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GERIATRIC APPROACH TO MENOPAUSE

Keith Walker, O.D., M.C.S.O.

Dr. Fred Adair, Professor Emeritus of the Department of Obstetrics and Gynecology of the University of Chicago, says that "sexual maturity, as distinguished from Somatic growth, is one of the latest of the developmental processes to occur, and is one of the first to begin its decline". It is reasonable to believe, therefore, that "The menopause is the frontier of the territory of old age" as someone has said.

Literally, the term "menopause" means pausing or stopping of the menstrual cycle in the female, but usage has given it a little broader meaning to indicate the climacteric or end of the reproductive function and, in this sense, may be applicable to the male as well as the female snice they both go thru somewhat similar endocrinal changes, albeit with considerable difference in noticeable reactions and at a later period usually, as far as the male is concerned.

To understand more fully the reasons for the reactions, let us remember the endocrine picture, herein we have the pituitary, thyroid, parathyroid, adrenals, and gonads acting as a corporation. With a delicate set of checks and balances, to carry on the vital functions of the human organism with the anterior pituitary sitting in the driver's seat, for it is from this portion of the pituitary that secretions emanate that activate all the other glands. Again, demands of the organism thru long periods of time – heredity - have determined the relative importance of the individual glands in this corporation. For example, bulls, wolves and cats - fighting animals- have a very powerful adrenal cortex, while rabbits and cows the opposite is the case. So, from mere function alone as civilization progressed, the female's greatest reason for existence became the producing, nourishing and rearing of offspring, thereby calling for a vigorous activity of the ovaries, and the posterior portion of the pituitary while the male became the protector, and food producing of the family, necessitating a strong adrenal cortex and anterior pituitary that he might fight and outwit his enemies or adverse environment, leaving only a minor role for the gonads.

With this picture in mind, it can be easily seen that, with her whole life centered around the ovarium function, the female is apt to have a much greater physical and mental disturbance than is the male, and as the ovarium secretions are withdrawn, much greater demands are going to be made on the other glands to maintain bodily function and metabolism, with a resulting earlier and more rapid aging in the female. Again, various types of individuals will show a wide variance in frequency and intensity of symptoms and length of period of adjustment. For example, sympathy from her more feminine sisters, while the effeminate man may go thru the tortures of the damned, show a decided break in the usual mental stability and agility, lose his business acumen, run off with his secretary, or what have you. In other words, the fading of the sex function is the first real break in the three great instinctive drives, viz. existence, preservation and reproduction.

The symptoms of ovarian hypo-function are quite definite and are the chief basis for diagnosis. They are both objective and subjective, the latter being much more distressing to the patient.

The objective signs are:

1. Disturbance of the regularity and volume of the menstrual flow ending finally with complete amenorrhea.

2. Deposit of fat over the trochanters and breasts.

3. Development of fine vertical lines on the upper lip.
4. Sparseness of hair on the outer third of the eye brow.

The subjective signs are much more numerous and can be divided into types viz. nervous, circulatory and general.

A Nervous:

1. Nervous tension – jumpy, trembly, feel like screaming.
2. Excitability – exaggerated responses to ordinary stimuli.
3. Irritability – hard to get along with; playing children, the radio almost anything stirs them into action.
4. Headaches – all types but mostly down the back of neck and shoulders. Fifty-eight percent of castrates and thirty-seven per-cent of women after menopause show this type of headache.
5. Melancholia – blues; crying without reason; "something dreadful going to happen; someone watching them; premonitions.
6. Decreased memory – especially for recent events, can't remember what they read.
7. Sometimes sensations of ants crawling on skin:
8. Insomnia – all types.

B. Circulatory symptoms:

1. Hot Flashes
2. Tachycardia, palpitation, and dyspnea, combined with a great amount of fatigue
3. Vertigo
4. Tinnitus
5. Scotomata
6. Cold Hands and low, pulse pressure.
8. Low blood pressure generality.

C. General Symptoms

1. Lassitude and fatigue
2. Constipation
3. Vague pains
4. Lessening of physical activities resulting in a greater use of the eyes which necessitates a more careful adaptation of lenses.

