MAYO CLINIC

Genitourinary Syndrome of Menopause: Management Strategies for the Clinician

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CME Activity

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Learning Objectives: On completion of this article, you should be able to (1) describe the signs and symptoms of genitourinary syndrome of menopause (GSM), (2) list the hormonal and nonhormonal treatment strategies for GSM, and (3) determine appropriate follow-up of patients with GSM.

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Abstract

Genitourinary syndrome of menopause (GSM), previously known as atrophic vaginitis or vulvovaginal atrophy, affects more than half of postmenopausal women. Caused by low estrogen levels after menopause, it results in bothersome symptoms, including vaginal dryness, itching, dyspareunia, urinary urgency and increased frequency, and urinary tract infections. Even though women with GSM can have sexual dysfunction that interferes with partner relationships, women are often embarrassed to seek treatment, and health care professionals do not always actively screen for GSM. As a result, GSM remains underdiagnosed and undertreated. Several effective treatments exist, but low-dose vaginal estrogen therapy is the criterion standard. It is effective and safe for most patients, but caution is suggested for survivors of hormone-sensitive cancers. Newer treatment options include selective estrogen receptor modulators, vaginal dehydroepiandrosterone, and laser therapy. Nonprescription treatments include vaginal lubricants, moisturizers, and dilators. Pelvic floor physical therapy may be indicated for some women with concomitant pelvic floor muscle dysfunction. Sex therapy may be helpful for women with sexual dysfunction. This concise review presents a practical approach to the evaluation and management of GSM for the primary care physician.

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Genitourinary syndrome of menopause (GSM) is a common, underrecognized, and undertreated condition that results from decreased estrogen levels. Affecting nearly 50% of postmenopausal women, GSM also occurs in other low-estrogen states, such as postpartum, during lactation, and with certain medications (eg, aromatase inhibitors [AIs]).[1] Other names for this condition include *vulvovaginal atrophy*, *vaginal atrophy*, and *atrophic vaginitis*.[2] A change in terminology was proposed and endorsed by the North American Menopause Society and the International Society for the Study of Women's Sexual Health in 2014 to (1) acknowledge the involvement of not only the vulvar and vaginal tissues but also the lower urinary tract, (2) identify menopause as an etiologic factor, and (3) avoid the negative connotations associated with the term *atrophy*.[2]

Although vasomotor symptoms typically improve over time, GSM is chronic and progressive, and symptoms are unlikely to resolve without treatment.[1] Findings from the Real Women's Views of Treatment Options for Menopausal Vaginal Changes (REVIVE) survey,[3] involving 3046 postmenopausal women with symptoms of GSM, suggested a lack of awareness that these changes relate to the menopause transition. Further, 59% of respondents reported that their symptoms considerably decreased their enjoyment of sexual activity, and 23% reported an adverse effect on general enjoyment of life.[3] The Women's EMPOWER survey[4] queried 1858 community-dwelling US women and found that women did not bring up the topic with their health care professional because of embarrassment or concerns that the topic was inappropriate for conversation, but most were willing to try a product for symptom relief and would welcome information and treatment suggestions from their health care professional. The Clarifying Vaginal Atrophy's Impact on Sex and Relationships (CLOSER) survey reported on 1000 married or cohabitating North American menopausal women with vaginal discomfort and their male partners and the impact of vaginal dryness and low-dose vaginal estrogen therapy (ET) on various parameters.[5] Results revealed that the women and their partners believed that vaginal discomfort had a considerable impact on intimacy. Women avoided intimacy because of vaginal discomfort (58%), experienced loss of libido (64%), and experienced sexual pain (64%). The majority of male partners believed that vaginal dryness caused avoidance of intimacy by their partners (78%), loss of libido (52%), and painful sex (59%). The use of low-dose vaginal ET was associated with less painful sex, greater satisfaction with sex, and an improved sex life.[5]

PRESENTATION AND EVALUATION

Genitourinary syndrome of menopause is a clinical diagnosis, and laboratory testing is usually unnecessary. Although some women with mild GSM remain asymptomatic, many women report symptoms such as vaginal dryness, burning, irritation, decreased lubrication with sexual activity, and dyspareunia with resultant sexual dysfunction.[1] Urinary symptoms of GSM may include frequency, dysuria, and increased risk for urinary tract infections.[1] For some women, symptoms can be severe enough to preclude penetrative sexual activity and to cause discomfort even with sitting or wiping. In women taking AIs, symptoms are more common and may be particularly severe.[1]

Changes on examination include scant pubic hair, loss of the labial fat pad, thinning and resorption of the labia minora, narrowing of the introitus, and increased vaginal pH.[1] Internal examination findings include reduced vaginal caliber; smooth, shiny, pale mucosa with loss of folds; and a cervix flush with the vaginal vault. With inflammation, the vagina may appear erythematous, develop petechiae, and bleed easily.[1]

A pelvic examination can be helpful to exclude other vulvar and vaginal conditions that may present with symptoms similar to those of GSM, including irritant, infectious, or inflammatory vaginitis; dermatoses; and neoplasia.[1]

MANAGEMENT OF GSM

Lubricants and Moisturizers

Lubricants and moisturizers are used for sexual comfort and pleasure and are particularly useful for women with mild to moderate vaginal dryness and for those who choose

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