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Genitourinary Syndrome of Menopause

The *genitourinary syndrome of menopause* (GSM) includes bothersome vaginal, vulvar (lips of the vagina), and urinary symptoms that can affect quality of life, sexual satisfaction, and even your relationship with your partner. Unlike hot flashes, which typically improve with time, GSM usually worsens over time without treatment.

Menopause and aging can affect the genitourinary system in these ways:

- Loss of estrogen at menopause may cause the vaginal tissues to become thin and dry, with decreased elasticity and lubrication, often resulting in pain with sexual activity or routine pelvic examinations and even discomfort wiping after urination or wearing certain clothing.
- Symptoms such as burning, itching, or irritation of the vulva; lack of lubrication; vaginal dryness; and discomfort or pain with sexual activity are common.
- Burning on urination, increased frequency or urgency of urination, and increased risk for urinary tract infections also can occur.
- Symptoms may be more severe in women who undergo menopause because of the surgical removal of both ovaries (surgical menopause) or because of chemotherapy for cancer treatment and in those who receive aromatase inhibitors for prevention or treatment of breast cancers.

Treatment options

There are many effective treatment options for GSM, including over-the-counter and prescription therapies. Therapies for less severe symptoms include nonhormone over-the-counter lubricants used as needed for sexual activity and moisturizers used regularly (several times per week) to maintain moisture. Prescription therapies include low-dose vaginal estrogens, vaginal dehydroepiandrosterone inserts, and oral ospemifene. Nonhormone lubricants and moisturizers can be used in combination with prescription therapies for more severe symptoms.

Nonhormone remedies

- **Vaginal lubricants** are used with sexual activity and reduce discomfort and increase pleasure by decreasing friction. These include water-, silicone-, and oil-based products. Oil-based lubricants may damage condoms and may increase the risk of vaginal infections. Lubricants should not contain flavors (sugar), warming properties, or solvents and preservatives such as propylene glycol and parabens that may cause irritation in some women.
- **Vaginal moisturizers** are used regularly, often several times weekly to maintain vaginal moisture, with a goal of reducing the daily symptoms of GSM.
- **Regular sexual stimulation** promotes vaginal blood flow and secretions. Sexual stimulation with a partner, alone, or with a device (such as a vibrator) may improve vaginal health.
- **Expanding your views of sexual pleasure** to include *outercourse* options, such as extended caressing, mutual masturbation, and massage, provides a way to remain sexually intimate in place of intercourse.
- **Vaginal dilators** can stretch and enlarge the vagina if it has become too short and narrow or if involuntary tightening occurs, preventing comfortable sexual activity. Dilators can be purchased online or at specialty stores and used with the guidance of a sexual medicine specialist, physical therapist, or sex therapist.
- **Pelvic floor exercises** can help to strengthen weak pelvic floor muscles and relax tight ones. Pelvic floor physical therapy is available with trained therapists or there are at-home devices to help strengthen the pelvic floor and treat incontinence.

Vaginal hormone therapy

- An effective and safe treatment, **low-dose local estrogen** applied directly to the vulva and vagina relieves vulvar and vaginal discomfort, irritation, dryness, or pain with sexual activity. Improvements usually occur within a few weeks or months with consistent use.
- **FDA-approved low-dose vaginal estrogen products** are available by prescription as vaginal creams (used daily for 2 wk, then 2 or 3 times/wk), a vaginal estradiol tablet or insert (used daily for 2 wk, then twice/wk), and an estradiol vaginal ring (changed every 3 mo).

- **Dehydroepiandrosterone** (DHEA; prasterone) is a hormone-containing insert placed in the vagina nightly that reduces vaginal dryness or pain with sexual activity.
- **Low-dose vaginal estrogen** or DHEA may be options for women with a history of breast or uterine cancer in the context of shared decision-making in collaboration with their primary care professionals and oncologists.

Systemic estrogen therapy

Systemic estrogen therapy provided for treatment of hot flashes also treats vulvar and vaginal dryness, although some women still benefit from the addition of low-dose vaginal hormone treatment. If only vaginal symptoms are present, low-dose vaginal hormone treatments are recommended.

