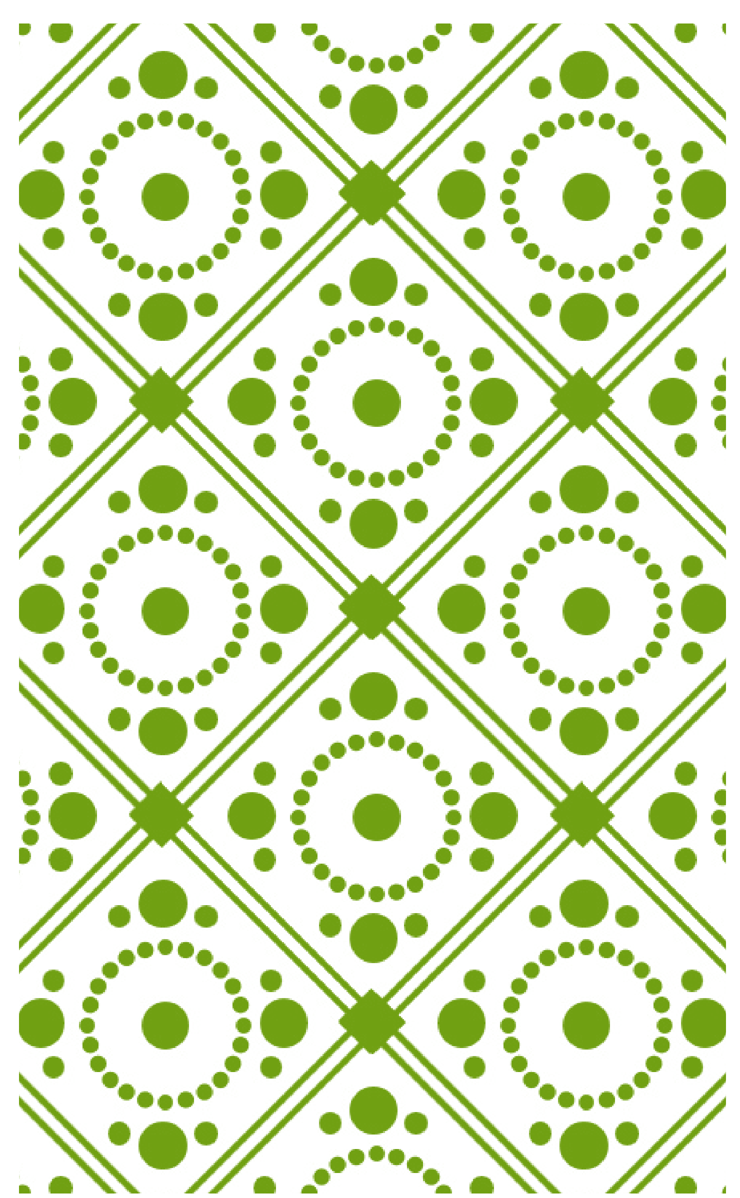


PRESCRIBING LOCAL (VAGINAL) ESTROGEN

Dr Juliet Balfour GP and BMS registered menopause specialist
Lead for Somerset NHS Menopause Service
November 2024

DISCLOSURES

Member of the BMS Medical Advisory Council

Paid facilitator on Menopause Special Skills Course (FSRH)

