)
To promote health	72 (35.3)
To alleviate the menopausal related symptoms	22 (10.8)
Perception of effectiveness	
Yes	179 (87.7)
Average	13 (6.4)
No	12 (5.9)
Number of CAM use	
Use 1 type	9 (8.8)
Use 2 types	17 (16.7)
Use more than 2 types	76 (74.5)

Discussion

CAM uses are becoming common in many countries throughout the world, including Thailand. According to Booning et al (2015), the prevalence of CAM use among Thai menopausal women was 63%[9]. This was consistent with the survey conducted on herbal medicine uses among menopausal women worldwide[8]. In the present study, the most preferred CAM approach among the participants was massage, followed by traditional Chinese medicine (e.g., acupuncture, cupping, and Tui-na therapy). The

Table 3. Menopausal related symptoms in association with CAM users and non-users

Symptoms	Total n (%)	CAM users (n = 102) n (%)	CAM non-users (n = 102) n (%)	*p*-value
1. Hot flushes	127 (62.3)	62 (60.8)	65 (63.7)	0.665
2. Night sweats	130 (63.7)	63 (61.8)	67 (65.7)	0.560
3. Sweating	114 (55.9)	58 (56.9)	56 (54.9)	0.778
4. Being dissatisfied with my personal life	166 (81.4)	81 (79.4)	85 (83.3)	0.472
5. Feeling anxious or nervous	122 (59.8)	57 (55.9)	65 (63.7)	0.253
6. Experiencing poor memory	142 (69.6)	69 (67.6)	73 (71.6)	0.543
7. Accomplishing less than I used to	178 (87.3)	89 (87.3)	89 (87.3)	1.000
8. Feeling depressed down or blue	179 (87.7)	88 (86.3)	91 (89.2)	0.522
9. Being impatient with other people	137 (67.2)	71 (69.6)	66 (64.7)	0.456
10. Feeling of wanting to be alone	175 (85.8)	88 (86.3)	87 (85.3)	0.841
11. Flatulence (wind) or gas pain	144 (70.6)	70 (68.6)	74 (72.5)	0.539
12. Aching in muscles and joints	76 (37.3)	42 (41.2)	34 (33.3)	0.247
13. Feeling tired or worn out	118 (57.8)	60 (58.8)	58 (56.9)	0.777
14. Difficulty sleeping	118 (57.8)	53 (52.0)	65 (63.7)	0.089
15. Aches in back of neck or head	116 (56.9)	53 (52.0)	63 (61.8)	0.157
16. Decrease in physical strength	128 (62.7)	63 (61.8)	65 (63.7)	0.772
17. Decrease in stamina	151 (74.0)	75 (73.5)	76 (74.5)	0.873
18. Feeling lack of energy	139 (68.1)	69 (67.6)	70 (68.6)	0.881
19. Drying skin	92 (45.1)	43 (42.2)	49 (48.0)	0.399
20. Facial hair	116 (56.9)	56 (54.9)	60 (58.8)	0.572
21. Weight gain	190 (93.1)	94 (92.2)	96 (94.1)	0.580
22. Changes in appearance, texture or tone of skin	120 (58.8)	59 (57.8)	61 (59.8)	0.776
23. Feeling bloated	132 (64.7)	62 (60.8)	70 (68.6)	0.241
24. Low backache	112 (54.9)	58 (56.9)	54 (52.9)	0.574
25. Frequent urination	153 (75.0)	74 (72.5)	79 (77.5)	0.419
26. Involuntary urination when laughing or coughing	166 (81.4)	85 (83.3)	81 (79.4)	0.472
27. Change in sexual desire	171 (83.8)	82 (80.4)	89 (87.3)	0.183
28. Vaginal dryness during intercourse	174 (85.3)	83 (81.4)	91 (89.2)	0.114
29. Avoiding intimacy	174 (85.3)	84 (82.4)	90 (88.2)	0.236

p-value from Chi-square test

Table 4. Mean Menopause Quality of Life (MENQOL) scores of CAM users and non-users

MENQOL domain (question number)	CAM users (n = 102), mean ± SD	CAM non-users (n = 102), mean ± SD	*p*-value
Vasomotor (1-3)	2.36±1.67	2.25±1.55	0.733
Psychosocial (4-10)	1.82±1.16	1.74±1.04	0.825
Physical (11-26)	2.38±1.37	2.20±1.08	0.597
Sexual (27-29)	2.01±1.75	1.51±1.14	0.084
Total (1-29)	2.18±1.15	2.01±0.88	0.593

p-value from Mann-Whitney U test, significant at the 0.05 level

difference between the top preferred CAM choices between the two studies might be due to the availabilities of the information and resources. In addition, the women's personal beliefs regarding the effects of the different CAM approaches on their health and well-being might influence their decision/perceptions on their choices of CAMs.

