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Impact and management of VVA / GSM - an evidence based approach

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The impact of VVA on quality of life continues to be underestimated. Women are reluctant to complain about the problem for risk of personal embarrassment, social and cultural reasons. Healthcare providers are reluctant to bring the problem up in consultation because they are uncomfortable discussing sexual issues and for fear of triggering extensive complex dialogue with limited time to deal with the consequences; they also lack knowledge as to the available effective treatment options, both hormonal and non-hormonal. Even though we have an ageing population where more than 50% of postmenopausal women suffer with VVA, the subject is avoided both in social conversation and in the media.

Whilst social and cultural taboos are difficult to deal with, there are a number of action points which the wider medical profession (doctors, pharma companies, health departments and regulators) should be urgently addressing to improve the situation. Formal research into VVA should be expanded to confirm the scale of the problem and the impact it has on quality of life. Although highly informative, all VVA surveys are biased by the type and size of study population selected and information is limited by the choice of questions asked. Is the scale of the VVA problem even larger than we think because women are reluctant to admit to having symptoms?

Individualisation of treatment should apply to vaginal as well as systemic estrogen therapy. Licensed dose ranges of vaginal estrogen would accommodate the significant proportion of women who require higher doses to fully alleviate their VVA symptoms. Menopause societies and pharma companies work with the regulators to change the labelling of vaginal estrogen preparations, which carry the same contraindications as systemic hormone therapy.

Ongoing research and development of new products is essential to expand our armamentarium for managing VVA symptom. Some women who do not wish to use estrogen, or in whom estrogen is genuinely contraindicated. Other women may find it uncomfortable or may not want, due to personal or cultural reasons, to use vaginal products. The development of novel approaches are therefore welcome; these include vaginally active, oral selective estrogen receptor modulators, vaginal androgens such as DHEA and vaginal laser treatment. Also, technological advances in non hormonal physiological vaginal moisturisers should banish the use of vaginal lubricant gel to the examination couch!

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