



**Primary Care
Women's Health
Forum**

**GUIDANCE ON DIAGNOSIS
AND MANAGEMENT OF**

**Urogenital atrophy or
Genitourinary Syndrome of
the Menopause (GSM)**



Dr Louise Newson and Dr Carrie Sadler on Behalf of the PCWHF

This guidance is designed to support you in diagnosing and managing urogenital atrophy.

OVERVIEW

Vaginal dryness is very common and is underdiagnosed and undertreated. This results in too many women needlessly suffering with often unbearable symptoms. It can affect women of all ages and it is not just related to the menopause. The NICE guidance gives clear recommendations regarding the optimal management of this condition in menopausal and post-menopausal women.

The symptoms associated with vaginal dryness can have a very negative effect on interpersonal relationships, quality of life and daily activities. As oestrogen receptors are present on the vagina, urethra, bladder trigone and the pelvic floor, all these areas can be affected by a lack of oestrogen, which occurs in the menopause and perimenopause.

For clinicians and women, the actual terminology of this condition can be confusing. Many people talk about vaginal dryness but this does not refer to all the different symptoms that can be present. Vulvo-vaginal atrophy does not incorporate the urinary symptoms that often occur in these patients.

Urogenital atrophy is often used which is a more accurate description. More recently, the term Genitourinary Syndrome of the Menopause (GSM) has been suggested. While not yet in common usage this term will be adopted in this guidance document.

GSM is extremely common. It is difficult to obtain a true prevalence as this condition is so under reported but some studies have shown it to affect as many as 80% of post-menopausal women. Although many other menopausal symptoms improve with time, symptoms of GSM can worsen with age in many women. Although GSM is more prevalent in postmenopausal women, it can occur in younger women and studies have shown it can affect around one in eight premenopausal women.

Women who have received chemotherapy, surgery and / or radiotherapy for certain types of malignancies have a higher risk of developing vaginal dryness. Treatment with hormones is not appropriate for these patients.



History

Many women are not being diagnosed with this condition as they are not asked the appropriate questions. Questions need to be asked in a sensitive manner and women should be given time to reflect and talk about this problem which understandably can be very embarrassing and awkward to discuss.

Menopausal women who present with urinary symptoms such as increased urinary frequency, urgency or recurrent urinary tract infections should also be asked if they experience any local vaginal symptoms. Although pain and discomfort may be present during sexual intercourse, many women find they experience symptoms at other times, for example when they are walking, cycling, horse riding or simply just sitting down.

Questions to consider asking

Atrophic symptoms affecting the vagina and lower urinary tract can be progressive and do not improve without treatment. Unlike hot flushes related to the menopause that usually resolve over time, GSM usually has a chronic progressive nature throughout the menopausal transition and beyond.

If the right questions are asked, in the right clinical setting, then women are more likely to be open about their symptoms.

- Have you noticed any vaginal dryness or less discharge than you used to have?
- Have you experienced any vaginal soreness, burning or irritation?
- Do you have any itching around your vagina or vulval area?
- Is sexual intercourse painful or uncomfortable?
- Have you noticed changes in any vaginal discharge (either increased or reduced)?
- Have you noticed any urinary symptoms such as increased urinary frequency or being less able to hold on to urine?
- Do you have any discomfort on passing urine?

Examination

An examination should be considered if there is anything in a woman's history to suggest any other underlying pathology. In addition, a genital examination should be undertaken if symptoms do not improve with initial treatment.

On examination atrophy of the vulva and vagina may be apparent. The vaginal

epithelium usually becomes thin and loses its rugae and elasticity. It can be visibly paler due to the reduced blood supply and petechial haemorrhages may be present.

Sometimes a woman may present with acute inflammation of the introitus.

Many women are diagnosed by health care professionals when they attend to have a cervical smear taken or a pelvic examination performed. The patient may experience pain or discomfort.



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Investigations

For the vast majority of women, investigations are not necessary. If a woman is due or overdue for her cervical smear, then this should be used an opportunity for this to be undertaken. In addition, the woman should be reassured during the smear taking process and extra lubrication should be used for the procedure. Some women may need to return after a few months of treatment with local oestrogen for their smear to be performed with less discomfort. Urine dipstix and microscopy should be undertaken in those women who present with urinary symptoms.

If there is abnormal vaginal bleeding then appropriate, relevant investigations (such as a pelvic ultrasound or consideration of fast-track referral) should be undertaken to exclude other causes.

For women who complain of a vaginal discharge, a vaginal swab should be undertaken to exclude any infections. NICE guidelines state that a direct access ultrasound scan should be considered to assess for endometrial cancer in women aged 55 and over with unexplained symptoms of vaginal discharge who:

- Present with these symptoms for the first time or
- Have thrombocytosis or
- Report haematuria

Referral

A presentation of postmenopausal bleeding or signs suggestive of malignancy on examination should prompt an urgent cancer pathway referral.

