Position Statement for Management of Genitourinary Syndrome of the Menopause (GSM)

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One of the most consistently identified predictors of impaired sexual health in women is the presence of vaginal symptoms. Up to 84% of postmenopausal women have symptoms associated with Genitourinary Syndrome of the Menopause (GSM)[1] yet only a minority receive any treatment. Unlike many other symptoms of the menopause, symptoms of GSM often worsen over time.

This guidance is designed to support healthcare professionals in diagnosing and managing this condition, including in those with a history of cancer.

Terminology

The term Genitourinary Syndrome of Menopause (GSM) was introduced in 2014. GSM is a comprehensive term that includes vulvovaginal symptoms and lower urinary tract symptoms related to low oestrogen levels. The terms *vulvovaginal atrophy and atrophic vaginitis* (which were previously in general use) were not ideal because they did not cover the full spectrum of symptoms and did not indicate that symptoms were directly related to decreased oestrogen levels in the menopausal state. GSM more accurately describes the postmenopausal hypoestrogenic state of the genitourinary tract [2] in peri and postmenopausal women.

Talking about GSM

GSM is very common but often underdiagnosed and undertreated.

One study found that around 70% of postmenopausal women who answered a survey had symptoms of GSM, yet only 7% receive treatment.[3]

Despite the high prevalence of GSM, only around 25% of women volunteer this information to their healthcare professional.

70% of healthcare professionals acknowledge they never, or rarely, ask about problems such as vaginal dryness.[3]

The prevailing attitude among both women and healthcare professionals is one that considers symptoms of GSM to be a natural and unavoidable part of the aging process.[4]

Unlike many other menopause-related symptoms, GSM does not improve spontaneously but usually worsens with time if not proactively managed.

NICE menopause guidance gives clear recommendations regarding the optimal management of this condition in menopausal and postmenopausal women.[5]

Treatments for GSM are usually effective, safe and cost effective.[5] Women need to receive individualised advice and treatment for this debilitating condition as a priority.

Symptoms and signs

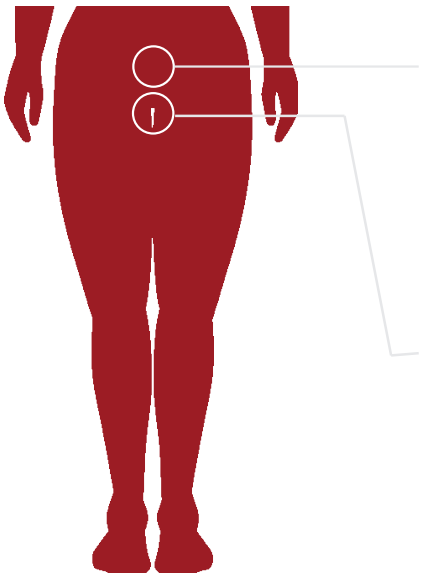
The symptoms and signs of GSM are detailed in figure 1.[2]

Symptoms	Signs
Genital dryness Decreased lubrication during sexual activity Discomfort or pain during sexual activity Post-coital bleeding Decreased arousal, orgasm, desire Irritation, burning, or itching of the vulva or vagina Urinary frequency and urgency	Decreased moisture Decreased elasticity Labia minora resorption Pallor, erythema Loss of vaginal rugae Tissue fragility, fissures, petechiae Urethral eversion or prolapse Prominence of urethral meatus Introiatal retraction Recurrent urinary tract infections

Impact of GSM

Oestrogen and testosterone receptors are present in the vagina, urethra, bladder trigone and pelvic floor. All these areas can be affected by a lack of oestrogen and testosterone during the perimenopause and menopause.