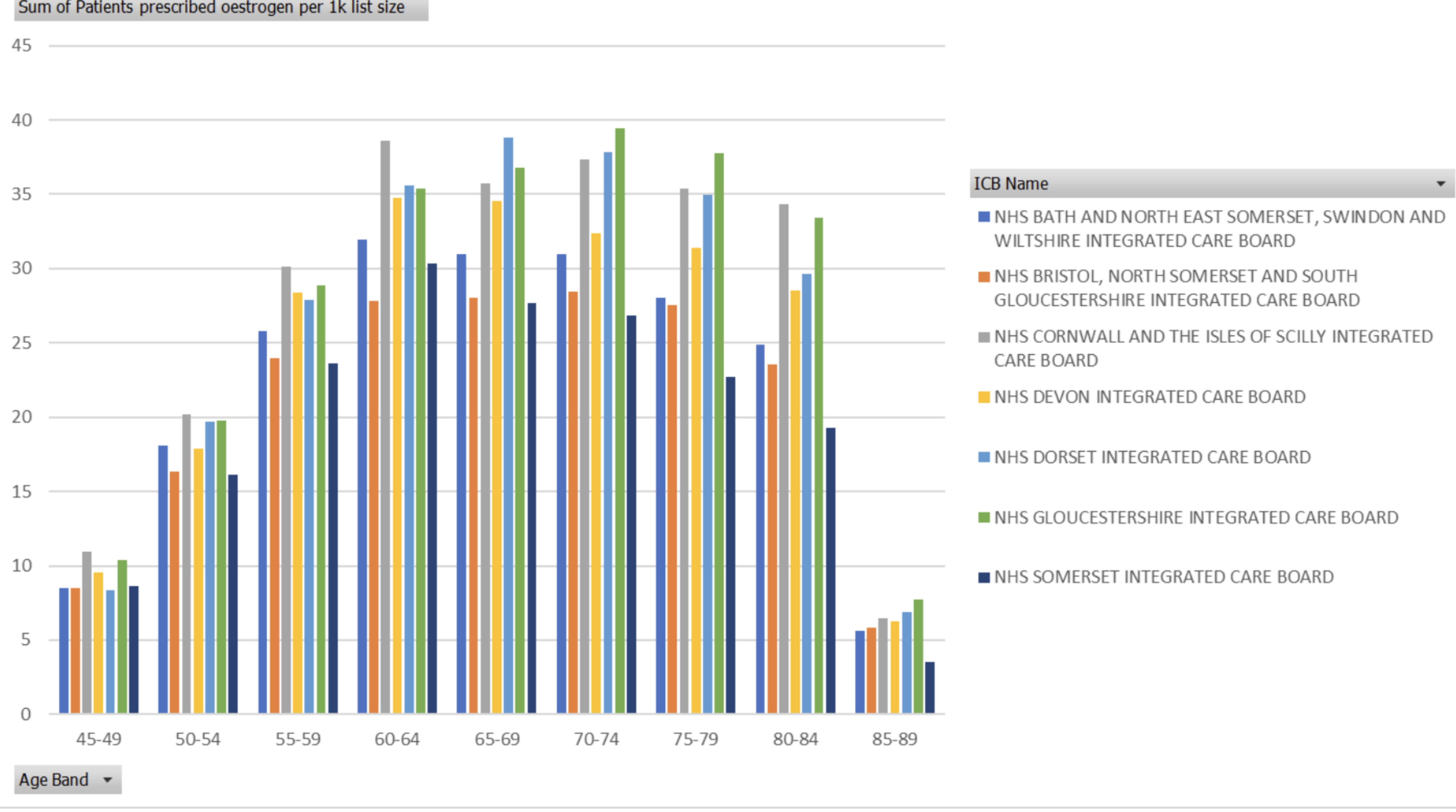
Director of a private menopause clinic, not taking on new patients at present

Non-promotional educational sessions sponsored by Theramex and Sylk

Part of the Menopause Mandate campaign group

AIMS OF THIS SESSION

- Current prescribing of vaginal estrogen in Somerset
- Why this needs to increase
- What genitourinary syndrome of the menopause (GSM) is
- How we can treat it
- Guidelines and resources


Sum of Patients prescribed oestrogen per 1k list size
45
40
35
30
25
20
15
10
5
0
45-49
50-54
55-59
60-64
65-69
70-74
75-79
80-84
85-89
Age Band
ICB Name
NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE INTEGRATED CARE BOARD
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE INTEGRATED CARE BOARD
NHS CORNWALL AND THE ISLES OF SCILLY INTEGRATED CARE BOARD
NHS DEVON INTEGRATED CARE BOARD
NHS DORSET INTEGRATED CARE BOARD
NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD
NHS SOMERSET INTEGRATED CARE BOARD

DEFINITION OF GSM

We used to refer to vulvovaginal atrophy and atrophic vaginitis

New term GSM introduced in 2014 (BMS urogenital atrophy)

GSM is defined as a collection of symptoms and signs associated with a decrease in estrogen and other sex steroids, involving changes to the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra and bladder

LACK OF ESTROGEN LEADS TO:

- Reduced thickness and vascularity of vulva, vagina, urethra and bladder
- Reduced elasticity and shortening of the vagina
- Loss of vaginal folds, loss of glycogen
- Reduction in secretions from cervix and Bartholin glands
- Urethral walls no longer keeping urethra closed
- Change in normal vaginal and urinary microbiome and rise in vaginal pH ->loss of lactobacilli and increase in E coli and other pathogens

WHO GETS GSM?

