COMMENTARY

clinical review

Time for Action: Managing Genitourinary Syndrome of Menopause

Nicole O. Williams, MD[1] and Maryam B. Lustberg, MD, MPH[1]

Genitourinary syndrome of menopause (GSM) is a constellation of symptoms affecting the female genital and urinary systems, which results from atrophy in the setting of lack of estrogen and leads to symptoms including vaginal dryness, vaginal burning, vaginal itching, dyspareunia, impaired sexual function, dysuria, urinary frequency, and increased risk of bladder and vaginal infections.[1] Symptoms of GSM are common after a breast cancer diagnosis and present an important survivorship issue. Breast cancer therapy often induces or exacerbates symptoms of GSM. Poor adherence and early discontinuation of adjuvant endocrine therapy are common and are associated with increased mortality after early breast cancer.[2] Literature suggests a link between treatment-related symptoms and early discontinuation and poor adherence. Thus, managing GSM may potentially improve breast cancer outcomes in addition to improving quality of life.

Use of vaginal estrogen is the gold standard treatment of GSM in postmenopausal women without a history of breast cancer.[3] However, this treatment is controversial in breast cancer survivors because of potential systemic absorption and the sensitivity of breast cancer to estrogen, particularly if hormone receptor positive. Although studies to date have not demonstrated an increase in the risk of breast cancer recurrence associated with the use of vaginal estrogen, studies have demonstrated an increase in serum estradiol in women using vaginal estrogens that may be of concern to many breast cancer survivors and their providers.[4]

ASSOCIATED CONTENT

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Accepted on June 13, 2019 and published at jop.ascopubs.org on July 10, 2019: DOI https://doi.org/10.1200/JOP.19.00350

In the accompanying article, Sussman et al[5] reviewed the available literature for use of nonhormonal, vaginal hormonal, and systemic therapy options for the treatment of GSM. The authors advocate for an individualized approach to treatment of GSM. They highlight that in concordance with current guidelines for the care of cancer survivors, they use nonhormonal treatments such as vaginal lubricants and moisturizers initially to manage symptoms of GSM especially in those receiving aromatase inhibitor therapy. The authors advise to consider vaginal estrogens if symptoms continue despite the use of nonhormonal treatments. Topical prasterone is another option that can be helpful in some women.[5]

There are several other options to consider if women are still experiencing symptoms with vaginal lubricants and moisturizers. Hyaluronic acid or lidocaine are additional topical therapies that are options for GSM.[6,7] Although these may provide some symptom relief from vaginal dryness, they do not treat the underlying cause of symptoms or loss of vaginal elasticity. Several small prospective nonrandomized trials have supported that the treatment is effective for relief of symptoms of GSM such as vaginal dryness, vaginal itching, and dyspareunia in postmenopausal and perimenopausal women.[8] In addition, studies have reported improvement in sexual function, quality of life, and urinary symptoms with vaginal fractional CO_2 laser therapy in postmenopausal women. These findings are promising, although to date there are only limited randomized trial data evaluating vaginal fractional CO_2 laser therapy, and additional data are recommended about efficacy and safety before routinely recommending this therapy to breast cancer survivors.

Because there are other clinical syndromes that can mimic GSM symptoms, a recent pelvic examination to rule out other causes of GSM, such as bacterial vaginosis, trichomoniasis, and candidiasis, is an important consideration. Lifestyle modification such as smoking cessation may help to improve new symptoms, because cigarette smoking is associated with accelerated vulvovaginal atrophy.[9] Women should also be counseled that continuing sexual activity, if possible, can be helpful in managing vaginal dryness, because it can increased blood flow to the genital area, helping keep tissue heathy. Pelvic floor therapy may be a useful treatment for women with nonrelaxing or high-tone pelvic floor muscle dysfunction trigged by painful sexual activity related to GSM.[9]

Although there are many potentially helpful therapeutic options available, many breast cancer survivors are hesitant to report symptoms of GSM, which, unlike vasomotor symptoms, typically worsen with time and do not resolve without treatment.[9] Providers need practical strategies and material resources to help foster discussions about sexual health and symptoms. Women need to be asked about vaginal health as well as sexual health, regardless of age, partner status, or

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recent sexual activity. Providers can inquire about vaginal/sexual health with a brief checklist to facilitate communication about patient needs.[10]

Given the burden of symptoms, additional options are needed for this patient population. Future directions in GSM will need to be multifaceted, focusing on investigation of additional local therapies that can better address the problem at tissue level, better address provider/patient communication, and consider often neglected therapeutic options such as sexual counseling and pelvic floor therapy.

AFFILIATION

[1]The Ohio State University Wexner Medical Center, Columbus, OH

CORRESPONDING AUTHOR

Nicole O. Williams, MD, Room 1202 Lincoln Tower, 1800 Cannon Dr, Columbus, OH 43210; e-mail: Nicole.Williams@osumc.edu.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST AND DATA AVAILABILITY STATEMENT

Disclosures provided by the authors and data availability statement (if applicable) are available with this article at DOI https://doi.org/10.1200/JOP.19.00350.

AUTHOR CONTRIBUTIONS

Conception and design: All authors
Manuscript writing: All authors
Final approval of manuscript: All authors
Accountable for all aspects of the work: All authors

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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Maryam B. Lustberg
Consulting or Advisory Role: Tempus, PledPharma
Other Relationship: Hologic/Cynosure

No other potential conflicts of interest were reported.

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