GSM results in unnecessary suffering for many women. Genitourinary symptoms may also be observed in women who are breast feeding or women using progestogen-only contraceptives, which both cause low oestrogen. Symptoms associated with GSM can impact negatively on interpersonal relationships, quality of life, daily activities[6, 7, 8] and self-esteem including in women who are not sexually active.[9]



Atrophy of the uretha, with a relative increase in urethal epithelial transitional cells - and a corresponding decrease in intermediate and superficial squamous cells - occurs after menopause.[10]

The smooth muscle in the lower urogenital tract atrophies, affecting the superficial muscle layers of the trigone, the proximal and distal uretha, and the lamina propria of the trigone and proximal urethra.[11]

A fall in oestrogen can result in the loss of superficial epithelial cells, collagen and elastin, resulting in loss of vaginal rugae.[12]

The vaginal epithelium becomes pale and friable and can tear and bleed, particularly during intercourse.

Women who have received chemotherapy, surgery, and/or radiotherapy for certain types of malignancies have a higher risk of developing GSM.[13] This can compound other biopsychosocial effects of cancer on sexuality and quality of life and therefore warrants a proactive approach.

Conditions, such as inflammatory bowel disease, diabetes mellitus, multiple sclerosis and stress can be associated with vaginal dryness.[14] Additionally, some medications including tamoxifen, antihistamines, decongestants, and some antidepressants, may cause genitourinary symptoms.[12]

Understanding the history

All perimenopausal and menopausal women should be asked about genitourinary symptoms regardless of their presentation.[15]

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

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.

Pain and discomfort during sexual intercourse or masturbation is often present, but many women find they can also experience symptoms at other times, for example when they are walking, cycling, horse riding or simply when sitting down.[16] They may also describe a change in sensation, altered sexual arousal, and anorgasmia.

It is important to screen for sexually transmitted infection in women with GSM with appropriate history taking +/- investigations.

Nurses undertaking cervical screening are well placed to enquire about symptoms – as are all healthcare professionals who see postmenopausal women as part of their clinical work. Many women avoid cervical screening because a speculum examination is too painful; non-attenders should be asked about symptoms and offered treatment, which may encourage attendance.

Useful questions to ask:
Does it feel different in any way around your vulva or vaginal area?
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 any changes in vaginal discharge (either increased or reduced)?
Have you noticed any symptoms such as increased urinary frequency or being less able to hold on to urine?
Do you have any discomfort on passing urine?
Have you noticed any changes in sexual arousal, sexual function, or your ability to climax?
Have you experienced any leakage or urine during sex?

Women with learning disabilities or dementia may present with behaviour change due to vulvovaginal discomfort or irritation, and/or recurrent urinary tract infections. There is a lack of research around how menopause affects women with learning disabilities, but clinicians should be aware that menopause may present earlier, especially in those with Down's syndrome.[17]

Women who have experienced female genital mutilation (FGM) may find that GSM significantly exacerbates FGM-related symptoms such as pain, irritation, and sexual dysfunction. FGM may be a barrier to seeking help and/or symptoms may not be volunteered by women who feel embarrassed or fear judgement. Research is urgently needed into the needs and preferences of this group of women.[18]

Another group of individuals who may have barriers to seeking help are trans individuals, for example, transmasculine individuals undergoing gender affirming care where systemic testosterone therapy will further reduce circulating oestrogen levels.[19]

Examination

Ideally, all women with GSM should be examined, but this is not always possible (for example, during a remote consultation) or wanted by the patient. Clinicians should use their clinical judgement, but treatment should not be delayed if an examination is not possible, and the symptoms are typical. Women should be advised to reattend for an examination if symptoms persist despite treatment.

Examination should be considered if there are symptoms in a woman's history to suggest any other underlying pathology or red flags:

Symptoms that would suggest examination needed
Severe symptoms
Persistent symptoms despite treatment
Symptoms worsen after an initial treatment period of at least three months
Symptoms change or worsen at any stage
Lumps or sores
Bleeding

On examination, you may see:
- Atrophy of the vulva and vagina
- Thinning of vaginal epithelium with loss of rugae and elasticity
- Paler vaginal epithelium due to reduced blood supply in this area
- Petechial haemorrhages
- Normal examination

Physical appearance does not usually correlate well with severity of symptoms. In addition, a normal examination does not exclude the diagnosis of GSM.

