PERIMENOPAUSAL DEPRESSION AND ITS MANAGEMENT THROUGH UNANI APPROACH: A REVIEW

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ABSTRACT

Perimenopausal women in particular are at risk for new onset and recurrence of major depressive episodes. Women with previous histories of PMS or postpartum depression are at increased risk. The symptoms may present with features of melancholia, agitation, somatic symptoms, or sleep disturbances. The increase in major depressive episodes occurring at this time has been found to be linked to hormonal changes of the menopausal transition, namely increased FSH levels, rather than to social or environmental triggers, although changes in valued lifestyle factors associated with, for example, motherhood, family, fertility, or physical rigor and attractiveness, may precipitate depressive mood changes in predisposed or vulnerable women. Women who worry about others are at increased risk for developing clinical depression. Other women may value the new-found independence that these lifestyle changes incur. Untreated depression may exacerbate heart disease, diabetes, and osteoporosis, as well as contributing to an increased risk for suicide and to a more debilitating course of the depression that is more refractory to intervention. Although antidepressant medication is the mainstay of treatment, adjunctive therapy, especially with estrogen replacement, may be indicated in refractory cases, and may speed the onset of antidepressant action. Many, but not all, studies, report that progesterone antagonizes the beneficial effects of estrogen. Although some antidepressants improve vasomotor symptoms, in general they are not as effective as estrogen alone for relieving these symptoms. Estrogen alone, however, does not generally result in remission of major depression in most (but not all) studies, but may provide benefit to some women with less severe symptoms if administered in therapeutic ranges. Phytoestrogens are naturally occurring plant compounds that are similar in some ways to estradiol, the most potent naturally occurring estrogen. Isoflavones are phyto-estrogens similar to women's estrogens and are bound to cellular estrogen receptors in various organs. In addition to attention to general health, hormonal status, and antidepressant treatment, the optimal management of perimenopausal depression also requires attention to the individual woman's psychosocial and spiritual well being.

Keywords: menopause, depression, management.

INTRODUCTION

The menopause transition is experienced by 1.5 million women each year and often involves troublesome symptoms, including vasomotor symptoms, vaginal dryness, decreased libido, insomnia, fatigue, and joint pain.¹,²,³ Although menopause is often believed to contribute to the onset of depression, research actually indicates that depression is more likely to occur in the period leading up to menopause, called the
perimenopausal years. It is during perimenopause that estrogen levels gradually decline, which some studies suggest may bring on depression.

**WHAT ARE THE SYMPTOMS OF MIDLIFE DEPRESSION?**

The most common symptoms include:

- Two or more weeks of depressed mood
- Decreased interest or pleasure in activities
- Change in appetite
- Change in sleep patterns
- Fatigue or loss of energy
- Difficulty concentrating
- Excessive feelings of guilt or worthlessness
- Extreme restlessness and irritability
- Thoughts of suicide

Depression and the onset of menopause share many of the same symptoms, including sleep problems, fatigue, irritability, anxiety and difficulty concentrating. Because of this, depression can go undiagnosed and untreated in women who may think these problems are a natural part of aging.

Untreated depression in older women can increase their risk of developing other serious medical conditions, including:

- Heart attack
- Loss of bone mineral density, increasing the risk of fractures

**THE CORE 4 SYMPTOMS:**

**Vasomotor, vaginal, insomnia, and mood**

**Vasomotor symptoms**

Vasomotor symptoms afflict most women during the menopausal transition, although their severity, frequency, and duration vary widely between women. Hot flashes are reported by up to 85% of menopausal women. Hot flashes are present in as many as 55% of women even before the onset of the menstrual irregularity that defines entry into the menopausal transition and their incidence and severity increases as women traverse the menopause, peaking in the late transition and tapering off within the next several years. The average duration of hot flashes is about 5.2 years, based on an analysis of the Melbourne Women’s Health Project, a longitudinal study that included 438 women. However, symptoms of lesser intensity may be present for a longer period. Approximately 25% of women continue to have hot flashes up to 5 or more years after menopause. A meta-analysis of 35,445 women taken from 10 different studies confirmed a 4-year duration of hot flashes, with the most bothersome symptoms beginning about 1 year before the final menstrual period and declining thereafter.

