
**Research Article**

## Spectrum of Gynecological Disorder in Geriatric Women: A Tertiary Care Centre Study

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### Abstract

**Background:** Geriatric care focuses on addressing the multifaceted needs of the elderly, emphasizing health promotion, disease prevention, and treatment. Ageing is a gradual, inevitable process, and geriatrics aims to distinguish between expected ageing effects and diseases, promoting healthy ageing. Gerontology, a broader field, encompasses the physical, mental, and social aspects of ageing. Specialized areas like geriatric gynecology tackle pathologies in postmenopausal women, including uterine prolapse, malignancies, and urinary issues. Despite the prevalence of these conditions, research on their collective impact needs to be improved, leading to poor quality of life, prognosis, and economic burden. Such research should be more noticed in health priorities.

**Aim of the study:** The study aims to know gynecological diseases with their demographics and to assess clinical profile and comorbidities in geriatric women.

**Methods:** This study was prospective and cross-sectional. The study was conducted in Sir Salimullah Medical College Mitford Hospital (SSMCH), and the data were collected from the gynae inpatient department. The study period was from May 13 2018 to November 12' 2018. One hundred sixty selected patients, aged between 60 and 79 years, admitted to six Gynae units (SSMCH), were included in this study and evaluated. The patients were managed according to standard clinical protocols. Written informed consent was taken from patients or their relatives. All data were collected in an individual case record form. Data were analyzed using the SPSS version 16.0 and presented as mean and percentage as applicable.

**Results:** In this study, 160 geriatric women were enrolled. Their age ranged from 60-79 years, mean age was 66.21±4.72 SD. 47.5% of the patients were from the 60-65 age group, while 40% were 66-70 years old. The majority of patients were married (67%), rural (69.37%), and illiterate (84.37%). Low socioeconomic condition was also remarkable (71.25%). The age of menopause extended from 35 to more than 50 years, with a mean menopausal age of 46.25± 3.51 SD. They were presenting age since menopause was 19.61±5.58 SD. The majority of the patients were multiparous (87%). Uterovaginal prolapse, urinary tract infections, and malignancies were the most frequent diseases encountered in the study, out of which prolapse was 37.5%. 3° UV prolapse was the most typical (28.12%) associated either with cystocele, rectocele, or both. Among malignancies (10.63%) had ovarian cancer, followed by cervical cancer. Urinary incontinence was also present in 19.32% of patients. The largest group of patients presented with the symptom of something coming down per vagina was 37.5%. Next to this, postmenopausal bleeding and frequency of micturition had the same frequencies (20.62%).

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The symptoms were more than two years in 42.50% of patients. Among systemic symptoms, generalized weakness (65.62%), backache (43.12%), and loss of appetite (39.37%) merits should be mentioned. Moreover, the majority (75%) had multiple symptoms. Anaemia was the most significant general examination finding (54.37%). Among comorbidities, Hypertension (39.38% and Diabetes mellitus (24.38%) were more prevalent than any other comorbidities in the study population.

**Conclusion:** In the present study, Pelvic organ prolapse and genital malignancy are the major gynecological causes of hospital admissions in patients above 60 years. Something coming down per vagina is the most typical complaint. The prolapse at this age is generally advanced and extensive. Ovarian and cervical cancers are showing a rising trend in this age group. The majority of the patients with cervical cancer presented at an advanced stage and hence were inoperable.

**Keywords:** Spectrum, Gynecological disorder, Geriatric Women, Tertiary Care Centre

## Introduction

Geriatrics emphasizes the health care of older adults. It promotes health by preventing and treating diseases and disabilities in older adults. The term geriatrics was derived from the Greek words "geron," meaning "old man," and "iatros," meaning "healer" [1]. Dr. Ignatz Natcher, an Austrian physician, coined the word Geriatrics in 1909. However, in 1935, a British doctor working in the USA, Marjory Warren, first developed the practical concept of geriatric rehabilitation. With her initiation, the elderly patients were gradually taken over by tertiary hospitals. Geriatrics is no longer interchangeable with medical gerontology, which is the ageing process [2]. Ageing is a natural phenomenon. Aging results in increased functional deterioration and vulnerability, ultimately culminating in the extinction of life. In most gerontological literature, people aged 60 years or above are considered elderly [3]. In developed societies, chronological age plays a paramount role, whereas, in developing countries, chronological age is unimportant in defining old age [3]. The elderly population in the context of Bangladesh has been defined as those who have reached 60 years of age, particularly taking into account average retirement age legislation, health conditions, and so on, in contrast to 65 years in developed ones [3]. Bangladesh is the eighth largest and one of the most densely populated countries (164,320,556 in 2017, 1266 per Km<sup>2</sup>) [4].

