SPEAK UP: many types of moisturisers and lubricants are available from your doctor that are effective in the treatment of GSM.

The ultimate guide for painless sex

It is a topic that often causes unease but genitourinary syndrome of the menopause need not be suffered, it can be treated writes Dr Heather Currie

When considering the effects of the menopause, hot flushes and sweats regularly come top of the list of expected symptoms. Increasingly though, women and healthcare professionals are becoming aware of other symptoms due to declining and low levels of estrogen following natural decline in ovarian function, ovaries affected by other treatments, or removal of the ovaries.

These may include sleep disturbance, low mood and joint aches. However, there is still a low level of awareness of the effects of estrogen lack on the vagina, bladder and pelvic floor, effects that can cause significant discomfort and distress yet still are hugely under reported and under treated.

To address this issue, let's start with the name. Many terms have been used including, vaginal dryness (to demonstrate a common symptom), vaginal atrophy (to indicate thinning changes of the vagina), vulvovaginal atrophy (to include thinning effects also of the vulva or "outer lips"), urogenital atrophy (to indicate that the urological system, i.e. bladder, can also be affected), and, the most recently recommended term—genitourinary syndrome of the menopause (GSM).

None of these rolls easily off the tongue, which is indeed part of the problem. Women often find it very difficult and embarrassing to discuss gynaecological issues, especially related to the vulva and vagina and confusing terminology does not help.

Whatever we choose to call the vulva and vagina, we need to recognise that the lack of estrogen can have significant and sometimes devastating effects on this very personal, sensitive area. In fact, it is thought that up to 50% of all postmenopausal women can experience symptoms due to GSM. However, it is believed that the true number of women affected is unknown since many women do not report symptoms and so this figure is likely to be an underestimate.

Symptoms include dryness, pain during intercourse, irritation and itching, susceptibility to vaginal infection and also bladder symptoms such as urgency to pass urine and urinary tract infections.

Vaginal dryness, irritation and pain during sexual intercourse are due to lack of estrogen affecting vaginal and vulval blood supply, lubrication, loss of elasticity and thinning and inflammation of the vaginal walls and vulval skin with reduced sensation and response. Not surprisingly, these changes often lead to reduced interest in sex.

In addition, estrogen helps to maintain vaginal acidity by facilitating production of lactic acid from lactobacilli (normal vaginal organisms). An acidic vaginal environment is a good barrier to infection. With less estrogen, vaginal acidity changes and both vaginal and urinary infection risk is increased.

Bladder symptoms are due to estrogen lack on bladder muscle contractions; estrogen is thought to play a role in regulating bladder and urethral muscle contractions so that estrogen lack can lead to increased muscle contractions and feeling of urgently needing to pass urine. Further, there has been recent increased interest in the effect of estrogen on support of the pelvic floor. With low estrogen levels, pelvic floor support is reduced leading to dragging sensation and even prolapse.

It has been recognised that GSM, particularly the vulval and vaginal symptoms, can have significant impact on quality of life and relationships.

Negative effect

Previous surveys from our *Menopause Matters* website visitors have shown that women often feel that these symptoms had a negative effect on their confidence, self-esteem and relationships and many made excuses not to have sex because of the discomfort.

These symptoms become noticeable a few years after periods have stopped, or a few years after stopping Hormone Replacement Therapy (HRT). This apparent delay in these effects appearing is due to the fact that estrogen lack on the vulva, vagina and bladder generally takes a few years to become evident, in contrast to the flushes, sweats, low mood and joint aches that are triggered early in the stage of falling and low estrogen levels.

The other important difference between urogenital symptoms and flushes and sweats is in relation to duration; while flushes and sweats can last many years, for many women they do reduce with time but urogenital symptoms do not reduce. Indeed, these symptoms gradually worsen with time and so any treatment needs to be continued long term.

