

Urogenital problems

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 50% 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 symptoms including 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 ("lips") 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 also 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 (lips) 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 micro-organisms 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 vaginal 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 vaginal 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. Ninety-five per cent 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 is believed to stimulate collagen producing fibroblasts associated with urogenital tissue restructuring increasing vaginal lubrication and acidity. There are two types of laser therapy for vaginal 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 and more research is needed to better understand effectiveness and safety.

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 post-menopausal women are found to have weakening of the front wall of the vagina (anterior vaginal wall prolapse); about a quarter have similar problems with the back (posterior) wall, and one-fifth 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.

Recurrent urinary tract infections (UTIs)

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

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.

Further tests and 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.

Jargon buster

Atrophic vaginitis – inflammation of vagina/vulva leading to discharge

Cervix – the neck of the uterus, at the top of the vagina

Dysuria – discomfort on passing urine

Dyspareunia – painful sex

Frequency – needing to pass urine often

HRT – hormone replacement therapy

Incontinence – involuntary leakage of urine

Local HRT – hormone replacement therapy delivered vaginally

Menopause – the last menstrual period

Nocturia – needing to pass urine at night, causing sleep disruption

Perimenopause – the phase before the menopause takes place – can last years

Postmenopause – the time in a woman’s life after the menopause

Premature ovarian insufficiency/ premature menopause – is when a woman goes through the menopause before the age of 40. The average age of menopause is 51

Prolapse – the descent of the vaginal walls or uterus into the vagina cavity

STI – sexually transmitted infection

Stress incontinence – leaking of urine when coughing, sneezing or laughing

Systemic – circulating throughout the whole body

Thrush (candida albicans) – a fungal overgrowth especially in the vagina

Urethra – tube from bladder to outside through which urine is passed

Urgency – needing to pass urine urgently!

Urge incontinence – Involuntary leakage accompanied by, or immediately preceded by a strong desire to void

Urodynamics – the study of pressure and flow relationships in the investigation of functional disorders of the lower urinary tract (LUT)

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This fact sheet has been prepared by Women's Health Concern and reviewed by the medical advisory council of the British Menopause Society. It is for your information and advice and should be used in consultation with your own medical practitioner.

Uterus – womb

UTI – urinary tract infection

Vagina – genital canal leading to the uterus

Vaginal atrophy – drying and thinning of the vaginal mucosa and vulval skin

Vaginal flora – the micro-organisms in the vagina

Vulva – the external lips of the vagina

Discussing difficult problems with a healthcare professional...

Top tips for discussing “embarrassing” problems with a healthcare professional include:

- Make a list of what you want to discuss
- Discuss the most important or most difficult questions first
- Write down what the doctor tells you
- If there is anything that you don't understand, ask for clarification
- If you feel embarrassed take along some information with you. It can be difficult to discuss embarrassing problems face to face, but if you find information on the internet about your symptoms you can use this to help explain and avoid having to make eye contact with your GP whilst discussing the problem
- If you still feel unable to discuss the subject, write it all down and hand it to the doctor
- Don't wait to be asked, give the doctor any information that you may feel is relevant including a history of the condition, symptoms, the impact they are causing you, any lifestyle factors that may have contributed, any medication you are taking, etc.

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