The aged population (60+ population) is about 5% (7.3 Million), with a male-to-female ratio of .97, which will reach

7% (14.6 million) of the total population by the year 2025 [5]. Bangladesh will face many difficulties in managing the challenges of a large elderly population. The most important challenge is geriatric illness, which will seriously affect society [6]. Geriatrics is different from adult medicine because it focuses on the unique needs of the older adult [7]. The decline in organ physiological reserve makes the elderly develop some kinds of. diseases and have more complications from mild problems. Multiple problems may compound. Moreover, some diseases commonly seen in the elderly are rare in adults. Many specialized geriatric and geriatrics-related services emerged to combat this, including medical, surgical, gynecological, and various other sub-specialties [8]. Geriatric gynecology deals with gynecological pathologies encountered in postmenopausal women aged 60 years and above [9]. In most cases, women in the geriatric age group remain well in their postmenopausal phase of life. Newer medical services have increased life expectancy significantly [10]. So, age-related geriatric problems have emerged significantly with enhanced longevity of life. The various gynecological disorders due to ageing are uterine prolapse, gynecological malignancies, benign adnexal masses, endometrial hyperplasia, endometrial polyp cervical polyp, urinary incontinence, genital tract infections, vulvovaginal disorders, and many of the patients have associated comorbidities also which will be encountered in this study [11].

The exact prevalence of diseases is unknown, but every disease has its prevalence rate. In a women's health initiative (WHI) trial in the United States, urinary prolapse was found in about 12% of the 27342 women enrolled in the study [12]. About malignancy in a study by the National Institute of Cancer Research and Hospital, Parvin Shahida et al. showed that Carcinoma of the Cervix accounts for 11% of all cancers and is second to carcinoma of the breast in frequency among all cancers in women. Some other studies revealed endometrial cancer about 7% whereas ovarian cancer was 3% [13]. Raul Raz et al. depicted that the prevalence of UTIs is about 10-12% of women aged 60-65 years and increases even further with age [14]. Our country's lack of dedicated geriatric services causes a deficient reflection of geriatric illness [15]. Hence, those who seek medical services usually present with something coming down per vagina, postmenopausal bleeding, lower abdominal pain, per vaginal discharge, dysuria, backache, vulval itching, and vulval growth [16]. Many patients present with other systemic symptoms like anorexia, weight loss, and generalized weakness. Anaemia, lymphadenopathy, hepatomegaly, and ascites are frequent findings on physical examination [17]. After admission into the hospital, a detailed history will be taken, and a thorough clinical examination will be performed. Routine investigations include complete blood count, blood biochemistry, and urine

examination. An ultrasonogram of the abdomen with attention to pelvic organs will be carried out. Urine C/S, vaginal swab culture, thyroid profile and Pap smear, CT abdomen, and biopsy followed by histopathology will be asked in the pertinent cases. Nevertheless, the patients will be treated with standard treatment protocols. Gynecological disorder potentially impacts the function and quality of life (QoL) of older women. Most diseases are usually present in advanced stages as there are no screening programs for early detection and no standard geriatric services. As postmenopausal life is increasing gradually with more life expectancy, prognosis remains a burning issue as well. Therefore, a healthy life for geriatric women becomes essential to improve survival and reduce the burden on society. In this study, women of 60 years and above will be included, their spectrum of diseases and common presentation of diseases will be evaluated, and relevant investigation will be done, if treatment will be given accordingly.

## Methodology & Materials

This is a descriptive type of cross-sectional study. The study was conducted at the Department of Gynaecology and Obstetrics of Sir Salimullah Medical College Mitford Hospital (SSMCH), Dhaka, Bangladesh. The study was carried out from 13<sup>th</sup> May 2018 to 12<sup>th</sup> November 2018. Women 60 years and above admitted to the Gynae ward of SSMCH were selected as the study population.

### • Inclusion criteria:

- Women aged 60 years or above are considered geriatric women.
- Patients who deal with gynecological pathologies encountered in postmenopausal women.

### • Exclusion criteria:

- Patients with breast diseases.
- Patients are receiving hormone replacement therapy.

