

Urogenital Problems

The International Menopause Society is grateful for permission to adapt for global use the information sheet that was originally produced by the **British Menopause Society**. The medical and scientific information provided might not be relevant to a particular woman's circumstances and should always be discussed with her own health-care provider.

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Urogenital Problems

www.menopauseinfo.org

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Info

International **IMS**
Menopause Society
Promoting education and research on midlife women's health



Did you know...

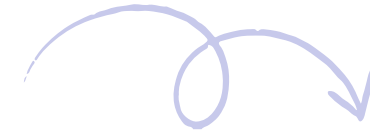
- As women get older physical changes can lead to vaginal dryness, which may affect sexual function and cause relationship difficulties
- Urogenital problems are common symptoms of the menopause and can involve the vulva (outside), vagina and bladder
- Up to 40% of postmenopausal women experience vaginal dryness during the menopause (vaginal atrophy)
- Many women experience incontinence
- Only 20 – 25% of women with symptoms seek medical help
- 50% of people over 70 are sexually active
- Some women have better sex after the menopause with no concerns regarding unplanned pregnancy

Introduction

After the menopause many women experience urogenital problems such as **vaginal dryness, itching and discomfort** especially in relation to sexual activity and urinary incontinence.

The information below will help to explain some of these problems.





Vaginal Atrophy: vaginal dryness, soreness and painful sex

Without the production of estrogen by the ovaries, the skin and supporting tissues of the vulva (outside) and vagina become thin and less elastic. This is a common consequence of the menopause and the majority of women will experience symptoms of one form or another. Vaginal dryness is commonly the first reported symptom, due to a reduction in urogenital mucus production.

Thinning of the lining of the vagina and vulval skin increases the risk of damage. This is most likely during sex, especially if lubrication is poor. Even quite gentle friction can cause pain and discomfort. If the vulval lips are thin and dry, rubbing against underwear can cause soreness. Some women find the physical changes to the vulva (outside) upsetting due to a reduction in fat content/plumpness. For many women, sex becomes difficult and painful.

Alteration in the normal vaginal discharge is noticed by many women after the menopause and this is rarely discussed. Without estrogen, the pH (acidity) of the vaginal secretions changes and the normal discharge becomes more alkaline (like caustic soda!). This change in pH affects the balance of the microorganisms in the natural secretions, which in turn suppresses the normal levels of “good” bacteria (lactobacillus). Vaginal discharge changes in nature, becoming watery, discoloured and slightly smelly. This often leads to irritation and can cause burning of the vulva and vagina.

Some women seek advice, but many don't ask for help for this under-recognised problem.

Management of urogenital atrophy



Some options that may help include:

- Avoidance of soaps to wash with (perhaps replacing with aqueous cream, available from most pharmacies)
- Treatment of underlying skin problems with topical creams, often after guidance by a specialist and perhaps a skin-biopsy if required. These may include moisturising barrier creams and occasionally steroid ointment
- Regular use of vaginal moisturisers and lubricants
- Local estrogen therapy. It is now well recognised that low doses of estrogen therapy, delivered locally in the vagina, can be effective (see below)

These treatments are effective and acceptable and unlike the conventional form of HRT, the effects are local, therefore the **risk of systemic side effects are reduced**.

Local estrogen therapy

Vulvovaginal **dryness, soreness, burning, irritation, itching and chafing** are likely to respond to local estrogen therapy, which can also **help greatly with discomfort or pain during sex, correct the vaginal pH and prevent overgrowth of abnormal vaginal flora**.

Local low dose treatment, with estrogen, delivered directly to the vulva and vagina has been found to have a **significant therapeutic effect** on postmenopausal urogenital symptoms.

Estrogen delivered locally can be in the form of:

- **Vaginal tablets:** gel or a pessary all initially used daily, then twice weekly
- **Creams:** used daily initially, then twice weekly
- A **vaginal silicone ring:** changed 3 monthly

Selective Estrogen Receptor Modulator

Ospemifene is a **selective estrogen receptor modulator** (SERM), (which means that it specifically targets estrogen receptors in the vagina and does not stimulate the breast or womb lining) taken orally in a dose of 60mg once daily. It can be used in women with a history of breast and endometrial cancer, who have completed treatment and is an appropriate choice for women who are not eligible for vaginal estrogen therapy or who prefer oral treatment to any form of vaginal administration. Hot flushes may occur as a side-effect and studies with extended follow up are required before long-term safety can be confirmed, which is particularly important as **treatment for urogenital atrophy needs to be long-term**.