Investigations

For most women, investigations are not necessary.

Cervical screening should be kept up to date and women should be given information about GSM during the cervical screening appointment and extra lubrication should be used for the procedure if necessary. If speculum insertion is uncomfortable or painful, women should be advised to return for screening a few months after starting local oestrogen treatment.

Urine dipstix and microscopy should be considered for women who present with urinary symptoms.

If there is abnormal vaginal bleeding then appropriate, relevant investigation should be undertaken to exclude other causes.

For women who complain of a vaginal discharge, a vaginal swab should be considered to exclude any infections (including STIs if indicated in the history).

Referral

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

Most women can be treated for GSM successfully in the primary care setting. In situations where symptoms are resistant to the various treatment options available, a referral to a specialist is indicated.

Management

There are a number of different treatment options for GSM. These include vaginal oestrogen, other local hormonal preparations, non-hormonal vaginal moisturisers and lubricants, and systemic hormone replacement therapy (HRT).

Principles of GSM management

The principles of management are to restore urogenital physiology and to alleviate symptoms. The correct treatment can relieve symptoms and considerably transform a woman's quality of life.[16]

As a lack of circulating, natural sex hormones is the primary cause of atrophic vaginitis, hormone replacement therapy and/or localised hormone treatment are the most logical choices of treatment and have been shown to be effective in the restoration of anatomy and the resolution of symptoms.

Non-hormonal treatments

Vaginal moisturisers and lubricants should be recommended to women with GSM, either alone or alongside vaginal/systemic hormone therapy. Vaginal moisturisers used on a regular basis offer relief from symptoms of vaginal dryness, whereas vaginal lubricants are intended for use with sexual or any penetrative activity, including pelvic examination and cervical screening.

However, care is needed in selecting preparations which are appropriate for the vaginal environment and free of potential irritants such as glycerol/glycerin, which can paradoxically lead to more irritation and episodes of thrush. YES VM (vaginal moisturiser) and YES WB (water based lubricant) and Sylk lubricant are suitable products and are often available on prescription. They are less likely to cause irritation, compared to some over-the-counter preparations.[20]

Vaginal moisturisers and lubricants do not restore normal vaginal physiology. They are suitable for women with mild symptoms, and/or can be used alongside vaginal hormones (oestrogen or DHEA). They are also suitable for women who prefer a non-hormonal treatment option for any reason.[21] Women should be advised that oil-based lubricants can negatively impact condom integrity.[22]

Vaginal moisturisers:

- Are bio-adhesive and attach to mucin and epithelial cells on the vaginal wall where they trap and retain water
- Can balance vaginal pH
- Often help with vulval sensitivity when used regularly
- Can be used more or less frequently depending on the severity of the woman's dryness
- Should be used regularly (typically every three days)
- Can be used in combination with local hormones but preferably used at different times of day as some products may prevent the dispersion of the hormone preparation

Vaginal lubricants:

- Come in a wide variety and are commercially available either as a water-, silicone-, mineral oil-, or plant oil-based product
- Are applied to the vagina and vulva (and the partner's penis if required) prior to sex
- Provide short-term relief for vaginal dryness and can prevent friction during sexual intercourse
- Are particularly beneficial for women whose vaginal dryness is a concern only, or mainly, during sexual intercourse or for those who experience post-coital cystitis
- Can also be used in combination with local hormones but again preferably at different times

Vaginal oestrogens and DHEA

The clinical response to treatment with topical oestrogen is usually rapid and sustained. [21]

Local oestrogen replacement can restore vaginal pH and thickens and revascularises the vaginal epithelium.[23] Vaginal oestrogen use is also associated with reduced urinary symptoms and a decreased incidence of urinary tract infections.[24, 25, 26]

Vaginal oestrogen can be absorbed from the vagina and surrounding area via a pessary, cream, gel or vaginal ring. There are two types of oestrogen used – oestradiol and oestriol.