## Operational definitions

Geriatrics which deals with the care of aged people. Aging Defined as a biological process with time-dependent irreversible changes leading to progressive loss of functional capacity.

### Uterine prolapse

Graded as per the Baden Walker system on a scale of 0 to 4:

**Grade 0:** Defined as no prolapse.

**Grade 1:** Prolapse halfway to the hymen.

**Grade 2:** Prolapse to the introitus.

**Grade 3:** Prolapse halfway beyond the hymen.

**Grade 4:** Complete prolapse.

**Cystocele:** Defect of the pelvic muscular support of the anterior vagina allowing the bladder to descend into the vagina.

**Rectocele:** Defect of the pelvic muscular support of the rectum, allowing the rectum to impinge into the vagina

**Enterocele:** Defect of the pelvic muscular support of the uterus and cervix (if still in situ) or the vaginal cuff

### Postmenopausal bleeding (PMB)

Defined as vaginal bleeding 12 months after spontaneous amenorrhoea.

### Atrophic vaginitis:

Inflammatory vaginitis accompanied by purulent discharge with atrophy of external genitalia and loss of vaginal rugae.

### Urinary Incontinence:

Any involuntary leakage of urine stress urinary incontinence was associated with increased Intra-abdominal pressure.

### Urinary tract infection (UTI):

It is defined as viable microorganisms within the urinary tract in cultured urine.

### Procedures of data collection:

When patients of 60 years or above were admitted to the gynecology inpatient department of Sir Salimullah Medical College Mitford Hospital (SSMCH), with various presenting features like heaviness in the lower abdomen, postmenopausal bleeding, dysuria, per vaginal discharge were selected to participate in the study. Each patient's eligibility was assessed, and all responsible family members of the patient were asked for informed consent. They were informed about the procedure and study objectives and assured that there would be no chance of harm to the patient by inclusion. The patient was also informed that they were free to refuse to participate or withdraw at any time without compromising their medical care, and this process would not involve any question that might hurt them or cause them to experience any embarrassment or regret. So, it did not cause ethical conflict. Then, written consent was obtained for the study. History and detailed information about patients were taken from patients/attendants. Data were recorded in a pre-formed semi-structured questionnaire. The principal investigator kept Complete data collection forms to which no one had any access.

### Data processing and statistical analysis:

Statistical analyses will be conducted using the statistical

package for social sciences version 16.0 for Windows (SPSS Inc. Chicago, Illinois, USA). The mean values will be calculated for continuous variables. Frequencies and percentages will indicate the quantitative observations. Chi-Square test with Yates correction will be used to analyze the categorical variables, shown with cross-tabulation. Student t-tests will be used for continuous variables. P values < 0.05 will be considered as statistically significant.

## Results

This study included 160 geriatric female patients with gynecological disorders diagnosed by suggestive history and clinical features from 13<sup>th</sup> May 2018 to 12<sup>th</sup> November 2018. All patients were enrolled after meeting the inclusion and exclusion criteria of the research proposal. Their age ranged from 60 to 79 years; the mean age was 66.21±4.72 SD, and 47.5% of the patients were from the 60-65 age group, while 40% were from 66-70 years. Most of the patients were married, and some were widowed. Only five patients were unmarried. The rural population represented most patients, with the rest from urban areas. As an important demographic variable, educational status reflected the patient's proportion of negligence about self-care. The majority, 135, were illiterate, 20 were up to SSC, and the remaining 10 were SSC and above. The socio-economic status also coincides with residence and educational background, which showed lower class people more (71.25%). The higher class contributed only 3.75%. Betel nut consumption was one of the important personal habits (37.5%), followed by smoking (5%). The majority of the respondents' habits were unremarkable (53.13%). Table 2 reveals that patients from different corners of Bangladesh were enrolled; among them, 85 (53.12%) were the largest group experiencing menopause during the age of 46-50 years, whereas only 11(6.87%) were over 50. Apart from this, more than fifty per cent of the patient's post-menopausal period until hospital contact was from 11 to 20 years. Another important thing to mention is that about 87% of patients admitted to our hospital have three or more children.