May get in perimenopause or any time afterwards (also when breast-feeding)

May not develop until 5 - 10+ years after the menopause so link with lack of estrogen not made

Symptoms range from mild to debilitating

Occurs in up to 80% of women

Can still occur in women on systemic HRT (at least 20-25%)

URINARY SYMPTOMS

Frequency

Urgency

Urge incontinence

Nocturia

Dysuria

Urethral prolapse

UTIs after sex

Recurrent UTI

VULVAL SYMPTOMS

Dryness, irritation, soreness, itching and burning

Skin thinning and/or splitting

Labial and clitoral shrinkage

Labial/clitoral hood fusion

Impaired response to sexual stimulation and decreased orgasm

Painful sex and painful smears

VAGINAL SYMPTOMS

Dryness, irritation, soreness, itching, burning

Lack of lubrication

Watery discharge (inflammatory)

Painful sex

Bleeding after sex

Worsening prolapse symptoms

Painful smears

IMPACT OF VULVOVAGINAL SYMPTOMS ON QOL

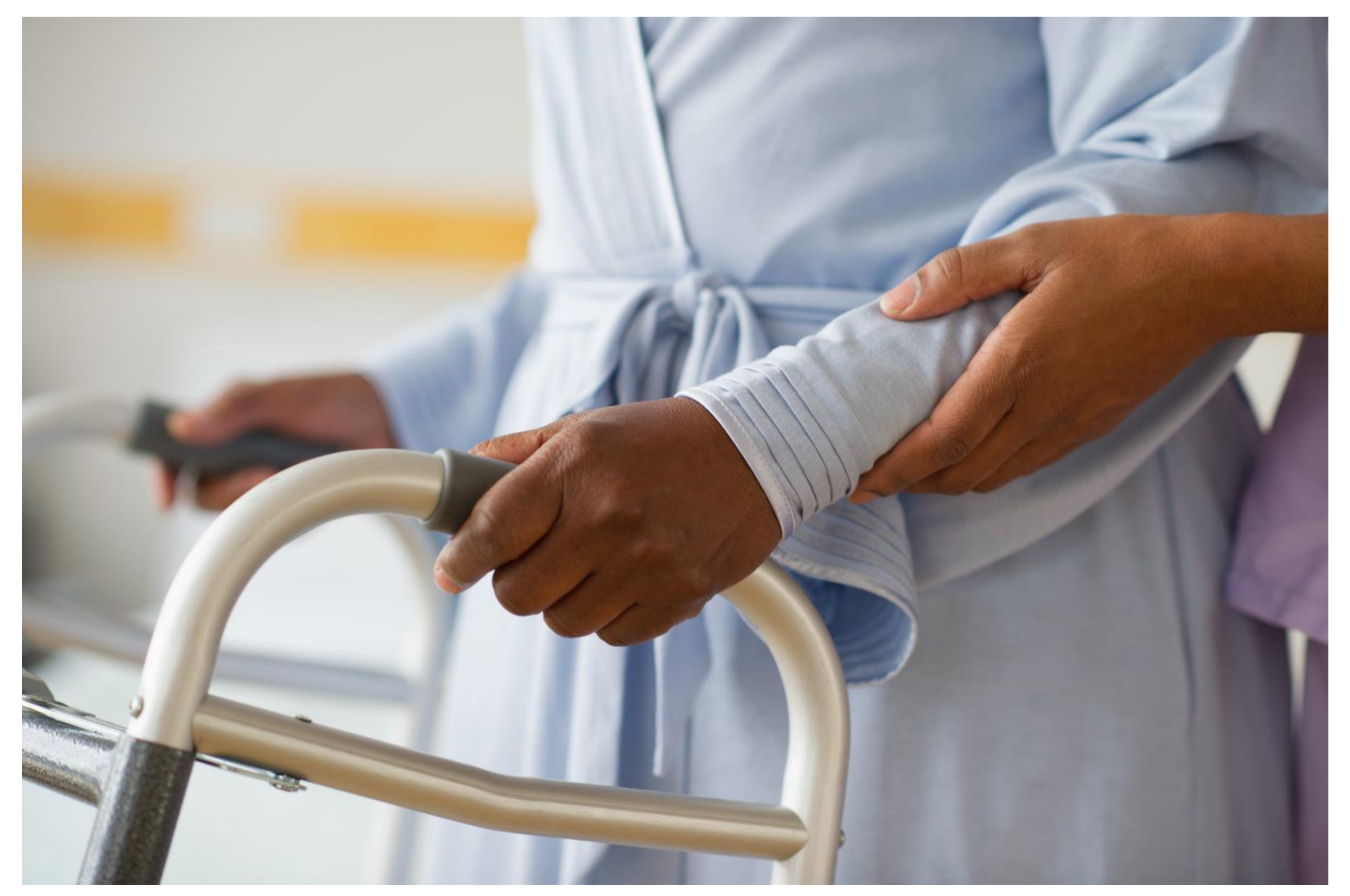
- Unable to have penetrative sex
- Stopping cycling or riding
- Unable to wear tight trousers
- Unable to wear underwear
- Painful to sit down