The dose of vaginal oestrogen is very low; [27] for example, if two 10mcg oestradiol pessaries are used twice weekly for one year, the total dose is roughly equivalent in dose to just one 1mg of oestradiol tablet assuming that 100% is absorbed (which is unlikely).

Intrarosa is a pessary treatment for vulval and vaginal atrophy in post-menopausal women with moderate to severe genitourinary symptoms. Prasterone, the active ingredient, is identical to dehydroepiandrosterone (DHEA). In the body it is converted locally to testosterone and oestrogen. In clinical trials it has been shown to improve dyspareunia, vaginal pH and vaginal epithelium.[28] Intravaginal DHEA has been shown to improve genitourinary symptoms, but absorption is negligible, and blood levels of testosterone and oestradiol do not significantly increase.[29]

Women should be treated initially for three months and then be offered a review. After this time, treatment can be put on a repeat prescription. It is preferable to start treatment early, rather than waiting for symptoms to worsen. If treatment is started earlier, it helps restore the anatomy and physiology and prevents progression to more severe changes such as labial resorption or clitoral atrophy.

All women should receive information about their condition and their treatment, preferably in written format. Women should also be signposted to other useful sources of information – see Resources section at the end of this article.

Women should be advised that the information leaflet included in the packaging is out of date and factually incorrect. This needs to be changed by the MHRA.

How can women access Gina?

Since 2022, some postmenopausal women are now able to buy Gina vaginal oestrogen tablets over the counter for the first time in the UK. There are many restrictions though as to which women can buy this product. [30]

Only postmenopausal women aged 50 years and above and who have not had a period for at least a year are able to buy the medication.

While the MHRA agrees the risk of side-effects are very low, they have stated that some women will still require a prescription including those who have had breast, endometrial or ovarian cancer, blood clots, heart disease, liver disease or stroke.

Pharmacists will use a checklist of questions to ensure that Gina is suitable for their customer.

Pharmacists will ask also about any medication women are taking.

Women with a history of endometriosis will be able to purchase Gina if they have previously had a prescription for vaginal oestrogen and have had no recent symptoms of endometriosis.

Women already taking systemic HRT can only buy Gina if they have previously had similar vaginal oestrogen or their GP has confirmed that Gina is a suitable option for them.

Formulation	Administration	Frequency of administration	Advantages	Disadvantages
Pessaries containing oestradiol: Vagifem (10mcg) and Vagirux (10mcg) (oestradiol)	Inserted into the vagina using an applicator.	Daily for first two weeks and then twice weekly. Can be used more frequently as dose is so low.	When used at nighttime, can stay in place for several hours. Vagirux more environmentally friendly as box contains one reusable applicator.	Vagifem less environmentally friendly. Low dose so often needs to be used more frequently.