Only 13.12% of patients have two children or less. Table 3 shows the study population distribution, revealing significant factors. Uterovaginal Prolapse stands out at 37.5%, indicating a prevalent geriatric disorder. Malignancies contribute significantly at 20.62%, highlighting a substantial proportion facing potential cancer risks. Out of genital prolapse, third degree is more marked (28.12%), followed by cystocele (26.25%) and rectocele (25%). Most of the third-degree prolapses (about 90%) had either cystocele, rectocele, or both. Table 4 reveals malignancies ovarian cancer (10.63%) is the highest in comparison to cervical cancer (6.87%) and endometrial cancer (3.12%). Vaginal and vulval cancer is not found in this study. Infection comprises a significant portion

**Table 1:** Demographical characteristics of the study population (N=160)

| Variables            | Frequency (n) | Percentage (%) |
|----------------------|---------------|----------------|
| Age group (Years)    |               |                |
| 66-65                | 76            | 47.5           |
| 66-70                | 64            | 40             |
| 71-75                | 11            | 6.88           |
| ≥76                  | 9             | 5.63           |
| Marital Status       |               |                |
| Married              | 107           | 67             |
| Unmarried            | 5             | 3              |
| Widowed              | 48            | 30             |
| Residence            |               |                |
| Rural                | 49            | 30.63          |
| Urban                | 111           | 69.38          |
| Educational Status   |               |                |
| Illiterate           | 135           | 84.37          |
| Below SSC            | 15            | 9.37           |
| SSC & Above          | 10            | 6.25           |
| Socioeconomic Status |               |                |
| Low                  | 114           | 71.25          |
| Middle               | 40            | 25             |
| High                 | 6             | 3.75           |
| Personal Habit       |               |                |
| Betel Nut            | 60            | 37.5           |
| Gul                  | 7             | 4.37           |
| Smoking              | 8             | 5              |
| None                 | 85            | 53.13          |

**Table 2:** Distribution of the study population based on menopause history and parity (N=160)

| Variables                | Frequency (n) | Percentage (%) |
|--------------------------|---------------|----------------|
| Age of Menopause (years) |               |                |
| 35-40                    | 6             | 3.75           |
| 41-45                    | 58            | 36.25          |
| 46-50                    | 85            | 53.13          |
| >50                      | 11            | 6.87           |
| Years Since Menopause    |               |                |
| Up-to 10                 | 7             | 4.38           |
| Nov-20                   | 86            | 53.75          |
| 21-30                    | 59            | 36.87          |
| <30                      | 8             | 5              |
| Parity                   |               |                |
| 1 to 2                   | 21            | 13.12          |
| 3 to 4                   | 82            | 51.26          |
| 5 and more               | 57            | 35.62          |

**Table 3:** Distribution of the study population based on geriatric disorders and genital prolapse (N=160)

| Variables                  | Frequency (n) | Percentage (%) |
|----------------------------|---------------|----------------|
| <b>Geriatric Disorders</b> |               |                |
| Uterovaginal Prolapse      | 60            | 37.5           |
| Malignancies               | 33            | 20.62          |
| Benign Ovarian Lesion      | 12            | 7.5            |
| Urinary Tract Infections   | 41            | 26             |
| Genital Infections         | 8             | 5              |
| Urinary Incontinence       | 31            | 19.37          |
| <b>Genital Prolapse</b>    |               |                |
| 2 UV Prolapse              | 12            | 7.5            |
| 3 UV Prolapse              | 45            | 28.12          |
| Vault Prolapse             | 3             | 1.87           |
| Cystocele                  | 42            | 26.25          |
| Rectocele                  | 40            | 25             |

**Table 4:** Distribution of the study population based on malignancy and infection (N=160)

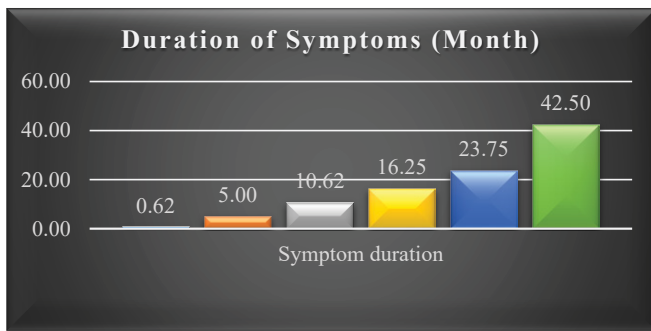
| Variables                       | Frequency (n) | Percentage (%) |
|---------------------------------|---------------|----------------|
| <b>Malignancy</b>               |               |                |
| Ovarian Cancer                  | 17            | 10.63          |
| Cervical Cancer                 | 11            | 6.87           |
| Endometrial Cancer              | 5             | 3.12           |
| <b>Infections</b>               |               |                |
| Urinary Tract Infections        | 42            | 26.25          |
| Genital Infections              | 8             | 5              |
| <b>Urinary Tract Infections</b> |               |                |
| Lower Urinary Tract Infections  | 26            | 16.25          |
| Asymptomatic Bacteriuria        | 16            | 10             |
| <b>Genital Infections</b>       |               |                |
| Vaginitis                       | 5             | 3.13           |
| PID                             | 3             | 1.88           |