IMPACT OF URINARY SYMPTOMS ON QOL

- Limit activities in case can’t find a loo
- Poor sleep
- Recurrent UTIs
- Antibiotic side-effects
- Antibiotic resistance
- Urosepsis

GSM is progressive

Symptoms only get worse with time if untreated



CONSIDER GSM IF PRESENTING WITH:

Symptoms as above

Painful smears

Recurrent thrush

Recurrent UTIs

Low libido

EXAMINATION FINDINGS

Vulva and vagina look pale, thin and dry with patchy redness due to tiny blood vessels under the skin

Labial shrinkage or fusion

Clitoris hidden or more prominent

May see a urethral mucosal prolapse

May see splits of vulval skin when stretched -> bleeding on speculum examination or inserting pessary

Shortened, narrow vagina with loss of rugae

Reduced secretions or increased discharge

EXCLUDE OTHER CONDITIONS – OFTEN CO-EXIST

Lichen sclerosus

Lichen planus

Allergic contact dermatitis/lichen simplex chronicus

Eczema/psoriasis

Infection – BV/thrush or UTI

VIN/vulval cancer

Vaginismus

Re-examine if not improving

WHAT ABOUT THRUSH?

Overdiagnosed in postmenopausal women ++

More common post-pubertal to menopause

Lower estrogen levels reduce incidence of thrush

We do still see in older women with diabetes, obesity, using topical or systemic steroids, on immunosuppression

Use of local estrogen and/or HRT can precipitate thrush initially

GSM IS UNDER REPORTED, UNDER DIAGNOSED AND UNDER TREATED

So, what can we do to help?

WASHING/EMOLLIENTS/VAGINAL MOISTURISERS

Wash with care – just water or use emollients eg Epaderm or Hydromol

Moisturising with emollients

- Hyalofemme
- Yes VM
- coconut oil

LUBRICANTS – TO USE DURING SEX

Oil or water based

Can use double glide effect

Avoid oil based if using condoms

- YES WB
- YES OB
- Sutil

AVOID USING

Soap or shower gel to clean the vulva

Shampoo in the bath or shower

Bubblebath, bath bombs, oils or disinfectant in the bath

Feminine wipes or vaginal products

Perfumed sanitary pads or panty liners

Washing excessively

Wearing synthetic trousers, pants or tights

Biological washing powders or fabric conditioner

Spermicidal lubricated condoms or flavoured condoms

LOCAL (VAGINAL) ESTROGEN

LOCAL ESTROGEN

This is not HRT

Important to start treatment early to reduce the risk of irreversible changes developing

Treatment needs to be continued to maintain benefits

Endometrial protection not needed as ultra-low dose

At least 20 - 25% of women on systemic HRT will also need local estrogen

Vaginal estrogen can help urinary symptoms

Safe for most women

ADVISING PATIENTS ON USING LOCAL ESTROGEN

Patient information leaflet is inaccurate

Early side-effects

May take months to respond, review if not helping

Is a long-term treatment - symptoms will return if stop using it

Need to find a product that suits the individual so happy to use long-term

May need higher maintenance doses after discussion with clinician

TYPES OF LOCAL ESTROGEN

Estriol

Imvaggis pessary

Blissel gel

Estriol 0.1% cream

(Estriol 0.01%) cream

Estradiol

Vagifem/Vagirux/Gina

Estring

VAGIFEM/VAGIRUX/GINA (OTC)

ESTRING

OVESTIN CREAM/BLISSEL GEL

IMVAGGIS PESSARY

VULVAL APPLICATION

Some women need this as well as vaginal application

Can use a small amount of estriol cream or Blissel gel and apply with finger-tip – including urethra

Not licensed but safe and effective

INTRAROSA (PRASTERONE)

6.5mg pessary every night

DHEA precursor, converted to estrogen and testosterone in vaginal mucosa

Limited data on efficacy so far and expensive so not first line

Mentioned in updated NICE menopause guidance 7.11.24 so hopefully going on Somerset formulary soon

Potential option for breast cancer patients on aromatase inhibitors

OSPEMIFENE

SERM

60mg oral tablet, used daily

Effective plus improves bone density

Can be considered if completed breast or endometrial cancer treatment

BUT

Expensive

C/I in breast cancer if still on treatment e.g. tamoxifen or AI, endometrial hyperplasia, past VTE, unexplained vaginal bleeding

Has side-effect of hot flushes

Need more studies with extended follow up

LASER THERAPY

Uncertain efficacy and safety

Private and expensive

Need more trials – could this useful for women who can't use local estrogen?