Dehydroepiandrosterone (DHEA) 6.5mg

This is delivered vaginally as a pessary on a daily basis. It is converted in the vaginal mucosa to both estrogen and testosterone. 95% of the active hormones made in the vaginal mucosa are inactivated at the site of synthesis, preventing any increase in hormone levels in the blood stream or a stimulatory effect on the lining of the womb. The urogenital tissue responds to both estrogen (improvement in mucosal thickness) and androgen (with improvement to the connective tissue and stimulation of the muscle layer below).

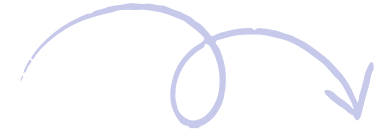
Vaginal Laser Treatment

Laser therapy is a relatively recent development, offering an **alternative to the existing treatment** choices already described and has the potential to provide particular benefits for women in whom use of hormonal therapy is contraindicated. Laser therapy **stimulates collagen** producing fibroblasts associated with urogenital tissue restructuring increasing vaginal lubrication and acidity. There are two types of laser therapy for urogenital atrophy, CO2 micro ablative laser and Erbium YAG - ablative photothermal laser therapy. Availability of both CO2 and Erbium -YAG laser is mainly in the private sector.

Recurrent urinary tract infections (UTIs)

UTIs can affect women of all ages, but this problem increases with age as a result of estrogen deficiency.





Pelvic-floor changes and prolapse

Many postmenopausal women become aware of **ballooning or bulging** of the walls inside the vagina, or even of a feeling of descent of the neck of the womb. Others simply experience a generalised pelvic **dragging sensation**. About half of postmenopausal women are found to have weakening of the front wall of the vagina (anterior vaginal wall prolapse); about 25% have similar problems with the back (posterior) wall, and 20% with the highest part of the vagina.

The muscles and ligaments of the pelvic floor (which should normally support the womb, bladder and other organs like a trampoline) are all estrogen-sensitive, and changes in collagen, due to estrogen deficiency can have a profound effect on the support mechanisms of the pelvic floor.

The protective covering of the clitoris (clitoral hood) may be affected by changes in the urogenital tissue quality. The clitoris can become exposed and hypersensitive or buried underneath the fused labia minora.

Lower urinary tract symptoms

Many women find that they have problems with their **urinary tract** (water-works) in association with the menopause due to estrogen deficiency.

Some suffer from **stress incontinence** – leaking of urine on coughing, sneezing or jumping, whilst others experience **urge incontinence** presenting as difficulty “holding on” once there is recognition of a need to empty the bladder. They may also leak and start to pass urine before they can get to the toilet.

The pattern of incontinence is often mixed

Symptoms of “overactive bladder” include **frequency** (recurrent need to pass urine) and **nocturia** (need to pass urine at night leading to recurrent waking). Some women also feel they need to pass urine, having only just done so due to over activity of the bladder muscle.

Management of urinary problems

Local estrogen

Local estrogen replacement therapy has been shown to **alleviate urgency, urge incontinence, frequency, nocturia, dysuria** (discomfort on passing urine) and also to reduce urine infections.

Genuine Stress Incontinence would not appear to be helped by estrogen alone, but it does seem to improve the action of other treatments currently used.

The newer treatments including **Ospemifene, DHEA and laser therapy** may all have a beneficial effect on bladder problems.

Pelvic-floor exercises

These can strengthen the pelvic floor **reducing the risk of uterovaginal prolapse**. Many women have learnt these techniques from childbirth, but it is well worth revisiting them.

Pelvic-floor physiotherapists are specialists in this field and are able to fully assess and monitor a woman's pelvic floor function and teach appropriate techniques to strengthen it and retrain the bladder. They often use devices to help women perform appropriate exercises, such as weighted vaginal cones, or vaginal trainers. Your practice nurse or GP should be able to refer you to a specialist pelvic-floor physiotherapist.

Surgery

Sometimes assessment is needed using "urodynamics" in a specialist clinic, but only rarely is surgery needed. Modern surgical methods, however, are as **non-invasive as possible**.