Formulation	Administration	Frequency of administration	Advantages	Disadvantages
Vaginal tablet containing oestradiol: Gina: (10mcg)	Inserted into the vagina using an applicator.	One tablet daily for first two weeks, then twice a week. Can be used more frequently as dose is so low.	Can be purchased over the counter.	Licence is only for postmenopausal women aged 50 years and older who have not had a period for at least 1 year and who suffer from vaginal symptoms due to oestrogen deficiency. Less environmentally friendly as single use applicator.
Pessaries containing oestradiol: Imvaggis (30mcg) (oestriol)	Inserted into the vagina using fingers.	Daily for first three weeks and then twice a week. Can be used more frequently as dose is ultra low.	No applicator.	Can result in waxy discharge. Can damage latex condoms.
Pessary containing DHEA: Intrarosa* (active ingredient Prasterone, 6.5mg, converts intracellularly to androgens and oestrogens) *Please refer to DHEA section	Inserted into the vagina with or without an applicator.	One pessary daily.	Easy to use.	Can damage latex in barrier contraceptives.
Creams: Ovestin (500mcg) (oestriol)	Inserted into the vagina with an applicator. Can also be applied to external genitalia.	Daily for two weeks and then twice weekly. Can be used more frequently as dose is so low.	Used for vulva itching and soreness.	Can be messy.
Creams: 0.01% oestriol (500mcg)	Inserted into the vagina with an applicator.	Daily until symptoms improve and twice weekly thereafter.	Some women find it less irritating than Ovestin.	More dilute so large volume needed. Contains peanut oil, avoid if allergy.
Gel: Blissel (50mcg) (oestriol)	Inserted into the vagina with an applicator.	Daily for first three weeks and twice a week thereafter.	Lower dose option.	
Ring: Estring (7.5mcg/24hrs) (oestradiol), a soft flexible silicone ring.	Inserted into the vagina by woman or by health professional if preferred.	Needs replacing every 90 days.	Doesn't require daily application and no discharge (as sometimes with pessaries or creams. Slightly stronger than Vagifem pessary. Can be removed for sex if preferred.	

Figure 2: Localised hormone treatment options

Further information on vaginal hormones

• Women should be reassured regarding the inaccuracy of the information in the product leaflet inside the vaginal hormonal preparations.
• If symptoms do not improve with vaginal oestrogen, consider increasing the dose, changing preparation (and/or consider DHEA), combining two local treatments – e.g., Vagifem, Vagirux or the Estring can be used internally and ovestin cream can be applied externally, or systemic HRT.
• The frequency of using these preparations can be increased in women who have persistent symptoms as the doses of these preparations are very low and absorption into the blood stream minimal.
• Women using vaginal oestrogen – even in the long term – do not need to take progestogens for endometrial protection, because the vaginal oestrogen dose is low, and it is not significantly absorbed. [31]
• Vaginal hormones can often improve urinary symptoms, including urinary infections and recurrent UTI. [32]
• The beneficial effects of localised hormonal treatments can take several months and potentially longer if women have severe symptoms.
• For most women, symptoms return after treatment is stopped. There is usually no need to stop treatment.
• Following the initial three-month review, local hormones can be put on a repeat prescription, as women need to use these preparations long-term.
• Local hormonal therapy may relieve pressure and irritant symptoms in women with a prolapse. A trial should be considered for women with a prolapse. [33]

Systemic Hormone Replacement Therapy (HRT)

Systemic HRT can very effectively treat GSM and is the treatment of choice for women who additionally have other menopausal symptoms. Body-identical hormone therapy is safe, and HRT has long-term health benefits including prevention of osteoporosis and a reduced risk of cardiovascular disease and dementia when initiated within 10 years of the menopause. The benefits of body identical HRT outweigh the risks for most women. [34]

It is essential that women receive the right dose, as women are likely to continue to experience symptoms if the dose is too low. Women should be reviewed and, if symptoms haven't fully resolved, the dose can be titrated until symptom relief is achieved. If symptoms don't respond to treatment, alternative causes should be considered.

Testosterone is also an important hormone in women. Before the menopause, testosterone is the most abundant female sex hormone. Testosterone levels decline in women from their 30s onwards and drop significantly during the menopause transition. Testosterone deficiency is a cause of GSM.

Testosterone can be prescribed for low libido that hasn’t responded to systemic oestrogen replacement. [5] It can also be used off-licence to treat GSM, and many women report additional benefits including improved energy and mood and reduced vasomotor symptoms and joint pain. [27]

Around 10–25% of women who take systemic HRT will have persistent urogenital symptoms. These women can be given vaginal hormones in addition to systemic HRT. It is important that all women taking HRT are asked about any GSM symptoms, including sexual function, sensation and arousal, in their annual review.