REMEMBER PELVIC HEALTH/WOMEN'S HEALTH PHYSIOS

HISTORY OF ESTROGEN-SENSITIVE BREAST CANCER?

General advice as above re moisturisers and lubricants

Local estrogen is an option in women with breast cancer on tamoxifen or who have completed their adjuvant endocrine therapy

Use estriol option - Imvaggis pessaries lowest dose so first line

- Blissel gel, next lowest dose

WOMEN ON AROMATASE INHIBITORS??

Tend to get bad GSM symptoms

Suggest using daily YES vaginal moisturiser from start of treatment

Need to discuss with their oncologist as local estrogen currently considered a contraindication if on an AI:

- consider changing to tamoxifen, can then have local estrogen if still needed

- consider using Intrarosa (DHEA) pessaries

- some oncologists are now using local estrogen with AI – controversial, varying results of studies, needs to be an individual discussion with patient re uncertainties and severity of symptoms

LOCAL ESTROGEN AND OTHER CANCERS?

Endometrial cancer

- tends to recur at vaginal vault
- caution with local estrogen initially

Cervical/vaginal/vulval cancer

- local estrogen is fine

https://www.bgcs.org.uk/wp-content/uploads/2024/09/BGCS-BMS-Guidelines-on-Management-of-Menopausal-Symptoms-after-Gynaecological-Cancer-09.09.24.pdf

Table 1: Summary of recommendations for use of systemic HRT and vaginal estrogen following treatment of gynaecological cancer

Primary Cancer	Subtype or Risk Group	Systemic HRT	Vaginal Estrogen
Ovarian Fallopian tube Primary peritoneal	High grade serous		
	Low grade serous stage 1		
	Low grade serous stage 2+		
	Endometrioid stage 1		
	Endometrioid stage 2+		
	Clear cell		
	Mucinous		
	Granulosa cell stage 1		
	Granulosa cell stage 2+		
	Germ Cell		
	Borderline tumour: No residual disease		
	Borderline tumour: Peritoneal implants, microinvasive disease, residual disease, recurrence		
Endometrial	Low and intermediate risk		
	High-intermediate risk		
	High risk: ER/PR negative		
	High risk: ER/PR positive		
	Advanced and metastatic		
Cervical	All		
Vulval	All		
Vaginal	All		
Uterine sarcoma	Leiomyosarcoma		
	Endometrial stromal sarcoma		

	Benefits usually outweigh risks. Suitable for non-specialist use.
	Refer to text of BGCS BMS guidelines. Discuss benefits and risks for the individual patient. Consider specialist advice.
	Not recommended. Refer for specialist advice if non-hormonal approaches are not effective.

Type of HRT	**Evidence is only with use of low/standard doses of estrogen*
Estrogen only HRT	Following hysterectomy NB. Combined continuous HRT is indicated when history of endometriosis
Continuous combined HRT	Uterus still in situ, including after radiotherapy or endometrial ablation Progestogen dose must be proportionate to estrogen dose

PAINFUL SMEARS

Many women stop attending smears due to pain

We need to train our smear takers re GSM (and vulval examination)

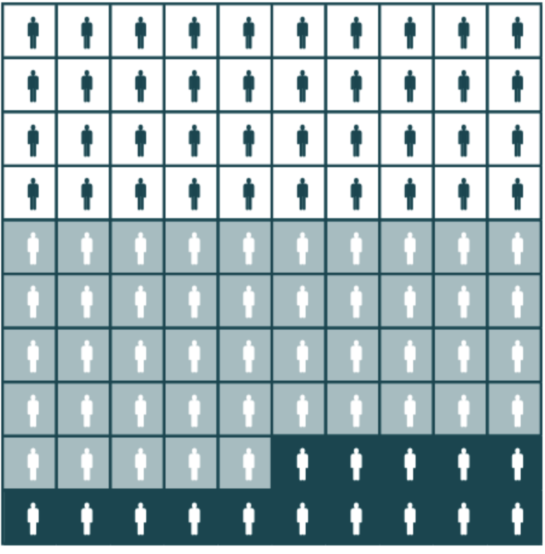
Need to be given local estrogen

- ideally for 2 to 3 months before smear
- advise on when to stop before smear (at least 48 hours)
- local estrogen needs to be continued long-term after smear