The exact cause of the hot flash has not been elucidated. The most accessible theory purports that there is a resetting and narrowing of the thermoregulatory system in association with fluctuations in or loss of estrogen production. In the past, hot flashes were thought to be related solely to a withdrawal of estrogen; however, there is no acute change in serum estradiol during a hot flash. Others have related hot flashes to variability in both estradiol and follicle-stimulating hormone (FSH) levels. It is thought that decreased estrogen levels may reduce serotonin levels and thus upregulate the 5-hydroxytryptamine (serotonin) (5-
HT$_{2A}$) receptor in the hypothalamus. As such, additional serotonin is then released, which can cause activation of the 5-HT$_{2A}$ receptor itself. This activation changes the set point temperature and results in hot flashes. Regardless of the exact cause of the hot flash, both hormone therapy and nonhormonal regimens can help to relieve vasomotor symptoms.

**Vulvovaginal atrophy**

Urogenital tissues are exquisitely sensitive to estrogen, and the fluctuations in estrogen that occur during the menopausal transition, followed by sustained low levels after menopause, can render these tissues fragile and cause distressing symptoms. Multiple population- and community-based studies confirm that about 27% to 60% of women report moderate to severe symptoms of vaginal dryness or dyspareunia in association with menopause. In addition to vaginal atrophy, narrowing and shortening of the vagina and uterine prolapse can also occur, leading to high rates of dyspareunia. Furthermore, the urinary tract contains estrogen receptors in the urethra and bladder, and as the loss of estrogen becomes evident, patients may experience UI. Unlike vasomotor symptoms, vulvovaginal atrophy does not improve over time without treatment.

Menopausal hormone therapy (MHT) is an effective treatment of vaginal atrophy and dryness. For this purpose, systemic or vaginal estrogen can be used, although locally applied estrogen is recommended and can be administered in very low doses. These low doses are believed to be safe for the uterus, even without concomitant use of a progestin. Data are currently insufficient to define the minimum effective dose, but vaginal rings, creams, and tablets have all been tested and demonstrated to reduce vaginal symptoms.

Although MHT is effective in reversing changes associated with vaginal atrophy, it is not beneficial for UI. The Women’s Health Initiative Hormone Trial found that women who received MHT and who were continent at baseline had an increase in the incidence of all types of UI at 1 year. The risk was highest for women in the conjugated equine estrogens (CEE)-alone arm. Among women experiencing UI at baseline, the frequency of symptoms worsened in both arms, and these women reported that UI limited their daily activities. This evidence clearly shows that the use of MHT increases the risk of UI among continent women and worsened the characteristics of UI among symptomatic women after 1 year of use.

Women who have urogenital atrophy symptom require long-term treatments. Over-the-counter lubricants and moisturizers may have some effectiveness for milder symptoms; however, for those with severe symptoms, hormonal treatment is the mainstay. Vaginal estrogen can be given locally in very small doses. Until recently, there were no alternatives available. However, the FDA approved ospemifene, a systemically administered selective estrogen receptor modulator, for vulvovaginal atrophy in 2013. Dehydroepiandrosterone vaginal preparations are also being tested for...
effectiveness in treating menopausal urogenital atrophy. These 2 compounds may be particularly helpful for women who have estrogen-sensitive cancers, such as breast cancer, in whom exogenous estrogen use is contraindicated. It is too early to evaluate the comparative effectiveness of these treatments.

Sleep disturbances and insomnia

Sleep quality generally deteriorates with aging, and menopause seems to add an additional, acute layer of complexity to this gradual process. Women report more trouble sleeping as they enter into the menopausal transition, and sleep has been shown to be worse around the time of menses, both by self-report as well as by actigraphy. Actigraphy studies indicate that as much as 25 minutes of sleep per night can be lost when a woman is premenstrual in her late reproductive years. Women report sleep difficulties approximately twice as much as do men. Further compromise in sleep quality is associated with the hormonal changes associated with the menopausal transition and with aging, apart from hormones. Over time, reports of sleep difficulties increase in women such that by the postmenopause more than 50% of women report sleep disturbance. Women seem to experience more detrimental effects on sleep in association with aging, when compared with men.

Hormonal changes alone are not likely to provide the complete explanation for the relationship between sleep difficulty and menopause. Consistent with this concept is the fact that hormones are not always successful in treating sleep problems in midlife and beyond. Chronic poor sleep hygiene habits and mood disorders contribute further to sleep problems.

