Q&A With Faculty

How do vaginal moisturizers work to relieve the symptoms of genitourinary syndrome of menopause (GSM)? What are some of the various products available?

Vaginal moisturizers provide long-term relief of vaginal dryness and are used continuously a few to several times a week. These products contain bioadhesive-based polymers that attach to mucin and epithelial cells on the vaginal wall; they carry and hold up to 60 times their weight in water on the vaginal epithelial surface.

The action of vaginal moisturizers lasts until the epithelial surface is sloughed off; they typically require 2 to 3 applications per week. Reapplication is not required prior to sexual activity.

Could you tell me more about the DIVA questionnaire?

The Day-to-Day Impact of Vaginal Aging (DIVA)¹ questionnaire is a multidimensional self-report measure. It was designed to assess the impact of vaginal symptoms such as dryness, irritation, itching, soreness, and pain on multiple dimensions of functioning and well-being in postmenopausal women. The items on this tool utilize 5-point, ordered-response options to assess the degree to which vaginal symptoms interfere with specific aspects of the patient’s day-to-day activities, sexual functioning, emotional well-being, self-concept and body image, and interpersonal relationships. Those items that are applicable only to sexually active women include a “not applicable” response option.

How do you counsel patients who want to try ospemifene?

Patients are advised that ospemifene is the only non-estrogen oral tablet that is approved for moderate to severe dyspareunia, a symptom GSM. It is characterized as an estrogen agonist/estrogen antagonist. In clinical trials, it was not necessary to use a progestin agent with ospemifene; as with all other products for vulvovaginal atrophy/dyspareunia, if abnormal bleeding should occur, a complete evaluation (which may be a transvaginal ultrasound and/or an endometrial biopsy) is warranted. Some women mention an increased incidence of hot flashes, but the attrition rate was <1%.

What vaginal moisturizers are available over the counter?

Several moisturizers are available over the counter and may be of benefit to patients with GSM. Replens and RepHresh do have some clinical data to support their utility. Luvena acts as both a vaginal moisturizer and a lubricant. K-Y Liquibeads, K-Y Long Lasting, and Emerita’s personal moisturizer are other choices. The patient should be advised to read all product labels carefully and to examine the ingredients.
What is genital pelvic floor physical therapy?
Genital pelvic floor physical therapy (PT) may be helpful to patients with GSM who also have a form of pelvic floor dysfunction. A specially trained therapist will do external and/or internal muscle manipulation to better assess and/or treat the pelvic floor muscles that may be implicated in sexual pain syndromes—such as interstitial cystitis, vulvar vestibulitis, or pelvic floor hypertonus—that may be causing or contributing to dyspareunia.

Does insurance cover pelvic floor physical therapy?
Most insurance plans cover pelvic floor PT if ordered by the physician for a set number of treatments.

When using vaginal estrogen cream, do you recommend placing it high up in the vagina or just in the lower part of vagina?
Place vaginal estrogen cream in the lower 1/3 of the vagina and/or introital area. Systemic absorption is greater near the top of the vagina.

Will vaginal estrogen therapy have any impact on the risk of bacterial vaginosis (BV) or vaginal yeast infections?
It may decrease BV because vaginal pH becomes more acidic with local estrogen therapy. However, local estrogen therapy has been associated with a slightly increased incidence of yeast infections.

Is there any indication for measuring estradiol levels when using vaginal estrogen?
This would be of concern primarily to women with a history of breast cancer. Those patients should be closely monitored in conjunction with their medical oncologist.

Are some forms of low-dose vaginal estrogen therapy less absorbed systemically? Which formulation results in the lowest amount of estrogen in the bloodstream?
The low-dose vaginal estradiol ring and tablet formulations are preferred when systemic absorption is a significant concern, eg, in patients with breast cancer, as data are available from controlled studies documenting minimal or no sustained increase in blood estradiol levels with the use of these products. Low doses of vaginal estrogen cream are minimally absorbed as well, but the amount of cream used is more variable and there are few controlled studies of resulting blood estrogen levels with vaginal estrogen cream use.
Is there an increased risk of deep venous thrombosis with ospemifene?

Ospemifene is a selective estrogen receptor modulator (SERM), also known as an estrogen agonist/antagonist with tissue-selective effects. All SERMs and oral estrogen products increase the risk of venous thromboembolic events (VTEs), including deep venous thrombosis (DVT) and pulmonary embolus (PE). For healthy postmenopausal women at low risk for VTEs, the increase is minimal, but women at high risk for VTEs should not use ospemifene. If feasible, ospemifene should be discontinued at least 4 to 6 weeks before surgery of the type associated with an increased risk of thromboembolism or during periods of prolonged immobilization.

Is it possible to combine several different formulations of low-dose vaginal estrogen, eg, estrogen cream and a ring?

Although it is possible to combine several different formulations of low-dose vaginal estrogen therapy, it is generally not advised, as estrogen blood levels may increase with the use of more than 1 product. If a woman has external vulvar symptoms that do not respond to the use of the low-dose vaginal ring or tablet, it would acceptable to use a very small amount of vaginal estrogen cream on the vulva intermittently, as needed.

In the case of postmenopausal bleeding on low-dose vaginal estrogen therapy, is measuring the endometrial thickness adequate, or is endometrial biopsy preferred?

A transvaginal ultrasound is an appropriate initial evaluation of postmenopausal bleeding, whether or not a woman is using low-dose vaginal estrogen therapy. If the endometrial thickness is <5 mm, the likelihood of significant pathology is low and endometrial biopsy is not required unless bleeding recurs. Recurrent postmenopausal bleeding would require evaluation with an endometrial biopsy, even if the endometrium were thin. Ideally, a study to rule out a focal endometrial lesion, such as a polyp, should be performed as well, eg, an office hysteroscopy or sonohysterogram.