Other treatments

Ospemifene is a selective oestrogen-receptor modulator (SERM). It is approved for the treatment of moderate to severe genitourinary symptoms in postmenopausal women as an alternative to vaginal or systemic hormones.[35, 36] Because Ospemiphene is an oral tablet and doesn't require vaginal application it can be useful for women with arthritis. It can also be considered for women with learning disability or dementia if they experience recurrent urinary tract infections, especially those requiring frequent hospital admission. Some women prefer an oral tablet because it is less messy.

Ospemiphene is generally well tolerated. The most common side effect is hot flushes, which are usually transient.[37] It does not appear to have any negative effects on the endometrium and is not associated with an increased risk of thromboembolism, [38] or breast cancer. [39]

Laser treatment can also be used to increase the thickness of the vaginal squamous epithelium and improve vascularity. Small observational studies have suggested that the carbon dioxide laser [40] and the infrared/Erbium laser [41] improve sexual function, vaginal tightening, vaginal dryness and stress incontinence.

However, two randomised controlled trials have demonstrated that laser treatment is no better than placebo.[42, 43, 44] Hence, laser treatment is not available in the NHS.

Advice to women

Perfumes, powders, soaps, bath additives, deodorants, panty liners, spermicides and many brands of lubricants often contain irritant compounds and women should be advised to avoid these products. In addition, tight-fitting clothing and long-term use of sanitary pads or synthetic materials can worsen symptoms.

Women should be advised to wash the perineum with an emollient such as Cetraben or Epaderm which can be mixed with warm water and used as a soap substitute. Cotton underwear is preferable to synthetic fibres.

Breast cancer and GSM

Breast cancer is the most common cause of cancer in women. Due to advances in treatment and earlier diagnosis, breast cancer mortality has almost halved in the last 30 years [45] and 95% of women diagnosed today survive long-term. [46]

Breast cancer treatments that result in oestrogen depletion, such as aromatase inhibitors and GnRH agonists, cause menopausal symptoms including GSM.[47] Women treated for breast cancer may also experience an earlier menopause and more severe menopausal symptoms including GSM. [48, 49]

Many breast cancer survivors struggle with symptoms including vaginal dryness and discomfort, pain during intercourse, urinary symptoms and recurrent urinary tract infections that impact negatively on sexual function and relationships.[43] GSM can also negatively affect other daily activities such as sitting, walking, and ability to exercise.

Non-hormonal approaches are considered the first-line treatment for urogenital symptoms experienced by women during or after treatment for breast cancer. [13, 44] Vaginal hormones are also an option, especially for women with severe or persistent symptoms.

Vaginal oestrogen is low dose and absorption across the vaginal epithelium is minimal/negligible. In other words, vaginal oestrogen is not associated with a significant increase in serum oestradiol levels. [50]

Observational studies have not demonstrated an increased risk of breast cancer recurrence or death in women using vaginal oestrogen after breast cancer, including in women treated with tamoxifen.[51, 52, 53, 54] Two of four recent observational studies have reported an increased risk of recurrence in women using vaginal oestrogen alongside an aromatase inhibitor,[51, 52] but the number of women using vaginal oestrogen with an aromatase inhibitor in the studies was very small, and none of the four studies have demonstrated an increased risk of dying from breast cancer in up to 15 years of follow up.[51, 52, 53, 54]

Women with GSM may also benefit from a change in their endocrine treatment regimen. For example, switching from an aromatase inhibitor to tamoxifen may be sufficient to alleviate symptoms, and/or using vaginal or systemic oestrogen alongside tamoxifen. This decision should be made in consultation with the breast specialist.