The nature of the sleep disturbance can help guide the clinician to appropriate treatment. Women who report nighttime awakening in association with night sweats are candidates for hormone therapy. However, the clinical history is not often so simple. Women with mood disorders, particularly anxiety and depression, may experience difficulty falling asleep and/or early awakening. Women aged 40 years and older also frequently report difficulty staying asleep. Lower socioeconomic status (SES), white race, and low marital happiness are social factors that have all been associated with worse sleep. Disorders such as sleep apnea and restless leg syndrome need to be considered. The clinical consequences of a poor night’s sleep include daytime fatigue and sleepiness, which can be subjectively measured and form the basis for a referral for a sleep study.

Polysomnography has become a clinically useful tool for assessing sleep complaints. When polysomnography is not available, clinicians can use sleep questionnaires to ascertain the principal issues surrounding the sleep complaint. Using polysomnography, investigators in the Study of Women’s Health Across the Nation (SWAN) study observed 20% of women with clinically significant apnea/hypopnea and 8% with periodic leg movements.
Treatment of sleep complaints depends on the clinical findings. For insomnia, the reader is referred to the practical clinical review by Buysse. Sleep apnea is often treated with continuous positive airway pressure devices. Restless leg syndrome can be treated with dopamine agonists, gabapentin, and opioids. Hormone therapy can be considered for women with difficulty maintaining sleep because of vasomotor symptoms but seems to be effective mostly in postmenopausal women with surgically induced menopause.

**Adverse mood**

One-fifth of the US population will have an episode of depression in their lifetime, and women are twice as likely to be affected. Although depression is more likely to occur in young adults, with peak onset in the fourth decade of life, there is evidence that the perimenopause represents another period of vulnerability for women. Several large prospective cohort studies have shown an increased risk of depressed mood during the menopause transition and an approximately 3-fold risk for the development of a major depressive episode during perimenopause compared with premenopause. Although a previous episode of depression has been shown to confer an increased risk, women with no previous episode of depression are still 2 to 4 times more likely to experience a depressive episode during the menopause transition compared with the premenopause. Anxiety symptoms have been found to precede depression in some instances, and anxiety may also be viewed as increasing a woman’s vulnerability to a midlife depressive episode.

Other independent risk factors for the development of depressed mood during the menopause transition include poor sleep, stressful or negative life events, lack of employment, higher body mass index, smoking, younger age, and race (African Americans twice as likely to have depressive symptoms). In addition, there is evidence that hormonal changes occurring during menopause play a role, as evidenced by increased risk for depression in association with variability in estradiol levels, increasing FSH levels, surgical menopause, the presence of hot flashes, and a history of premenstrual syndrome. Contrary to prior belief, hot flashes are not necessary to the development of depression. Some have proposed the cascade theory, in which hot flashes lead to sleep disturbance and then to daytime fatigue, poor quality of life, and then depressive symptoms. Research instead shows that depressive symptoms more often precede hot flashes when they co-occur.

There may also be significant environmental stressors present at the time that a woman reaches menopause. During midlife, a woman may be faced with changes in her marriage and family structure, with children no longer living in the home. She may experience changes in her career path, possibly returning to work or retiring. She may be taking on new responsibilities as a caregiver to her parents or in-laws, a well-known risk factor for depression. Although these factors do not likely cause depression on their own, they can certainly contribute...
and should be considered, particularly if supportive resources may be of help.

**Therapeutic approach**

In regards to the therapeutic approach of depression during perimenopause, the main challenges are the capacity of identifying women at risk of having depressive symptoms and the choice of the treatment that offers the best therapeutic results with the least side effects. Regarding the first question, although it would be very interesting to systematically use screening instruments to detect women at risk, Whooley et al. found that the affirmative answer to one of the following questions «During the past two weeks, have you felt down, depressed or hopelessness?» and «During the past two weeks, have you lacked interest or desire to do things?» had the same predictive value as the CES-D, with the consequent savings in time and money. Those women considered to be «at risk» would then be clinically interviewed in order to establish or rule out a solid diagnosis of major depression. Regarding the decision on what the best treatment would be, many factors must be taken into account, such as severity of the disorder, the patient's own opinion, or the presence of somatic disease or risk factors that contraindicates the use of some drugs.

**Psychotherapy**

There are practically no studies that evaluate the efficacy of psychotherapy in the treatment of depressive symptoms or major depression in perimenopause. In one study that was not limited to the study of perimenopause that asked the experts for their opinion on the best antidepressant treatment in women, psychotherapy was considered as coadjuvant to drug treatment when the symptoms were severe; there was a greater balance between those who considered that drugs, psychotherapy and other strategy should be the treatment of choice in the case of moderate symptoms; and finally it was suggested that psychotherapy should be treatment of first choice for less severe cases.