Although the efficacy of CAM in improving quality of life was inconclusive, improving quality of life (i.e., to promote health) is one of the most common self-reported reasons for using CAM as found in our study. This maybe because of more people turn to have self-healthcare nowadays. Whereas some studies report positive relationships between CAM use and

quality of life, some do not. One randomized controlled trial (RCT) study found an improvement in quality of life in the users of yoga, exercise and omega-3 supplements[10]. In contrast, another study determined that the CAM users experienced worse menopause-specific symptoms[16]. In the present study, the overall quality of life between the CAM users and non-users was not significant difference. The discordant results could due to the different experimental design used in the studies. It was, therefore, difficult to compare the results from our findings to other studies due to difference in definition of CAM, quality of life assessment tools (i.e., Menopause Rating Scale [MRS], MGCS, Utian Quality of Life [UQOL]), population's characteristics, and participants' health statuses. Nevertheless, the present study is important as it is the first study conducted in Thai women population.

In terms of the impacts of CAMs on the menopausal women's quality of life, there was no significant difference between the CAM user and non-user groups in our study. However, the results showed a pattern that suggested a potential negative impact of CAMs among the CAM users. This may be an indirect indicator to identify non-effectiveness of CAM. However, the present study design cannot answer on how effective CAM is, so further studies to evaluate effectiveness of CAM with appropriate designs are needed. Moreover, one cross-sectional study conducted in Italy[17] indicated that post-menopausal women, who suffered severe post-menopausal symptoms, were more likely to turn to CAMs for help to alleviate the symptoms. This could be a reason for explaining why women who use complementary therapies tend to have a lower quality of life.

Considering of each CAM types, the users of almost all specific types of CAM had lower quality of life, especially in energy therapy group which was the only statistically significant group. In spite of that, this happened to be in a small population because the number of the users in this group was quite low (n = 12). On the other hand, while no statistical significant, we observed a distinct pattern among women who used mind-body interventions (e.g., meditation, yoga, and Qigong). These women reported higher quality of life. This finding corresponded with the previous studies that found yoga can improve menopausal symptoms[18] and meditation-based program can reduce the degree of bothering and distress women experience from hot flashes and night sweats[19].

Limitation

There were several limitations in the present study. First of all, the study used a cross-sectional design. This means changes in the quality of life associated with the CAM uses over a period of time could not be assessed. Second, the dataset in the present study was based on women that came to the Phramongkutklao Hospital and agreed to take the survey. Hence, this sample set may not accurately reflect the Thai women population at large. Third, the present study was designed to evaluate the overall quality of life based on a selected set of CAM uses. The results cannot be used to infer the quality of life based on specific modality. Finally, the study was based on participants' self-reports. This means the quality of the data was solely based on the participants' memories and the willingness to truthfully answer the questions.

To improve the study, a longitudinal sample is preferred. The new sample set, with appropriate study designs, will allow us to gain better insights into specific areas, such as the impacts of CAM therapies on the quality of life scores over a period of time and whether the different types of the CAM therapies would have different effects on the menopausal women.

Conclusion

Overall, there was no significant difference in the quality of life between the CAM users and CAM non-users in the selected women with menopause-related symptoms. The analysis showed associations between some of the CAM approaches used in the study and the quality of life scores. However, due to the limitations in the current study, additional studies with more suitable experimental designs are needed, in order to gain a better understanding of the CAM impacts on the quality of life in menopausal women. And further studies are needed to evaluate efficacy of CAM in specific modalities.

What is already known on this topic?

The association between CAM and quality of life in women with menopause-related symptoms has not been determined. Some of the existing studies showed improvements in the quality of life in women who used CAM, but some showed the opposites. Data in this area, particularly in Thailand, are currently insufficient.

What this study adds?