Other therapies

- **Ospemifene** is a prescription selective estrogen-receptor modulator (SERM) available as an oral tablet taken daily for the treatment of vulvar and vaginal dryness or sexual pain.
- **Vaginal laser therapy** such as fractional CO_2 laser or radiofrequency devices are FDA cleared for vaginal use but not specifically for treatment of GSM. Evidence does not support their use for treatment of vulvar and vaginal dryness, discomfort, irritation, quality of life, pain with urination, or pain with sexual activity. For those women who are not candidates for or prefer alternatives to government-approved therapies, CO_2 laser treatment may be considered in the context of shared decision-making and with the understanding that these treatments are considered experimental outside of clinical trials.

Treatment Options Summary

Vaginal lubricants (nonprescription). Many available products.

Vaginal moisturizers (nonprescription). Many available products.

Vaginal estrogen therapy (prescription required).

Estrace or Premarin vaginal cream (0.5-1 g placed in vagina daily for 2 wk, then 2-3 times/wk generic available).

Estring (small, flexible estradiol ring placed in vagina and changed every 3 mo: 7.5 µg/d).

Vagifem (estradiol tablet placed in vagina daily for 2 wk, then twice/wk: 10 µg generic available).

Imvexxy (estradiol softgel insert placed in vagina daily for 2 wk, then twice/wk: 4 µg, 10 µg).

Intravaginal dehydroepiandrosterone (Intrarosa; prescription required).

A 6.5 mg vaginal insert used nightly.

Ospemifene (Osphena; prescription required).

Oral 60 mg tablet taken once daily.

Vaginal "exercise"

Sexual activity (with or without a partner). Stretching exercises with lubricated vaginal dilators. Pelvic floor physical therapy.

Vaginal and vulvar symptoms not related to menopause include yeast infections, allergic reactions, and certain skin conditions, so consult your healthcare professional if symptoms do not improve with treatment.

Compounded vaginal estrogen and testosterone are not government regulated or recommended for treatment of GSM in most cases.

The Menopause Society

This *MenoNote* provides current general information but not specific medical advice. It is not intended to substitute for the judgment of a person's healthcare professional. Additional information can be found at **www.menopause.org**. The Menopause Society is committed to leading the conversation about improving women's health and healthcare experiences during the menopause transition and beyond. The Society develops evidence-based position statements and consensus recommendations to ensure that healthcare professionals and the public have access to the most up-to-date information.

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Deciding About Hormone Therapy Use

Many women experience hot flashes, vaginal dryness, and other physical changes with menopause. For some women, the symptoms are mild and do not require any treatment. For others, symptoms are moderate or severe and interfere with daily activities. Hot flashes improve with time, but some women have bothersome hot flashes for many years. Menopause symptoms often improve with lifestyle changes and nonprescription remedies, but prescription therapies also are available, if needed. Government-approved treatments for bothersome hot flashes include hormone therapy (HT) containing estrogen, as well as two nonhormone medications (paroxetine and fezolinetant).

Hormone therapy involves taking estrogen in doses high enough to raise the level of estrogen in your blood in order to treat hot flashes and other symptoms. Because estrogen stimulates the lining of the uterus, women with a uterus need to take an additional hormone, progestogen, or a tissue-selective estrogen complex (TSEC) to protect the uterus. Women without a uterus just take estrogen. If you are bothered only by vaginal dryness, you can use very low doses of estrogen placed directly into the vagina. These low doses generally do not raise blood estrogen levels above postmenopause levels and do not treat hot flashes. You do not need to take a progestogen when using only low doses of estrogen in the vagina. (The *MenoNote* "Vaginal Dryness" covers this topic in detail.)

Every woman is different, and you will decide about whether to use HT based on the severity of your symptoms, your personal and family health history, and your own beliefs about menopause treatments. Your healthcare professional will be able to help you with your decision.