This message was confirmed by the recently published NICE guideline on Diagnosis and Management of the Menopause, recommending that "Treatment should be started early before irreversible changes have occurred and needs to be continued to maintain benefits" (NICE guideline. Menopause:diagnosis and management.)

For such a common consequence of the menopause, which can have significant effects, it is clear that effective treatment is required, should be started early and continued long term, perhaps even indefinitely. Before discussing treatments that are available, it is worth emphasising the need for women to be aware of this consequence, to look out for early signs and to feel able to seek help and treatment.

Hopefully the wide distribution of this magazine, along with the popularity of our website and increasing use of social media will help more women to access this information.

Regarding treatment options, vaginal estrogen has been shown to be able to reverse the changes of estrogen lack and significantly reduce symptoms. For women in whom symptoms of GSM are the predominant effect of the menopause, vaginal estrogen alone can be offered and is recommended in the NICE guideline.

Vaginal estrogen needs to be prescribed and can be taken in the form of a small vaginal tablet inserted using an applicator, a vaginal cream, which can also be applied to the vulval area, or a vaginal ring. Personal preference, dexterity and discussion of symptoms should lead to individualisation when choosing the type to use.

Minimally absorbed

Vaginal estrogen is not the same as taking HRT; HRT replaces estrogen throughout the body and is taken by a tablet, patch or gel. Vaginal estrogen is concentrated in the vagina and bladder and is minimally absorbed throughout the body. This major difference means that vaginal estrogen will not control symptoms such as flushes and sweats (systemic symptoms) nor have any effect on bone or heart health, unlike HRT. Women who may have concerns about taking HRT because of past medical history, can often still use vaginal estrogen.

Women who take HRT for systemic symptoms may find that the HRT also helps GSM, but in some, while systemic symptoms may be controlled, vaginal estrogen may be needed in addition to reduce vaginal and bladder symptoms.

This need for both HRT and vaginal estrogen may be increasing as lower doses of HRT are now often used. Regarding duration of treatment, many women stop treatment after a few weeks if they have not noticed a benefit, or after a few months if symptoms have reduced assuming that the problem has been cured.

It is important to understand that vaginal estrogen needs to be used for a few months before full benefit can be realised, especially if significant changes are already present when treatment is started. Also, symptoms do often return after treatment is stopped and so continuing treatment is recommended.

For many women, the use of vaginal lubricants and moisturisers can help the dryness and reduce discomfort. While these do not correct the cause i.e. estrogen deficiency, they may be preferred for women with mild to moderate vaginal dryness or for those who do not wish to use vaginal estrogen. The value of moisturisers and lubricants was confirmed in the NICE guideline, which states "...women with vaginal dryness... moisturisers and lubricants can be used alone or in addition to vaginal estrogen".

Many types of both lubricants and moisturisers are available and knowing which to choose can be very difficult. Lubricants provide a rapid effect and are applied just before sex. They can be particularly helpful for women who experience discomfort only during sex due to dryness. Lubricants are available as water, silicone, mineral oil or plant oil based.

Products vary

Moisturisers are applied more regularly such as daily or every two to three days. They rehydrate the vagina and maintain the moisture for two to three days. The longer lasting effect may be helpful for women who experience discomfort not just during sex. Moisturisers mostly contain water but different products vary in the content of other ingredients.

When choosing a moisturiser or lubricant, the pH (acidity) and osmolality (measure of concentration of chemical particles) should be considered. Many commercially available products show a high osmolality, which may cause tissue irritation. It is recommended that products with pH, which most closely resemble healthy vaginal pH of 3.8 to 4.5 and with low osmolality are preferred.

If lubricants are used as well as vaginal estrogen, they should be used at different times of the day since estrogen absorption may be reduced if used immediately after a lubricant. In addition regarding timing, it is recommended not to have sexual intercourse immediately after applying vaginal estrogen since absorption by the partner may occur; wait at least one hour.

It can be difficult to talk about sex and vaginas, but maintaining vaginal and vulval health after the menopause is essential. It's time to speak up, whatever name we choose to use!