This is the first study conducted in the Thai menopausal women population. The presented results

showed no associations between the quality of life and CAM uses in the women with menopause-related symptoms. Some CAM uses showed associations to poorer quality of life.

Acknowledgements

The present study was supported by the Department of Obstetrics and Gynecology, Phramongkutklao Hospital, Bangkok, Thailand.

Potential conflicts of interest

None.

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Appendix.

The original questionnaire was written in Thai

The questionnaire related to CAM use

1. Have you ever used complementary and alternative medicine (CAM)? ☐ Yes ☐ No
   (Yes = CAM use for at least three months in the last one year)
   If yes, please proceed to question number 2-5
2. Choose the CAM that you have used (you can choose more than 1 category)

Group 1 Alternative Medical Systems
☐ Traditional Chinese medicine (e.g., acupuncture, cupping, and Tui-na therapy)
☐ Ayurvedic medicine of India ☐ Others……

Group 2 Mind-body interventions
☐ Meditation ☐ Yoga ☐ Qigong ☐ Others……

Group 3 Biologically Based Therapies
☐ Herbs…… ☐ Vitamin ☐ Ozone therapy ☐ Others……

Group 4 Manipulative and body-based methods
☐ Massage ☐ Osteopathy ☐ Chiropractic ☐ Others……

Group 5 Energy therapies
☐ Pray ☐ Body energy ☐ Universal energy ☐ Others……

3. When did you used CAM?
   ☐ Currently use ☐ Not currently use but I have used in the last 1 year
4. For what reasons did you use the CAM (You can choose more than 1 choice)
   ☐ To treat any disease ☐ To promote health
   ☐ To alleviate the menopausal related symptoms ☐ Others……
5. In your opinion, do you think CAM is effective?
   ☐ Yes ☐ Average ☐ No

Menopause specific quality of life (MENQOL) questionnaire

- Please mark √ in ☐ No if you do not have any symptoms
- Please mark √ in ☐ Yes if you have symptoms and circle the number according to the degree of symptoms
  : 0 = you have symptoms but no effect in daily living
  1-6 represent severity of symptom from minimal to very bothered

	Symptoms	No effect in daily living → very bothered							
1.	Hot flushes and flashes	☐ No	☐ Yes →	0	1	2	3	4	5	6
2.	Night sweats	☐ No	☐ Yes →	0	1	2	3	4	5	6
3.	Sweating	☐ No	☐ Yes →	0	1	2	3	4	5	6
4.	Being dissatisfied with my personal life	☐ No	☐ Yes →	0	1	2	3	4	5	6
5.	Feeling anxious or nervous	☐ No	☐ Yes →	0	1	2	3	4	5	6
6.	Experiencing poor memory	☐ No	☐ Yes →	0	1	2	3	4	5	6
7.	Accomplishing less than I used to	☐ No	☐ Yes →	0	1	2	3	4	5	6
8.	Feeling depressed down or blue	☐ No	☐ Yes →	0	1	2	3	4	5	6
9.	Being impatient with other people	☐ No	☐ Yes →	0	1	2	3	4	5	6
10.	Feeling of wanting to be alone	☐ No	☐ Yes →	0	1	2	3	4	5	6
11.	Flatulence (wind) or gas pain	☐ No	☐ Yes →	0	1	2	3	4	5	6
12.	Aching in muscles and joints	☐ No	☐ Yes →	0	1	2	3	4	5	6
13.	Feeling tired or worn out	☐ No	☐ Yes →	0	1	2	3	4	5	6
14.	Difficulty sleeping	☐ No	☐ Yes →	0	1	2	3	4	5	6
15.	Aches in back of neck or head	☐ No	☐ Yes →	0	1	2	3	4	5	6
16.	Decrease in physical strength	☐ No	☐ Yes →	0	1	2	3	4	5	6
17.	Decrease in stamina	☐ No	☐ Yes →	0	1	2	3	4	5	6
18.	Feeling lack of energy	☐ No	☐ Yes →	0	1	2	3	4	5	6
19.	Drying skin	☐ No	☐ Yes →	0	1	2	3	4	5	6
20.	Weight gain	☐ No	☐ Yes →	0	1	2	3	4	5	6
21.	Facial hair	☐ No	☐ Yes →	0	1	2	3	4	5	6
22.	Changes in appearance, texture, or tone of skin	☐ No	☐ Yes →	0	1	2	3	4	5	6
23.	Feeling bloated	☐ No	☐ Yes →	0	1	2	3	4	5	6
24.	Low backache	☐ No	☐ Yes →	0	1	2	3	4	5	6
25.	Frequent urination	☐ No	☐ Yes →	0	1	2	3	4	5	6
26.	Involuntary urination when laughing or coughing	☐ No	☐ Yes →	0	1	2	3	4	5	6
27.	Change in sexual desire	☐ No	☐ Yes →	0	1	2	3	4	5	6
28.	Vaginal dryness during intercourse	☐ No	☐ Yes →	0	1	2	3	4	5	6
29.	Avoiding intimacy	☐ No	☐ Yes →	0	1	2	3	4	5	6