DHEA pessaries

Use of Prasterone (Intrarosa) in women who have survived breast cancer and are being treated with an aromatase inhibitor has been shown to significantly improve vaginal health, without increasing serum oestradiol levels. Prasterone appears to be a safe and effective option to treat GSM in breast cancer survivors receiving aromatase inhibitors.[55]

One randomised study demonstrated that DHEA pessaries can improve both vaginal pain or dryness, and sexual health measures (including arousal, lubrication and satisfaction) in women with a history of breast cancer, including those treated with an aromatase inhibitor.[56]

Shared decision making with women with a history of breast cancer

Ideally, randomised clinical trials are needed to confirm safety. However, the available evidence is reassuring and suggests that vaginal oestrogen is likely to be safe. Women with a history of breast cancer, including those treated with aromatase inhibitors, can have vaginal oestrogen to treat GSM provided that the evidence has been discussed and they have been supported to make an informed treatment choice.

An individualised, patient-centred approach is consistent with shared decision-making guidelines[57, 58] and likely to improve the quality of breast cancer after-care for breast cancer survivors.

Gynaecological cancers and GSM

Women with a history of gynaecological cancer may experience severe oncological treatment-induced GSM. For example, pelvic irradiation or pelvic surgery may affect the blood and nerve supply to the local tissue, causing dryness, stenosis and scarring. This may cause severe urogenital symptoms, psychological distress, and sexual dysfunction.[59]

Vaginal moisturisers and lubricants may help but do not treat the underlying cause, and many women will benefit from using local hormone therapy. An individualised, patient-centred approach is also key to improve quality of life and care for gynaecological cancer survivors.[60]

Sexual dysfunction is the third most commonly reported side effect following a gynaecological cancer diagnosis and subsequent treatment. Women should be routinely asked about GSM during and after their cancer treatment and offered appropriate support and treatment.[61, 62]

Review after starting treatment for all women with GSM

Women should be reviewed approximately every three months after starting treatment until symptoms have abated, and then annually. Compliance and any concerns about treatment should be addressed, and symptoms reassessed. Women with ongoing symptoms may benefit from a change in the dose or frequency of application or trying an alternate vaginal oestrogen or DHEA product and/or combining products (for example creams and pessaries or the Estring).

Some women need to use vaginal oestrogen more often to obtain sufficient relief from symptoms - for example, using Vagifem on alternate days instead of twice a week (the usual recommended dose). It is safe to use the treatment in this way if needed as the dose is very low.

Women should be reassured that it is safe for topical hormones to continue in the long term (medication should be on a repeat prescription). Women should continue to be reassured about the long-term safety of vaginal hormonal preparations.

Women should also be encouraged to use regular vaginal moisturisers and or lubricants during sex, if they are not already doing so.

All women taking HRT should be asked about any possible symptoms related to GSM as part of routine questioning and localised treatment should be given, as appropriate, for these women.

Systemic HRT can be considered for women with persistent symptoms; the systemic oestrogen dose and/or formulation may need to be adjusted in women already using HRT. If the above alterations bring no improvement to symptoms, an alternative diagnosis should be considered depending on the individual case and appropriate examination. Further investigation and referral should then be undertaken.

Any woman who experiences abnormal vaginal bleeding needs to be investigated and referred according to local guidelines.

It is imperative that women can access appropriate support and be given the most up-to-date and evidence-based information regarding their GSM treatment options, in order to make an informed choice.

Summary

The majority of postmenopausal women experience symptoms related to GSM.
Only a small minority of women with GSM currently recieve treatment.
Too many women do not talk about their symptoms and too many healthcare professionals do not enquire.
GSM symptoms do not improve spontaneously.
Treatment is safe, cost effective and usually works very well.
Oestrogen deficiency can also lead to urinary symptoms.
Vaginal oestrogens and DHEA can be safely 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.
Women should be reassured regarding the innacuracy of the information packaged with vaginal hormonal preparations.
Women with a history of breast cancer can usually be given vaginal hormone preparations.

Useful resources for women

Balance menopause library and free menopause support app at www.balance-menopause.com
Patient (2023) Vaginal dryness www.patient.info/womens-health/menopause/vaginal-dryness-atrophic-vaginitis
NHS.uk (2021) Vaginal dryness www.nhs.uk/conditions/vaginal-dryness

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