of patients (31.25%) admitted to hospital seeking treatment. Urinary tract infections (26.25%) were more common than genital ones. Lower urinary tract infections and asymptomatic bacteriuria were prevalent, whereas pyelonephritis and septicemia were not found. Among genital infections, vaginitis and pelvic inflammatory diseases were present. Table five shows the gynecological symptom where something coming down per vagina was the leading symptom (37.5%), followed by post-menopausal bleeding and frequency of micturition. Urinary incontinence also contributed closely to these symptoms. Lower abdominal pain, heaviness in the lower abdomen and abdominal distention were also present in variable proportions. Dysuria, vaginal discharge and vulval itching were less marked. Apart from this, many patients had urinary difficulties (47.5%). Some were noted to have

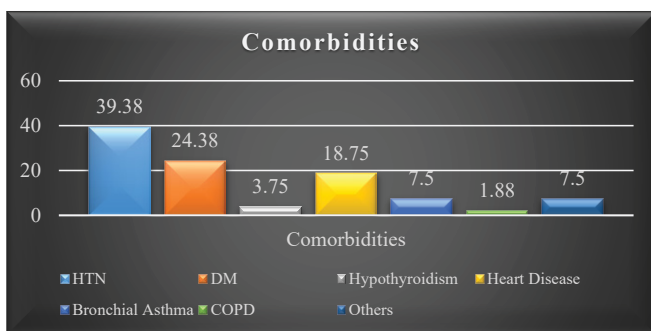
post-coital bleeding. Apart from gynecological symptoms, systemic symptoms were also present. About two-thirds of the patients had generalized weakness (65.62%), Followed by backache (43.12%). Many patients also lost appetite (39.37%) and weight loss (26.25%). Figure 1 illustrates the duration of symptoms recorded among the study population. Most patients had symptoms for more than two years, 42.50%. On the other hand, acute presentation was present only in a minority of patients. It suggested that before accounting for gynecological services, the patient had suffered from diseases for some years. Table 6 presents general, respiratory, and abdominal examinations, which revealed several important findings. More than half of the patients were anemic. Again, anemia was mild in most of the patients. Besides anemia, the other general examination finding was unremarkable. The Chest Examination data reveals potential respiratory issues, with 5.62% exhibiting Ronchi and 5% Crepitation's. However, the respiratory examination pointed to some obstructive airway diseases, while ascites and abdominal mass were found in some patients during the abdominal examination. Figure 2 illustrates comorbidities, which are important in evaluating the study population. Among the findings, HTN and DM were the most prevalent diseases in the patients. Heart disease also had a good contribution, whereas bronchial asthma, hypothyroidism and other diseases were also present in some proportion.

**Table 5:** Symptoms of the study population (N=160)

| Variables                      | Frequency (n) | Percentage (%) |
|--------------------------------|---------------|----------------|
| <b>Gynecological Symptoms</b>  |               |                |
| SCOV                           | 60            | 37.5           |
| PMV                            | 33            | 20.62          |
| Lower Abdominal Pain           | 18            | 11.25          |
| Abdominal Distension/Lump      | 18            | 11.25          |
| Heaviness in the Lower Abdomen | 20            | 12.5           |
| Vaginal Discharge              | 6             | 3.75           |
| Vulval Itching                 | 12            | 7.5            |
| Dysuria                        | 12            | 7.5            |
| Frequency of Micturition       | 33            | 20.62          |
| Urinary Incontinence           | 31            | 19.38          |
| Urinary Difficulties           | 76            | 47.5           |
| Defecation Problem             | 24            | 15             |
| With Post Coital Bleeding      | 15            | 9.37           |
| Without Post Coital Bleeding   | 18            | 11.25          |
| <b>Systemic Symptoms</b>       |               |                |
| Loss of Appetite               | 63            | 39.37          |
| Weight Loss                    | 42            | 26.25          |
| Generalized Weakness           | 105           | 65.62          |
| Backache                       | 69            | 43.12          |
| Constipation                   | 27            | 16.87          |



