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Menopause is defined as permanent cessation of menstruation at the end of reproductive life due to loss of ovarian follicular activity. It is a natural and inevitable phenomenon and serves as a natural event.

Climacteric is the physiologic period in women’s life during which there is regression of ovarian function.

When Menopause is induced it is known as artificial or induced menopause. It is induced artificially by surgical removal of both ovaries called SURGICAL MENOPAUSE or by suppressing ovarian function by external gamma radiation, or intracavitary radiation called radiation induced menopause.

Menopause occurs at median age of 51 years (according to western data). In India, age of menopause is 44-50 years. It occurs earlier in cigarette smokers, nulliparous women, high altitude inhabitant. It appears to be genetically predetermined. But approximately 1% of women undergo menopause before the age of 40 years known as premature ovarian failure (R. Barbee, H Abdulla, J Studd Vol. 9, 209).

The women of post menopausal group suffer from symptoms of vasomotor instability (i.e. hot flushes, night sweats, palpitations, insomnia etc.), urogenital atrophy (i.e., vaginal dryness, dyspareunia, itching, urinary incontinence,
frequency, urgency, nocturia and dysuria etc), Psychosomatic changes (i.e. irritability, depressive symptoms, insomnia, diminished libido etc). and late consequences such as bone pain, spontaneous fracture, cardiovascular diseases and Alzheimer disease. The young age of artificially induced menopause causes abrupt onset of these symptoms as compared to natural menopause.

Numerous studies suggest that lack of ovarian function is responsible for altered lipid profile, which increases the risk of coronary artery diseases, and osteoporosis via altering calcium metabolism in both natural menopause or induced menopause.

Not so long ago women viewed menopause as a natural process of aging, to be tolerated with static silence. Over a past few decades, we have achieved significant progress in our understanding of menopause and have come to view this period of life more and more as a state of estrogen deficiency.

Current demographic trends indicate that due to increase in life expectancy and increased incidence of panhysterec-tomies at an early age for various gynecological causes, about 1/3rd of women’s life is in her post menopausal period. On the other hand, women are now playing increasingly active roles in the social and professional areas. So improving quality of life during post menopausal years has grown to be an important issue.
Estrogen deficiency causes quality of life to be poor at and after menopause. Estrogen can be given by a variety of routes- oral, transdermal, subcutaneous, vaginal.

It has become abundantly clear that patients, who are on long term estrogen replacement therapy are at lower overall mortality risk than women who do not receive any replacement. However, benefit of HRT needed to be weighed against possible risk associated with long term use such as uterine and breast cancer and thromboembolic phenomenon.

Selective Estrogen Receptor Modulators are the new class of drugs which is believed to have ideal properties for a product designed for menopausal women. One most widely studied member of this class is RALOXIFENE. It is a nonsteroidal derivative of benzothiophene.

Accumulating evidence is there from many studies that SERMS - Raloxifene may confer health benefits related to cardiovascular disease, osteoporosis, endometrial cancers.

The present study is conducted to compare the effects of estrogen replacement therapy and Raloxifene in post menopausal women of Bundelkhand region.