Most women will be able to be treated successfully in the community with the treatment options detailed in this guidance. In situations where the symptoms are resistant to the various treatment options available a referral to gynaecology or a dermatologist with an interest in vulval skin disorders is indicated.

Management

A number of different treatments are available. These include vaginal lubricants and moisturisers, vaginal oestrogen and hormone replacement therapy (HRT).

The principles of management are to restore urogenital physiology and to alleviate symptoms. Treatments are hormonal, non-hormonal or a combination of both. The correct treatment can really transform a woman's life.

All women should receive information about their condition and their treatment, preferably in a written format. Women should also be signposted to other useful sources of information, for example relevant websites.



Vaginal oestrogen:

- Available as slow-release vaginal pessaries, vaginal creams and vaginal rings.
- The pessaries and creams should be used daily for two weeks and then twice a week thereafter.
- The vaginal ring should be inserted and used for three months and then replaced with a new one.
- NICE guidance states that vaginal oestrogen can be continued for as long as needed to relieve symptoms.
- It is important that treatment is started early, if possible, to reduce any irreversible changes occurring.
- Vaginal oestrogen can be safely given in those women who are taking systemic HRT.
- If symptoms do not improve with using vaginal oestrogen, then consider increasing the dose after seeking advice from a healthcare professional with expertise in the menopause.
- Women using vaginal oestrogen, even in the long term, do not need to take progestogens or have their endometrial thickness measured.
- Vaginal oestrogens can often improve urinary symptoms.
- Beneficial effect of topical oestrogens can take a few months.
- For the majority of women, symptoms return after treatment is stopped.
- Note: The only absolute contra-indications to use of topical oestrogens are active breast cancer and also undiagnosed vaginal or uterine bleeding. The amount systemically absorbed is very low; *one year's supply of topical oestrogen is equivalent to one tablet of standard HRT.*
- In addition, consideration of local oestrogen therapy should always be considered as part of the management of prolapse. Not only does it minimise local pressure effects of a ring or pessary but it has also been shown to alleviate symptoms of pressure from a prolapse.

Hormone replacement therapy:

- Systemic HRT is not usually recommended as first-line treatment for women with only vaginal symptoms and no menopausal symptoms.
- Around 10-25% of women receiving systemic HRT still have symptoms of GSM and so will require topical oestrogen in addition to HRT.

Vaginal moisturisers:

- These are bio-adhesive so attach to mucin and epithelial cells on the vaginal wall and therefore retain water.
- They can also balance vaginal pH.
- Moisturisers should be used regularly and can be used in the long term if they are beneficial.
- They can be used more or less frequently, depending on the severity of the woman's dryness.
- They should be used regularly rather than during sexual intercourse.
- They can be used in combination with local oestrogen, but should preferably be used at different times.
- Refer to BNF for list of vaginal moisturisers available to prescribe.



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Vaginal lubricants:

- A wide variety of personal lubricants are commercially available, either as water-, silicone-, mineral oil-, or plant oil-based products, and are applied to the vagina and vulva (and the partner's penis if required) prior to sex.
- These provide short-term relief for vaginal dryness and can prevent friction during sexual intercourse.
- They are particularly beneficial for women whose vaginal dryness is a concern only or mainly during sexual intercourse.
- Any type of oil-based lubricant is not suitable for use with condoms.
- They can also be used in combination with local oestrogen but preferably at different times as some products may prevent the dispersion of the oestrogen pessary.
- Refer to BNF for list of vaginal lubricants available to prescribe.

Laser:

- The CO₂ laser has been shown to lead to impressive results in some studies.
- The laser is well tolerated and has been shown to increase thickness of the squamous epithelium and improve vascularity of the vagina.
- This is not currently available on the NHS.

Other treatments:

- There is increasing evidence to demonstrate the benefits of the oral medication ospemifene which is an oestrogen agonist/antagonist.
- It does not appear to have any negative effects on the endometrium or be associated with an increased risk of thromboembolism.
- However, this is not currently licensed in the UK.

Review

Women should be reviewed after three months of starting treatment. Compliance and any concerns about treatment should be addressed in their appointment.

If a patient has not responded to treatment, then an alternative diagnosis should be considered and the appropriate investigations and referral should be undertaken. Any women who experience any abnormal vaginal bleeding need to be investigated and referred according to local guidelines.

Women should then be reviewed annually. They should be reassured that it is safe for topical oestrogen to continue in the long term and that the risks of local oestrogen are not the same as those for systemic oestrogen.



References

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Useful links

www.pcwhf.co.uk

www.menopausedoctor.co.uk

“Take Home” Points

- Too many women do not talk about their symptoms and are not receiving treatment
- Oestrogen deficiency can also lead to urinary symptoms
- Vaginal oestrogens can safely be used in the long term
- A combination of different treatments can be given
- Women can receive systemic and local oestrogen concomitantly
- Some lubricants and moisturisers are available on prescription



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