**Antidepressive drugs**

There is still no clear recommendation regarding the type of antidepressant, these including tricyclics or heterocyclics, selective serotonin reuptake inhibitors (SSRIs), selective norepinephrine receptor inhibitor, alpha 2-antagonists, norepinephrine and dopamine reuptake inhibitors, or serotonin norepinephrine reuptake inhibitors, that offers a better clinical outcome, impact on disease in terms of functioning and better quality of life or cost. Most cases of depression (basically mild and moderate ones) are adequately treated in primary care. Conventional antidepressants have been shown to be efficient at six weeks in peri- or post menopausal women, and a maintenance period of 6-12 weeks after clinical improvement is recommended. It has been reported that SSRIs would be effective when the depressive symptom is primary and not accompanied by vasomotor symptoms or other menopausal symptoms. Regarding dual action antidepressants (SNRI), data from an observational study...
with venlafaxine suggest that this antidepressant improves the general condition, reduces depressive symptoms and can reduce vasomotor symptoms in perimenopausal depressive patients.\textsuperscript{35}

In those cases in which there is little or no clinical response after six weeks of treatment at adequate doses, the treatment dose could be increased two to four weeks more (above all if there has been some response).\textsuperscript{22} However, if after 8-12 weeks of treatment at maximum doses, no adequate response is found, the antidepressant drug should be changed for another one of the same class or a different one or the patient could be referred to psychiatry. It has been calculated that only 50\% of the patients with major depression who are treated in primary care respond to the first antidepressant drugs, 20\% stop taking it due to side effects and 30\% abandon it due to lack of response.

**Hormone replacement therapy**

The role of hormone replacement therapy (HRT) has not been clearly established in perimenopausal mood disorders.\textsuperscript{36} It has been suggested that a short-duration HRT (3-6 weeks) could relieve the depressive symptoms associated to vasomotor symptoms during perimenopause.\textsuperscript{37,38}

In a longitudinal study (8 years) with 231 perimenopausal women with no previous background of depression, it was found that the transition to menopause was associated to an increased risk of depressive symptoms and depressive disorders, related with the «intra-subject» increase of follicle-stimulating hormone (FSH) and luteinizing hormone (LH), lower levels of inhibin B and greater variability of FSH levels and estradiol. The authors suggested that the depressive symptoms could be due to destabilization of the typical fluctuations of estradiol related with aging. This is interesting since it supports the hypothesis that the perimenopausal depressive conditions could be treated with estrogens,\textsuperscript{39,40} even though perimenopausal depression does not seem to be secondary to an estrogen level\textsuperscript{41,42} but rather to its variability. In a study conducted in women who had had their menopause 5-10 years earlier, no improvement was observed in the depressive symptoms using estadiol treatment.\textsuperscript{43} As indicated,\textsuperscript{44} it seems that antidepressive efficacy of the estrogens in perimenopause and their ineffectiveness in menopause suggests that perimenopausal depressive disorders are due to hormone changes (sudden decline or fluctuations) rather than to an estrogen deficit itself.

**Etiopathogenesis of menopause in Unani**

The menopause has been described in the classical Unani literature as physiological cessation of mense (ehtebase tams) which occurs between 35 to 60 years of age. One of the causes of ehtebase tams is barudat and yabusat.\textsuperscript{45} According to the classification of age in Unani medicine, the menopausal age group comes under sine kuhulat and the mizaj of sine kuhulat is barid yabis.\textsuperscript{46} It has been also mentioned that during sine kuhulat production of sauda increases and its mizaj is also barid yabis.\textsuperscript{47} Sign and symptoms found during menopausal age is due to barid yabis mizaj and excess of khilt sauda. The menopausal women are more prone to develop saudavi
diseases. Saudavi diseases are produced by Sauda-e-ghair taba’i (abnormal sauda) which is formed as a result of ehteraq (oxidation) of any kind of khilt, including sauda itself. These kind of abnormal sauda serves no physiological functions in the body and precipitates diseases like carcinoma, melancholia, depression, insanity which are common in this age.  