Consider giving an information leaflet when come for smears in 40s

NICE 2018

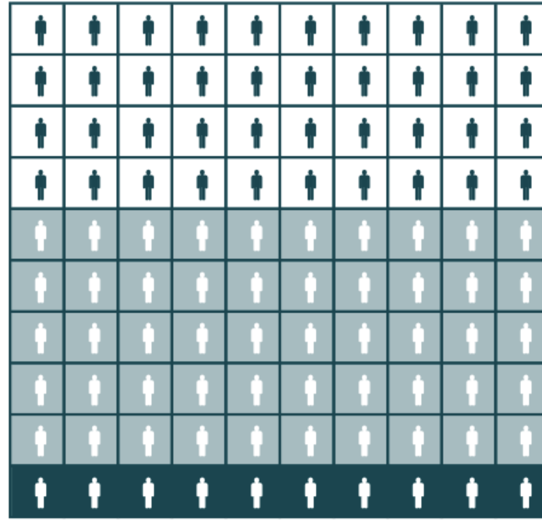
Recurrence of UTI with vaginal oestrogen



If 100 women with recurrent UTI use vaginal oestrogen we would expect that, over **8** months **on average about**:

- 40 women don't get a UTI, but would not have done anyway
- 45 women avoid getting a UTI because they use vaginal oestrogen
- 15 women get a UTI even though they use vaginal oestrogen

Recurrence of UTI with an antibiotic



If 100 women with recurrent UTI use an antibiotic we would expect that, over **6–12** months **on average about**:

- 40 women don't get a UTI, but would not have done anyway
- 50 women avoid getting a UTI because they use an antibiotic
- 10 women get a UTI even though they use an antibiotic

RECURRENT UTI NICE GUIDELINE NG112 10/2018

Recommendations | Urinary tract infection (recurrent): antimicrobial prescribing | Guidance | NICE

Treatment for women with recurrent UTI who are not pregnant

Oestrogen

1.1.5 Consider the lowest effective dose of vaginal oestrogen (for example, estriol cream) for postmenopausal women with recurrent UTI if behavioural and personal hygiene measures alone are not effective or not appropriate. Discuss the following with the woman to ensure shared decision-making:

- the severity and frequency of previous symptoms
- the risk of developing complications from recurrent UTIs
- the possible benefits of treatment, including for other related symptoms, such as vaginal dryness
- the possible adverse effects such as breast tenderness and vaginal bleeding (which should be reported because it may require investigation)
- the uncertainty of endometrial safety with long-term or repeated use
- preferences of the woman for treatment with vaginal oestrogen.

Review treatment within 12 months, or earlier if agreed with the woman. In October 2018, this was an off-label use of vaginal oestrogen products. See NICE's information on prescribing medicines.

<table>
<tr><th>ILLNESS</th><th>KEY POINTS</th><th>TREATMENT</th><th>ADULT DOSE (unless otherwise stated)</th><th>DURATION OF TREATMENT</th></tr>
<tr><td>Recurrent UTIs in adult patients that are not catheterised or pregnant

Patient Information
Cystitis - NHS (www.nhs.uk)

Target UTI leaflet

Advice-sheet-self-start-antibiotics-for-recurrent-urine-infections.pdf (scot.nhs.uk)</td><td colspan="4">Investigate
Consider the diagnosis whether 'recurrent' or 'relapse'.
<table>
<tr><th>Recurrent -</th><th>Relapse</th></tr>
<tr><td>3 or more culture proven UTIs in 12 months.
This does not include bacteriuria without UTI symptoms (asymptomatic bacteriuria).
If the same organism is identified more than two weeks after completion of antibiotic therapy, this should be counted as a new infection.</td><td>The same organism is identified in the urine within two weeks of appropriate antimicrobial treatment.
Relapsed infections should not be counted as 'new' infections when defining woman with recurrent UTIs</td></tr>
</table>
Request MSU to identify the organism.
Note - Urine cultures in the absence of symptoms are unlikely to be helpful, may detect asymptomatic bacteriuria and lead to inappropriate antibiotic use. Antibiotic treatment of asymptomatic bacteriuria is harmful in patients with recurrent urinary tract infections.
'Clearance' cultures are not recommended at the end or treatment if symptoms have resolved.

All women with recurrent UTIs should be offered renal ultrasound. See below for other referral criteria.