Now the review of all of this information which is available to us in the literature on this very interesting phase of life would be of little avail unless we do something about it. Let us first realize that this is a natural phenomenon and what we all are going to go thru it sooner or later, with great majority between the ages of forty to fifty years, one eighth before forty, three eights from forty to forty-five, three eights from forty-five to fifty, and one eight after fifty, and that the job of the professions is not to prevent it, but to assist in making the required adjustment with as little distress as possible. If the loss of the gonadal secretions is abrupt, as in the case of disease or castration, different technics should be used than when the loss is natural or gradual. Too often every patient gets the same dose, a few shots of theelin, the ovarian principle. But if you look at your symptoms most of them are also found in hypo- or hyper – function of the other glands, e.g., fatigue is a definite result of lack of thyroid and adrenal secretions; loss of memory, lack of pituitary; excitability, over-secretion of the thyroid. You have all types of individuals with varying degrees of secretion from the various glands, each one of which may vary from hyper, to barely sufficient, to hypo secretion during the normal reproducing period of life, and now as the gonads go out of the picture, the other glands have to pick up the burden with the result that the hyper secretion may now become barely adequate, the adequate is now hypo and the hypo is more pronounced and may fail entirely or become diseased, e.g., Addison's disease. Another factor to be considered is the fact that synthetic feeding seldom gives the precise effect as natural secretion, and the sensitivity to therapy varies greatly with different individuals, so that the shot of a hormone may give a complete relief in one case and comparatively none in another and the latter comes to your office with a history of having gone to this doctor and that doctor with no relief and is to all intents and purposes your complete neurasthenic.

My suggestion is that you study each of your endocrine cases pretty carefully, from the signs you all know – skeletal formation, skin texture, hair distribution, tooth formation, fat distribution, etc., determine in your mind which glands are over or under active and then talk this over with some physicians in whom you have confidence, and gradually as he realize you know what you are talking about you can suggest the type of Rx that each patient should receive. This is particularly true with younger physicians.

Of course, you know many of these cases can be handled successfully with Syntonics, when the actual glandular deficiencies are not too pronounced, but in many of them polyglandular feeding is definitely indicated.

This method of care came to me some ten years ago when I was affected in the same manner. I became morose, uninterested in my family, my office, and my surroundings; I couldn't think, I could hardly remember what happened the day before. My family still talk of many things we did and that happened at that time, things that are a complete blank to me today. I was disagreeable, and I simply didn't care whether school kept or not, and was as tired in the morning as when I went to bed after eight hours sleep. Gentlemen, I tell you, it was a terrible state to be in and yet I knew I should not be that way. I was too indolent to try Syntonics so I finally went to a medical friend and told him what I wanted. He rather scoffed at the idea but gave me the Rx I asked for, a heavy dose of anterior pituitary and adrenal cortex, put up in capsular form and even tho I am naturally a hyperthyroid I added one of thyroid per day. The results were profound, so far as I was concerned, and I think some of you will remember I was clicking along pretty well at our Syntonic meetings. Since that time, I have continued to use the same Rx, varying the number of capsules per day as I have felt the need and have cut the thyroid to one-half grain per day. In the last five years – particularly during the war period – I have worked eight to ten hours per day in the office and carried many civic responsibilities besides, and have not lost a day

because of illness in the last ten years. However, I have checked many times to see if this was all in my mind or not. It takes about ten days without either the capsules or the thyroid and I begin to get drowsy and find myself cutting corners with my work, and putting off thigs that I know should be done.

I hope you will pardon this personal history but I know this case better than any other and am positive of my facts, and I felt I wanted to give them to you.

The final point I want to make is that the Rx I use might not be the one for you. You might need only a slight or heavy amount of thyroid and no pituitary or you might react to pituitary and no thyroid. You have to work each case out for yourself. Some cases react better to shots with little effect from capsules, while with others the capsules are sufficient. This should be worked out with your physician.

The foregoing, of course, is just a start on this subject. All of the glandular imbalances noted have a direct effect on the autonomic nervous system and each of the above listed symptoms should be tabulated as normal or abnormal as the patient is typed as asthenic, syntonic or pyknic, and the appropriate syntonic Rx's worked out.

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By -

Keith Walker, O.D., M.C.S.O.8

57 Oak Avenue
Bellflower, California