MANAGEMENT OF SINE YAAS

1. Prevent the production of Sauda-e-ghair taba’i
2. Correction of mizaj
3. Removal of excess of sauda

<table>
<thead>
<tr>
<th>S.No.</th>
<th>Unani Name</th>
<th>Botanical Name</th>
<th>Family</th>
<th>Part studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Aabnoos</td>
<td>Diospyros ebenum</td>
<td>Ebenaceae</td>
<td>Leaves 49</td>
</tr>
<tr>
<td>2</td>
<td>Abhal</td>
<td>Juniperus communis</td>
<td>Cupressaceae</td>
<td>Berries 50</td>
</tr>
<tr>
<td>3</td>
<td>Afiyun</td>
<td>Papaver somniferum</td>
<td>Papaveraceae</td>
<td>Seeds 51</td>
</tr>
<tr>
<td>4</td>
<td>Afsanteen</td>
<td>Artemisia vulgaris</td>
<td>Compositae</td>
<td>Leaves 52</td>
</tr>
<tr>
<td>5</td>
<td>Akhrot</td>
<td>Juglans regia</td>
<td>Juglandaceae</td>
<td>Bark 53</td>
</tr>
<tr>
<td>6</td>
<td>Alsii</td>
<td>Linum usitatissimum</td>
<td>Linaceae</td>
<td>Seeds 54</td>
</tr>
<tr>
<td>7</td>
<td>Amla</td>
<td>Emblica officinalis</td>
<td>Euphorbiaceae</td>
<td>Fruit 55</td>
</tr>
<tr>
<td>8</td>
<td>Anantmol</td>
<td>Hemidesmus indicus</td>
<td>Periploaceae</td>
<td>Leaves 56</td>
</tr>
<tr>
<td>9</td>
<td>Anar</td>
<td>Punica granatum</td>
<td>Punicaceae</td>
<td>Fruit peels 57</td>
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<tr>
<td>10</td>
<td>Anisoon</td>
<td>Pimpinella anisum</td>
<td>Apiceae</td>
<td>Seeds 58</td>
</tr>
<tr>
<td>11</td>
<td>Anjbar</td>
<td>Poligonum histotora</td>
<td>Polygonaceae</td>
<td>Root 59</td>
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<tr>
<td>12</td>
<td>Arjun</td>
<td>Terminalia arjuna</td>
<td>Combretaceae</td>
<td>Bark 60</td>
</tr>
<tr>
<td>13</td>
<td>Asgandh</td>
<td>Withania somnifera</td>
<td>Solanaceae</td>
<td>Root 61</td>
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<td>14</td>
<td>Ashok</td>
<td>Saraca indica</td>
<td>Fabaceae</td>
<td>Bark 62</td>
</tr>
<tr>
<td>15</td>
<td>Atees</td>
<td>Aconitum heterophyllum</td>
<td>Renunculaceae</td>
<td>Root 59</td>
</tr>
<tr>
<td>16</td>
<td>Babool</td>
<td>Acacia arabica</td>
<td>Mimosaceae</td>
<td>Bark 63</td>
</tr>
<tr>
<td>17</td>
<td>Badranjboya</td>
<td>Melissa officinalis</td>
<td>Lamiaceae</td>
<td>Leaves 64</td>
</tr>
<tr>
<td>18</td>
<td>Bael</td>
<td>Aegle marmelos</td>
<td>Rutaceae</td>
<td>Fruit pulp 65</td>
</tr>
<tr>
<td>19</td>
<td>Balela</td>
<td>Terminalia bellerica</td>
<td>Combretaceae</td>
<td>Fruit66</td>
</tr>
<tr>
<td>20</td>
<td>Baranjasif</td>
<td>Achillea millefolium</td>
<td>Asteraceae</td>
<td>Leaves, flowers seeds67</td>
</tr>
<tr>
<td>21</td>
<td>Bhangrah</td>
<td>Eclipta alba</td>
<td>Asteraceae</td>
<td>Plant 68</td>
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<tr>
<td>22</td>
<td>Chirchita</td>
<td>Achyranthus aspera</td>
<td>Amaranthaceae</td>
<td>Plant 69</td>
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<tr>
<td>23</td>
<td>Chobchini</td>
<td>Smilax chinensis</td>
<td>Liliaceae</td>
<td>Root 70</td>
</tr>
<tr>
<td>24</td>
<td>Darchini</td>
<td>Cinnamomum zeylanicum</td>
<td>Lauraceae</td>
<td>Bark 71</td>
</tr>
</tbody>
</table>
2. Correction of mizaj

In all types of sue mizaj, barid yabis is worst. To correct the mizaj those methods should be used which causes hararat and rutubat (hot and moist) in the body. These methods include ilaj bil ghiza, ilaj bil tadbeer.