Self-management
Ensure the patient is following basic self-management guidance.
Try to identify triggers that may be causing UTIs and address these. (See Patient Information links)
Lifestyle fluid intake >1.6 L / day (avoiding sugary and caffeinated drinks)
Voiding
Urge initiated voiding.
Pre and post coital voiding – avoidance of cosmetics/spermicides and diaphragm
Encourage relaxation of pelvic floor during voiding to ensure full bladder emptying.
Hygiene
Wiping front to back
Using water to wash after voiding.
Having showers rather than baths
Bowel management</td></tr>
<tr><td>Guidelines and resources

BMS- Urogenital Atrophy Guidance-SEPT2023)

NICE NG112 recurrent UTI

NICE NG112 2-page visual summary

PHE UTI: diagnostic tools for primary care

Breastfeeding information links (SPS)

Continued overleaf</td><td>Management – Key points
First Line
1. In perimenopausal or postmenopausal women, consider local estrogen to treat the genitourinary syndrome of the menopause (GSM). GSM increases the risk of recurrent UTIs and also causes symptoms that can be confused with a UTI such as dysuria and frequency. Vulval examination is needed to confirm the diagnosis and exclude other causes.

Local vaginal estrogen if no contra-indication. (Trial for at least 3-6 months, review treatment within 12 months and at least annually.) After initial treatment dose, (2-4 weeks depending on preparation). If improvement noted, consider dose reduction to maintenance dose for ongoing treatment. Do not stop local estrogen unless there is a clinical indication to. Stopping local therapy will result in regression of vaginal health and likely increase UTIs. Women using vaginal estrogen should report unscheduled vaginal bleeding to their GP-see HRT page for information.
D-Mannose / Cranberry
Non-pregnant women may wish to try D-mannose or cranberry products - evidence uncertain. (Caution -sugar content)

Second Line
Single prophylactic antibiotic
For females with a known trigger where avoidance, modifications and hygiene has failed. e.g (e.g intercourse, prolonged walking)
Review needed at 3 months and stop by 6months.
Self start antibiotics
< 1 episode / month
Supply a patient information sheet and boric acid container for pre-antibiotic MSU. Safety net to present if develop loin pain, fever or non-resolving symptoms after 48hours. Use antimicrobial as per previous sensitivities and Somerset Primary Care guidelines.
If requesting >1 prescription / month over a 3month period consider methenamine or extended course antibiotic.</td><td>Consider treatments in order of preference – See Key Points for more information.
First Line
Local (vaginal) estrogen
Available in vaginal tablets, pessaries, cream, gel, ring. At least 20% of women on systemic HRT will need long- term local estrogen as well.
See Somerset Local Estrogen Guidance for more details, including the management of patients with breast cancer.
If failed management but GSM confirmed- add Second line options to local estrogen.

D-mannose or cranberry
(OTC) (Caution -sugar content)
If failed management consider differential diagnoses. Examination may be indicated.

Second Line
Single dose antibiotic
For females with a known trigger where avoidance, modifications and hygiene has failed.
Or
Self start antibiotic course
< 1 episode / month
Supply a patient information sheet (see suggested link) and boric acid container for pre-antibiotic MSU. Safety net to present if develop loin pain, fever or non-resolving symptoms after 48 hours
Or</td><td>Lowest effective dose– See Somerset Local Estrogen Guidance for preparations.

Duration of initial daily dose is 2 to 4 weeks depending on the product, then the long-term maintenance dose is used.

Trimethoprim 200mg single dose post trigger
Or
Nitrofurantoin 100mg single dose post trigger

See Lower urinary tract infection in non-pregnant women and men (aged ≥ 16 yrs)</td><td>Continue local estrogen long-term or symptoms will recur.
If symptoms not settling, other causes need to be considered (see differential diagnosis later).

Review needed at 3 months and stop by 6 months.
Add a stop date to prescriptions.

Review requests every 3 months – see Key points.
Add a stop date to prescriptions.</td></tr>
</table>

Differential diagnoses

If recurrent symptoms with no growth / sterile pyuria, consider other causes including non-infective causes, sexually transmitted infection and atypical bacteria including TB. Other causes of dysuria include:

- Genitourinary syndrome of the menopause (up to 80% of women will develop this at some stage in their lives, sometimes not until their 70s or 80s)
- Malignancy
- Vulval conditions such as lichen sclerosus and dermatitis
- Sexually transmitted and other infections
- Vulvodynia
- TB affecting the urinary tract
- Overactive bladder
- Interstitial cystitis
- Bladder stones

Referral for Renal ultrasound

-A primary care renal ultrasound with post micturition residual volume should be offered to all women with recurrent UTIs.

-Patients with suggestion of upper tract involvement e.g. loin pain, unwell with vomiting and pyrexia. Check renal function and request USS urinary tract and consider referral.