การเปรียบเทียบคุณภาพชีวิตของสตรีไทยที่มีอาการสัมพันธ์กับภาวะหมดระดูอายุตั้งแต่ 45 ปีขึ้นไป ที่ใช้และไม่ใช้การแพทย์ทางเลือก

มนันยา ศิลปกิจ, ปองรัก บุญญานุรักษ์

วัตถุประสงค์: *เพื่อเปรียบเทียบคุณภาพชีวิตสตรีไทยอายุตั้งแต่ 45 ปีขึ้นไป ที่มีอาการสัมพันธ์กับภาวะหมดระดูที่ใช้และไม่ใช้การแพทย์ทางเลือก*

วัสดุและวิธีการ: *เป็นการศึกษาเชิงวิเคราะห์ภาคตัดขวาง กลุ่มตัวอย่างได้แก่สตรีไทยที่มีอาการสัมพันธ์กับภาวะหมดระดูอายุตั้งแต่ 45 ปีขึ้นไป ที่มารับบริการด้านสุขภาพที่คลินิกนรีเวช โรงพยาบาลพระมงกุฎเกล้า ผู้เข้าร่วมการศึกษาจะได้ทำแบบสอบถามด้วยตนเอง ประกอบไปด้วยข้อมูลทั่วไป ข้อมูลด้านการใช้แพทย์ทางเลือก และแบบสอบถามคุณภาพชีวิตสำหรับวัยหมดประจำเดือนโดยใช้ menopause specific quality of life (MENQOL) ฉบับภาษาไทย จำนวน 29 ข้อ คะแนนต่ำหมายถึงคุณภาพชีวิตที่ดี ตัววัดที่สำคัญคือความแตกต่างของคุณภาพชีวิตระหว่างสองกลุ่มดังกล่าว*

ผลการศึกษา: *สตรีที่เข้าร่วมการศึกษาทั้งหมด 204 คน แบ่งเป็นกลุ่มที่ใช้และไม่ใช้แพทย์ทางเลือก กลุ่มละ 102 คน โดยอายุเฉลี่ยทั้งหมดคือ 56.45 ปี จากการศึกษาพบว่าคะแนนคุณภาพชีวิตเฉลี่ยไม่ต่างกันระหว่างสองกลุ่ม คือ คะแนนคุณภาพชีวิตเฉลี่ย ± ส่วนเบี่ยงเบนมาตรฐาน ของกลุ่มที่ใช้และไม่ใช้แพทย์ทางเลือก เท่ากับ 2.18±1.15 คะแนน และ 2.01±0.88 คะแนน ตามลำดับ ($p = 0.593$) เกือบทุกประเภทของแพทย์ทางเลือกสัมพันธ์กับคุณภาพชีวิตที่แย่ โดยเฉพาะกลุ่ม energy therapy ที่พบว่ามีคุณภาพชีวิตที่ต่ำกว่าอย่างมีนัยสำคัญ ($p = 0.019$) อย่างไรก็ตามมีเพียงกลุ่ม mind-body interventions ที่พบว่ามีคุณภาพชีวิตที่ดีกว่า แต่ก็ไม่พบความแตกต่างอย่างมีนัยสำคัญ*

สรุป: *ในภาพรวมไม่พบความสัมพันธ์ในด้านคุณภาพชีวิตของสตรีวัยหมดระดูระหว่างกลุ่มที่ใช้และไม่ใช้การแพทย์ทางเลือก และการศึกษาเพิ่มเติมเพื่อดูความสัมพันธ์ในด้านต่าง ๆ ของการใช้แพทย์ทางเลือกเป็นสิ่งจำเป็น*