Tips and Tricks for the Perimenopause

(Answers to 22 Questions in 22 Minutes in '22)

Lindsay Shirreff, MD, MSc(HQ), FRCSC

Assistant Professor, University of Toronto

Everyday Gynaecology CME

October 7, 2022

Learning Objectives

To increase your confidence in treating the perimenopausal patient by:

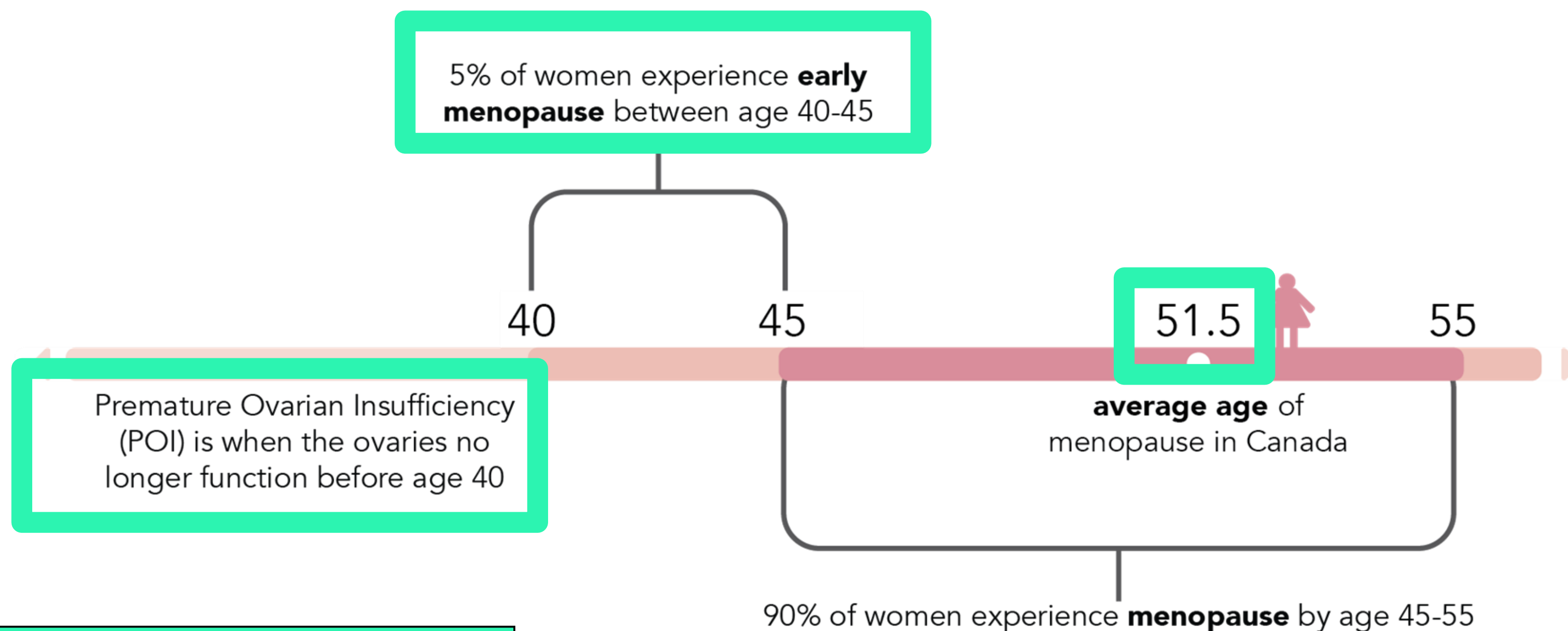
1. Reviewing 22 relevant facts about perimenopause in 2022.
   - Definition and Physiology
   - Gynaecologic Considerations
   - Management Approach

2. Providing ‘*Toolkit Tips*’ that you can apply in your own practice when considering different options.

Toolkit Tips

Question 1:
What is menopause?

Menopause **occurs when the ovaries decrease their functioning and no longer release eggs.** Usually, menopause is diagnosed after someone has gone 12 months without a menstrual period.



Toolkit Tips
Different types of menopause:
Surgical, Induced, POI, Early, Natural Menopause

Question 2:
What is perimenopause?

STRAW +10

Standardized Staging System for Reproductive Aging

	Menarche						FMP (0)			
Stage	-5	-4	-3b	-3a	-2	-1	+1 a	+1b	+1c	+2
Terminology	**REPRODUCTIVE**				**MENOPAUSAL TRANSITION**		**POSTMENOPAUSE**			
	Early	Peak	Late		Early	Late	Early			Late
					Perimenopause					
Duration	*variable*				*variable*	1-3 years	2 years (1+1)		3-6 years	*Remaining lifespan*
PRINCIPAL CRITERIA										
Menstrual Cycle	Variable to regular	Regular	Regular	Subtle changes in Flow/ Length	*Variable Length* Persistent ≥7- day difference in length of consecutive cycles	Interval of amenorrhea of >=60 days				
SUPPORTIVE CRITERIA										
Endocrine FSH AMH Inhibin B			Low Low	Variable Low Low	↑ Variable Low Low	↑ >25 IU/L** Low Low	↑ Variable Low Low		Stabilizes Very Low Very Low	
Antral Follicle Count			Low	Low	Low	**Low**	Very Low		Very Low	
DESCRIPTIVE CHARACTERISTICS										
Symptoms						Vasomotor symptoms *Likely*	Vasomotor symptoms *Most Likely*			*Increasing* symptoms of urogenital atrophy