Potential benefits

Hormone therapy is one of the most effective treatments available for bothersome hot flashes and night sweats. If hot flashes and night sweats are disrupting your daily activities and sleep, HT may improve sleep and fatigue, mood, ability to concentrate, and overall quality of life. Treatment of bothersome hot flashes and night sweats is the principal reason women use HT. Hormone therapy also treats vaginal dryness and painful sex associated with menopause, as well as some urinary symptoms such as increased urinary frequency, urgency. Hormone therapy keeps your bones strong by preserving bone density and decreasing your risk of osteoporosis and fractures. If preserving bone density is your only concern, and you do not have bothersome hot flashes, other treatments may be recommended instead of HT.

Potential risks

As with all medications, HT is associated with some potential risks. For healthy women with bothersome hot flashes aged younger than 60 years or within 10 years of menopause, the benefits of HT generally outweigh the risks. Hormone therapy might slightly increase your risk of stroke or blood clots in the legs or lungs (especially if taken in pill form). If started in women aged older than 65 years, HT might increase the risk of dementia. If you have a uterus and take estrogen with progestogen, there is no increased risk of cancer of the uterus. Hormone therapy (combined estrogen and progestogen) might slightly increase your risk of breast cancer if used for more than 4 to 5 years. Using estrogen alone (for women without a uterus) does not appear to carry the same risk.

Some studies suggest that HT might be good for your heart if you start before age 60 or within 10 years of menopause. However, if you start HT further from menopause or after age 60, HT might slightly increase your risk of heart disease. Although there are risks associated with taking HT, they are not common, and most go away after you stop treatment.

Potential adverse effects

Hormone therapy can cause breast tenderness, nausea, and irregular bleeding or spotting. These adverse effects are not serious but can be bothersome. Reducing your dose of HT or switching the form of HT you use often can decrease adverse effects. Weight gain is a common problem for midlife women, associated with both aging and hormone changes. Hormone therapy is not associated with weight gain and may lower the chance of developing diabetes.

Hormone therapy options

Each woman must make her own decision about HT with the help of a healthcare professional. If you decide to take HT, the next step is to choose between the many HT options available to find the best dose and route for you. With guidance from your healthcare professional, you can try different forms of HT until you find the type and dose that treats your symptoms with few adverse effects.

Pill or non-pill

Hormone therapy is available as a daily pill, but it also may be taken as a skin patch, gel, cream, spray, or vaginal ring. Non-pill forms may be more convenient. Hormone therapy pills need to be taken every day, but skin patches are changed only once or twice weekly, and the HT vaginal ring is changed only every 3 months. Hormone therapy taken in non-pill form enters your blood stream more directly, with less effect on the liver. Studies suggest that this may lower the risk of blood clots in the legs and lungs compared with HT taken as a pill.

Estrogen alone or estrogen plus progestogen

If you have a uterus, you will need to take progestogen or a TSEC with your estrogen. Many pills and some patches contain both hormones together. Otherwise, you will need to take two separate hormones (eg, estrogen pill with progestogen pill or estrogen patch with progestogen pill). Taking both hormones every day usually results in no bleeding. Women who prefer regular periods can take estrogen every day and progestogen for about 2 weeks each month. Another option is to take estrogen combined with a nonhormone medication (bazedoxifene) to protect the uterus. If you do not have a uterus, you can take estrogen alone, without a progestogen.

Dose of estrogen

As with all medications, you should take the lowest dose of estrogen that relieves your hot flashes. You can work with your healthcare professional to find the right dose for you. It typically takes about 8 to 12 weeks for HT to have its full effect, so doses should be adjusted slowly. Even low doses of estrogen will preserve your bone density and reduce your risk of a fracture.

Stopping hormone therapy

There is no "right" time to stop HT. Women may choose lower doses or change to non-pill forms of HT. You and your healthcare professional will work together to decide how long you should remain on HT. Reasons to consider longer-term HT use include recurrent, persistent hot flashes or night sweats, prevention of osteoporosis, or for perceived enhanced quality of life. Because there may be greater risks with longer duration of use and as you age, you and your healthcare professional should work together to decide what is the best option for you.

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