**Figure 1:** Distribution of the study population based on symptom duration (N=160)



**Figure 2:** Comorbidities of the study population (N=160)

## Discussion

This study highlighted common geriatric gynecological disorder, their demographic variations, clinical presentation, analysis of presenting features, and associated comorbidities. This study on geriatric gynecological disorders can be discussed and compared under the following criteria. The present study found the peak incidence of different diseases in the sixth decade of life. The mean age was  $66.21 \pm 4.72$  SD years, and 87.50% of the patients were from the 60-70 years age group, more from the first half of the decade, while 6.87% and 5.62% were from 71-75 years and more than 76 years respectively. This finding is comparable to other studies in which the maximum presentation was from a similar age group [9]. The study shows married women (66.87%) being affected more than any other group, such as unmarried (3.125%) or widowed (30%). Probably, this can be explained by the fact that women are still dependent on their husbands to avail treatment facilities rather than being individual enough to have the services. The proportion of the rural population (69.38%) is much higher than the urban population (30.62%) in this study. This differs from the study by Kaur et al., which showed almost equal presentation from rural and urban areas [18]. The probable reason for this deviation could be the greater number of rural patients attending a tertiary government hospital or the urban population not preferring the government hospital to have services. Most attending females in our hospital are illiterate (84.37%), with a few

exceptions. Moreover, most women coming to the hospital are from low socioeconomic conditions (71.25%) [19]. Low literacy rates and low socioeconomic factors could contribute to not achieving proper geriatric services. Some other studies in India showed that the lack of adequate geriatric gynecological care is also responsible for the suffering of older adults [20].

Regarding the profession, homemakers mostly encountered problems, followed by some maidservants. It is quite dissimilar from different studies in America, which showed differences in occupational incidences where there is a good percentage of active people [21]. Betel nut chewing is credited as one of the major personal habits (37.5%), followed by gul users and smoking. The largest group's habit was unremarkable. Their causal relationship to different malignancies is not established in this study. This study shows that the average age of menopause is  $46.25 \pm 3.51$  SD years, which is consistent with an Indian study done by Ahuja M, who reported the average age of menopause in northern India to be  $45 \pm 3$  years. Menopausal age of a woman serves as a biomarker for subsequent disease prediction and mortality [22,23]. Different epidemiological studies all over the world have established that the risk of uterine/ovarian cancer increases by 5% with each increasing year of age at menopause [24]. Our study has proven this by a lower incidence of malignancy, which could be due to early menopause, in contrast to studies in developed countries. Apart from that, in 4.2% of patients, menopause was secondary to hysterectomy, which is much lower than that reported by Merrill RM12, which was as high as 33% by the age of 55 years in some of the American states [25]. Parity remains an important factor in influencing the development of various gynecological diseases, especially genital organ prolapse.

This is consistent with our study, provided that about 87% of patients are multiparous. Uterovaginal prolapse (37.5%) is the most frequent disease prevalent in older women, followed by gynecological malignancies (20.62%). This is a very dissimilar finding found in other studies like a study by Sood N et al., which showed malignancy at the top (54.01%), and Kaur et al. 32% but close to other studies done by Kumari et al. with genital prolapse of 43.2%, [9,10 & 17]. This variation may be due to a lack of screening programs, low literacy rate, lack of awareness, and late presentation of malignancies. Pelvic organ prolapse is a major cause of hospital admissions and surgery in geriatric women. In the present study, uterovaginal prolapse was present in (37.5%) of patients, out of which 28.12% were classified as grade 3. This shows that the symptoms forced them to seek medical attention 27 Pelvic floor weakness, either congenital or involvement in heavy household activities immediately after delivery, might be the reason for this large number of prolapsed patients.

Some studies mentioned that postmenopausal estrogen deficiency has adverse effects on biological aging and pelvic floor support mechanisms [26]. For example, Olsen AL et al. showed in their study that the age-specific incidence of genital prolapse increased with advancing age, and most patients were older, postmenopausal, parous, and overweight [27]. Chronic lung diseases are also contributing factors. This was similarly found in our study. There is a wide variation of data about cystocele and rectocele in different studies, but in our study, most 3° patients had either cystocele or rectocele or both. Among the gynecological malignancies (33 patients), ovarian carcinoma is the most common (10.63%), followed by cervical carcinoma (6.87%). This is consistent with the trend increasingly reported from our subcontinent in which ovarian and corpus uteri malignancies have risen in the past two decades [21]. However, this contrasts with a Western population where endometrial carcinoma is the most common [28]. The cervix is the second most common malignancy seen in females after breast cancer in Bangladesh [29,30]. In the present study, the incidence of cervical cancer seems to be less. This may be because the incidence of invasive cervical cancer is lower in women aged 65 and over. However, mortality is higher, largely because the stage at the time of diagnosis is more advanced [31].