a. Ilaj bil ghiza (Dietary management): According to Unani concept haar and moist component of the body is destroyed fastly as compared to other component and the nutritional property of food is present in the haar and moist component only. As the mizaj of menopausal age women is barid yabis so foods having haar ratab mizaj will be helpful like, badam (Prunus amygdalus), narial (Coco nucifera), pista (Pistachia vera), kaju (Anacardum occidentalis), kishmish (Vitis vinifera), sabil kharbuzah (Cucumis melo), gajar (Daucus carota), injeer (Ficus carica), khajur (Phoenix dactilifera), taroi (Luffa cylindrical), palak (Spinacea oleracea), cow and goat milk, sweet aam (Mangifera indica), sweet curd, jaggery, ghee, butter, half boiled egg. Stale, salty, astringent and spicy foods should be avoided. Spicy foods have hot mizaj but it also produce dryness and causes burning of khilt and thus produce sauda.

b. Ilaj bil tadbeer: People should be kept in balanced environment neither very hot not very cold. Excess physical activity should be avoided. Proper rest and taweel neend (extra sleep) will help. Jima (Sexual intercourse) is harmful for these kind of sue mizaj because it will further increase in dryness. Riyazate muskchina and light massage will be helpful. People should apply those oils over the body having ratab (moist) quality like roghane banafshan (Viola odorata), roghane badam (Prunus amygdalus) and roghane kaddu etc. Hammam and abzan (sitz bath) is beneficial in these people.

3. Elimination of excess sauda

Elimination of excess sauda is done by use of munzij wa mushil drugs. Munzij drugs assembled the akhlate raddiyah (morbid matter) in order to evacuate easily from the affected part. Once the akhlat-e-raddiya (abnormal/deranged humours) are ready for elimination from the superficial and deeper structure of affected organ, then mushilat (purgatives) are used to facilitate the elimination of material from the body. There are four types of muzijat and mushilat specific for elimination of particular ghalbae khilt (excess humour). In menopausal age there is excess of sauda, so munzije sauda and mushile sauda drugs is used either single or in combination.

Table 2. List of munzije sauda and mushile sauda drug

<table>
<thead>
<tr>
<th>Munzije Sauda</th>
<th>Mushile Sauda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ustukhudus (Lavendula stoechas)</td>
<td>Shahm hanzal</td>
</tr>
<tr>
<td>Aftimoon vilayati (Cuscuta epithymum)</td>
<td>Aftimoon vilayati (Cuscuta epithymum)</td>
</tr>
<tr>
<td>Gauzaban (Borage officinalis)</td>
<td>Halela siyah (Terminalia chebula)</td>
</tr>
<tr>
<td>Unnab sativa (Zizyphus sativa)</td>
<td>Kharbuq siyah (Helleborus niger)</td>
</tr>
<tr>
<td>Shahitra officinalis (Fumaria officinalis)</td>
<td>Gharigoon (Agaricus albus)</td>
</tr>
<tr>
<td>Badranjaboya officinalis (Mellisa officinalis)</td>
<td>Turbud (Ipomea turpbum)</td>
</tr>
<tr>
<td>Badiyan vulgare (Foeniculum vulgare)</td>
<td>Jamal gota (Croton tiglium)</td>
</tr>
<tr>
<td>Sapistan latifolia (Cordia latifolia)</td>
<td></td>
</tr>
<tr>
<td>Aslussoos (Glycyrrhiza glabra)</td>
<td></td>
</tr>
</tbody>
</table>
CONCLUSION:

Most authors consider perimenopause as a period of greater depressive vulnerability of both depressive symptoms and de novo depression disorders. Some studies suggest that depression in perimenopause would have specific clinical characteristics, especially greater emotional withdrawal. From the etiopathogenic point of view, both genetic factors and hormonal, psychosocial and cultural ones would be involved. The therapeutic approach of depression in perimenopause involves pharmacological and/or psychotherapeutic strategies based on the severity level. In spite of the generalized acceptance of the role of hormone fluctuations in perimenopausal depression, currently there are no conclusive data on the role of hormone replacement therapy in its treatment. The treatment strategy of menopausal syndrome has been to replace the deficient oestrogen. This strategy of hormone replacement has got alarming physical hazards. Although HRT prevents osteoporosis and fracture at 75 years but causes carcinoma at 55 years. Unani system of medicine basically wants this transition to be smooth one. It wants to transit a woman from sine shabab to sine yaas in keeping up the relative humoral balance. This will help in reducing the morbidity of menopausal women as well as mortality rate by preventing carcinoma.

ACKNOWLEDGEMENT

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CONFLICT OF INTEREST

Nil.

REFERENCES:


