台灣更年期婦女現況

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台灣總人口約有 2322 萬人，女性人口達 1,158 萬人，其中 40 歲以上佔了 48%, 這幾近一半全國之婦女 （內政部人口統計 2011）。 若可能處於更年移轉期（menopausal transition) 在 40 - 54 歲 的話，台灣目前約有 278 萬多婦女處於更年移轉期，且有各式更年移轉期症狀如熱潮紅與冒汗 、經常疲憊、失眠 、月經不規則、腰酸背痛、心情起伏大容易低落鬱悶、陰道乾澀、頻尿 、焦慮急躁 (行政院衛生署國民健康局 2011)。 停經年齡後婦女若保守以地以 55 歲以上來計算，台灣有 275 萬停經後。這 275 萬婦女呈現停經後，多項疾病機率明顯增加之現象：諸如癌症，肥胖、新陳代謝不適 、血脂肪升高、心臟血管疾病、 失眠、憂鬱、骨質疏鬆與骨折等疾病。 台灣的更年期及停經後婦女之不適症狀和其他亞洲國家或歐美國家相比較起來，與亞洲婦女較相似，而與歐美婦女有相當明顯的差別 [1-3]：我們婦女以熱潮紅為主訴比例是遠不及歐美婦女，而以肌肉骨骼系統之症狀如膝關節痛、 下背痛為主訴則居多。而失眠，情緒不穩易怒與頭痛則遠高於歐美婦女，我們婦女對諸多更年期及其後的相關症狀有自覺該治療的比例也遠低於歐美婦女，尤其是性功能失調部份。

在近十年台灣學術界對中年以後婦女面臨完全停經前後的研究是愈來愈多而且探討廣度深度其實也不亞於歐美國家， 在學術網站中查得到的，以英文發表及以中文發表集合起來，高達 200 多篇，包括了各種生理病理及社會人文在更年期之研究探討， 諸如賀爾蒙代謝與變化、症狀與生活品質相關因素、更年期高血壓、 心律變異度、 柯氏憂鬱量表 、憂鬱情緒 ，憂鬱症狀相關因素 、更年期疲憊感及相關因素、 身體活動量與更年期自覺症狀、 運動與骨質疏鬆症、婦女對更年期觀點之轉銜與改變， 迎接新旅程－更年期更年輕、更年期障礙是「事先的警告」, 更年期之後的人生－面對癌症衝擊、醫病關係與女性醫療照護 、 更年期陰道泌尿道症狀困擾及其自我處理調查。台灣護理學界在更年期研究 [4-21] 指出：台灣更年期婦女由過去傳統的台灣婦女對自我的束縛，逐漸轉變婦女對於自我身體健康的掌控。也表現出台灣更年期婦女需要更多面向護理照顧、健康管理、和訊息需求，來陪同更年期婦女處理多變的、不可預測的的身心變化。2011 年起護理學界積極呼籲正視更年期婦女未來健康自我管理，協助更年期婦女增強正向的健康管理效能，並且爭取家人的諒解與陪伴。此外，別具文化特色之中醫學界，也提供了不少對更年期的台灣本土研究報告[1, 22-26]， 如更年期綜合徵、更年期營養、證型與自律神經相關性、中醫對更年期證候群的治療研究進展，中醫藥治療更年期婦女失眠症探討，中醫談女性更年期保養，中醫預防照護與更年期女性，傳統中醫藥對於更年期女性之養生保健，婦女更年期障礙之中醫治療，應用耳穴貼壓改善更年期症狀困擾、更年期婦女的中醫照護、更年期證候群流行病學研究與現代中西醫治療觀點等等以中醫式療法協助婦女更年期不適。當然所有的健

康工作者對全球共識的停經後賀爾蒙治療效應與另類荷爾蒙療法的內容、植物性雌激素的臨床作用、輔助療法在更年期症候群的應用，都應該有一定的瞭解與認識，若持之以恆共同努力，共同切搓， 是台灣婦女之福氣！

就醫療照顧部分，黃國恩院長為台灣更年期及停經後婦女創建了 2 個很重要的醫學會：台灣更年期醫學會和台灣骨鬆醫學會，並加入泛太平洋亞洲之聯盟，除了能集合相關有志一同的多位醫師對於臺灣婦女的打造更好的下半生，也讓台灣醫界在此領域有走入全球之舞台。臺灣醫者對更年期的相關研究中，不祇在更年期在台灣婦女對於更年期症狀的調查 [1-3, 23, 25-55]、更深入心臟疾病 [3, 36, 56-63]、荷爾蒙使用 [32, 43, 44, 49, 60, 64-74]、停經後使用荷爾蒙與乳癌的關係 [1, 3, 33, 36, 43, 44, 60, 61, 69, 75-91]、更年期骨質疏鬆藥物臨床試驗 [2, 3, 35, 36, 41, 44, 62, 69, 74, 81, 92-102]、新陳代謝 [58, 103-110] 、 肥胖 [103, 107, 108, 110-114] 、合併健康照護治療 [41, 47, 54, 76, 115-117]、更年期憂鬱 [32, 37, 39, 45, 46, 48, 55, 56, 118-124] 、睡眠障礙 [1, 3, 30, 36, 48, 119, 124-128] 、更年期泌尿系統疾患 [28, 29, 43, 61, 66, 72, 73, 86, 128-146] 、癌症 [25, 36, 43, 44, 53, 60, 61, 69, 81-91, 102, 116, 147-150]、等在這十年內其實都有相當深入不亞於歐美之研究。不過參與相關研究畢盡只是一小部份醫師，整體醫界醫師們的更年期認知比率其實仍須大幅提升。距ＷＨＩ發佈合併賀爾蒙治療有諸多聳人聽聞之風險 10 年後的今天，更多進階的研究，釐清了很多賀爾蒙治療的迷思，不過面對現今更龐大複雜的資訊，婦女無一適從，反而更漠視 使用賀爾蒙帶來的正向面， 負面的態度其實也導至很多的醫療問題 。台灣婦女應慶信我們因黃院長 總是帶給大家 第一手最新更年期資訊：2013 年來自全球更年期專家對停經賀爾蒙治療的共識 (Global consensus statement on menopausal hormone therapy)，共 12 條， 翻譯如下， 這真是提供給全國婦女 一套相當完整明確的停經後賀爾蒙治療準則：

1. 停經後賀爾蒙治療(menopausal hormone therapy, MHT)是停經相關血管舒縮症狀(vasomotor symptoms)最好的治療方法，不論任何年齡停經之婦女皆可使用。不過使用利益絕對優於風險之使用時期是小於六十歲或停經十年之內的婦女。
2. 停經後賀爾蒙治療可以有效而且適當的預防骨質疏鬆相關之骨折，尤其建議於具有高危險骨折因子之小於六十歲或停經十年之內的婦女。
3. 隨機分組、臨床試驗，觀察型研究和許多的統合分析(meta analysis)都證實，對於小於六十歲或停經十年之內的婦女，以單一雌激素(estrogen-alone)作為停經後荷爾蒙治療，可以減少冠狀動脈心臟病及相關各種原因之死亡率(all cause mortality)。然而對於雌激素合併黃體素使用(estrogen plus progestogen)作為停經後荷爾蒙治療，則沒有明顯的增加或減少冠狀動脈心臟病。
4. 局部低劑量的雌激素(local low dose estrogen therapy)是最先建議給更年期症狀僅限於陰道乾澀或性交疼痛的婦女。
5. 單一雌激素(estrogen)系統療法適用於做過子宮切除的婦女，然仍有子宮者則需併用黃體素。
6. 停經後賀爾蒙個人化的治療以促進其生活品質和健康因素為目標，同時考量其危險因

子，風險包括使用時之年紀，停經年齡，靜脈栓塞，腦中風，缺血性心臟病，乳癌。

7. 使用口服性停經後荷爾蒙藥物的婦女，靜脈栓塞和缺血性中風的風險會上升。但絕對風險(absolute risk)，在六十歲前使用其實是相當低的。觀察性研究指出經皮膚吸收治療的停經後荷爾蒙風險相對更低。
8. 50 歲以上婦女因荷爾蒙治療而造成的乳癌風險增加的牽涉的因子很多。荷爾蒙治療對乳癌的主要風險是來自於加入黃體素，與使用的期間長短有關。其實停經後賀爾蒙治療所造成的乳癌風險很低，而且一旦停止使用賀爾蒙其風險就會下降。
9. 使用停經後賀爾蒙治療的劑量與使用期間(duration)，主要以治療目標和安全考量，而且治療應該個人化。
10. 對於早發性卵巢功能不全(premature ovarian insufficiency)的女性，在到達平均婦女停經年齡之前，應該使用停經後賀爾蒙治療。
11. 不建議使用客製化合成類賀爾蒙治療(custom-compounded bio-identical hormone therapy)。
12. 目前以安全性考量之證據，不支持乳癌存活者(breast cancer survivors)使用停經後賀爾蒙治療。

在此呼籲我們族性保守的婦女，也請醫師同時多多正視停經後陰道炎（乾癢澀痛）其實只要很簡單的局部低劑量的雌激素治療就解決，還可預防很多不該衍生出來的問題，如經常性尿道感染。

台灣婦女有更健康之未來，一定需要政策上整體規劃之協助，聯合國第四屆婦女大會，提出了「性別主流化（gender main streaming）」之後。2002 年台灣通過了性別健康政策。對此，衛生署對於婦女政策中，由國民健康局著手擬訂一系列的政策規劃，特別也提到更年期婦女照顧服務這一環，並且規劃提供資源關注更年期照顧。 2011 年更年期照顧的政策在健康照顧體系終於開始站穩腳步，未來的 10 年台灣更年期婦女將擁有國家、政策、社會體制、醫療體系於更年期服務各領域的關注。2011 年台灣婦權會通過「性別平等政策綱領」中提到，建立醫療體制下，推動醫院的服務必須建立友善的醫療照顧環境及體系。成立更年期聯合門診 (Combined Specialty Clinic) 為多元且性別取向的性別友善更年期門診。 我們期盼能再加上如歐美之國家級較長期（數年以上）且大規模上千人次的整合型、且持續之更年期流病調查， 提供現今婦女最迫切需於政府在改良和規劃婦女政策之用，實為台灣婦女大幸。

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