Vulval and vaginal cancer are not reported in this study. The benign adnexal lesion was a relatively less frequent finding. Other than prolapse and malignancy, urogenital infections comprise a large number of patients seeking treatment from our center. Urinary tract infection ranges from asymptomatic bacteriuria to lower urinary tract infections. There was no pyelonephritis or septicemia. Ineffective voiding and incomplete bladder emptying probably lead to urinary stasis and colonization by pathologic bacteria, resulting in UTI [32]. In the case of genital infections, vaginitis and pelvic inflammatory diseases are encountered in this study. Several studies show that in older women, vaginal pH changes owing to lack of estrogen predispose to candida vaginitis [32]. Urinary incontinence represents an important spectrum of diseases mostly associated with other diseases, mainly genital prolapse, which comprises only stress incontinence. The most frequent symptom noted is something coming down per vagina, 37.5%, followed by postmenopausal bleeding 20.62%. Abdominal pain, distension, and lower abdominal heaviness also contributed. Apart from these, lower urinary tract symptoms make up a significant portion. The majority of the patients have multiple symptoms rather than a single symptom. Something coming down per vagina was mostly associated with urinary difficulties in the form of incontinence. In our study, the prime cause of postmenopausal bleeding was malignancy, which is consistent with other studies [33]. Symptoms were prolonged in a significant portion of the patients (42.5%). The reason behind this may be that most of the women come to the hospital when symptomatic.

Lack of awareness of screening programs, lack of health education, and the non-availability of medical facilities could be plausible explanations. Most patients did not have a pap smear or any other screening test. One of the possible reasons is that gynecological care is so distinct from general medical care that non-gynecologists are less well-trained to provide sufficient gynecological care. 36 An American study revealed similar results. One possible explanation is that, overall, gynecological conditions may become less frequent in older women once they are naturally menopausal or have gynecological surgery, such as a hysterectomy [34]. Other than organ-specific symptoms, systemic symptoms are also present in many patients. Generalized weakness is the main symptom (65.62%), followed by loss of appetite. Weight loss is classical in case of malignancy, whereas backache is due to uterovaginal prolapse. Anemia tops the general examination finding with no other notable abnormalities. The etiology of anemia could not be determined due to economic constraints. Nevertheless, anemia could be due to nutritional deficiency in our country. Abdominal examination reveals masses in several patients, which indicates malignant lesions. Some patients had irregular hepatomegaly suggestive of metastatic diseases. Besides these, some patients had ronchi with breath sound of vesicular expiration, indicating that they had obstructive airway disease. Reduced breath sound with dullness in the base of the lung correlated with metastatic malignancy. Comorbidities are great challenges in managing elderly patients. Hypertension and Diabetes mellitus are the most common diseases prevalent in geriatric patients. Coronary artery diseases are also present in several patients and need special attention.

## Conclusion

The text discusses the significant health challenges faced by older women in Bangladesh, focusing on geriatric gynecological disorders such as pelvic organ prolapse and genital malignancy. Patients over 60 years often experience advanced and extensive prolapse, with the common complaint of something coming down per vagina. Ovarian and cervical cancer, though rare, show a rising trend in this age group, often presenting at advanced stages, making them inoperable. Infections also contribute to the health issues. The postmenopausal period is crucial in a woman's life, and the ageing process adds complexity to treatment procedures. The responsibility of gynecologists as primary physicians for geriatric patients increases to detect disorders early and manage them to reduce morbidity and mortality. The establishment of geriatric units is proposed to improve the health and quality of life for women over 60. The text recommends screening programs for postmenopausal women, addressing reluctance for pelvic examinations, establishing geriatric clinics in the primary healthcare system, adopting a multidisciplinary approach, creating separate operation theatre units for high-

risk surgeries, and utilizing the study for healthcare policy decisions and resource allocation. Ultimately, the goal is to ensure that old age becomes a boon rather than a curse for older women in Bangladesh.

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