-Recurrent Urea-splitting bacteria on culture (e.g. Proteus, Yersinia)

Referral to secondary care – consider if any of the following features:

- Pregnant women (to be discussed with Obstetrics team)
- Male, for assessment of prostate involvement
- Prior urinary tract surgery or trauma.
- Prior abdominopelvic malignancy.
- Visible and non-visible haematuria after resolution of infection (this should be managed as per NICE suspected cancer guidance — gynaecological cancer; urological cancer – 2WW).
- Urea-splitting bacteria on culture (e.g. Proteus, Yersinia) in the presence of a stone, or atypical infections (e.g. tuberculosis, anaerobic bacteria)
- Bacterial persistence after sensitivity-based therapy.
- Pneumaturia or faecaluria.
- Obstructive symptoms (straining, weak stream, intermittency, hesitancy).

OR any of these on ultrasound:

- Hydroureter or hydronephrosis.
- Bladder OR ureteric OR obstructive renal stones (for non-obstructive renal stones please use advice and guidance).
- Post-micturition residual volume greater than 150ml.

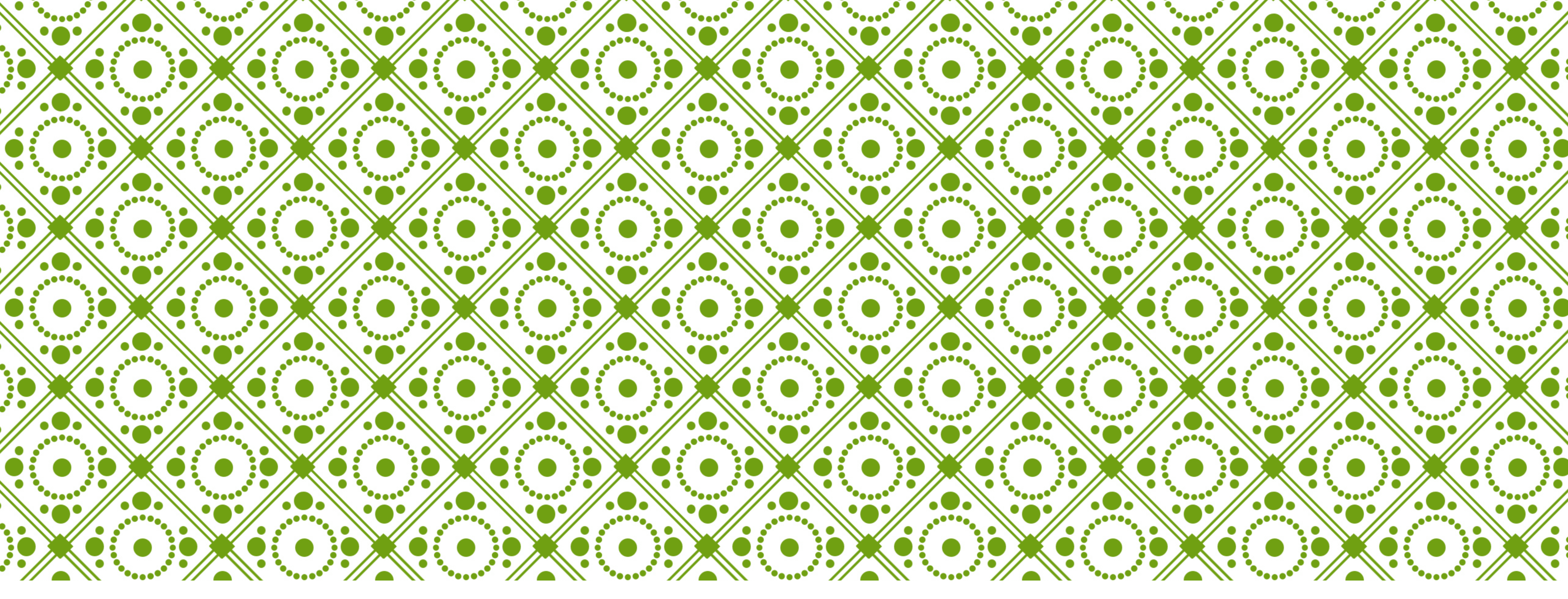
RESOURCES – PATIENTS AND CLINICIANS

womens-health-concern.org

https://www.womens-health-concern.org/wp-content/uploads/2022/12/25-WHC-FACTSHEET-VaginalDryness-NOV2022-B.pdf

https://www.womens-health-concern.org/wp-content/uploads/2022/12/23-WHC-FACTSHEET-UrogenitalProblems-NOV2022-B.pdf

thebms.org Consensus statement on Urogenital atrophy (members only)



THANK YOU

On Instagram
@menopausehealth