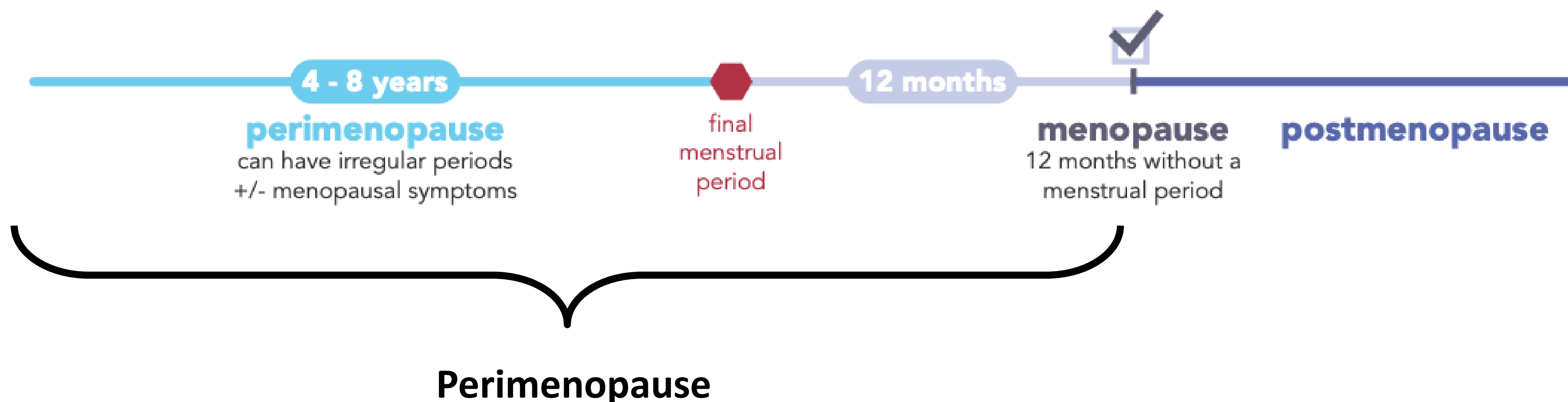
* Blood draw on cycle days 2-5 ↑ = elevated

**Approximate expected level based on assays using current international pituitary standard[67-69]

North American Menopause Society, 2012.

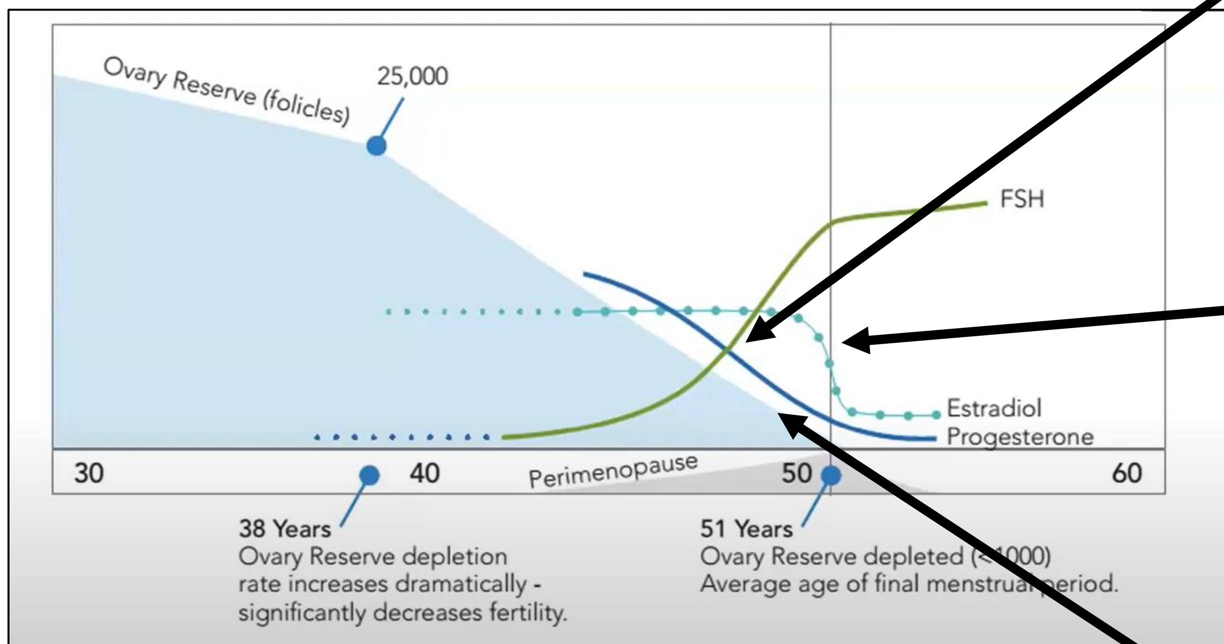
Question 2:
What is perimenopause?

Perimenopause **precedes natural menopause and occurs during a time of fluctuating hormones.** People may experience irregular periods and menopausal symptoms. It can last **4 to 8 years** and typically starts with changes in the length of time between periods and ends 1 year after the final menstrual period.



Question 3:
How do I explain the endocrinology to patients?

Ovaries stop being as responsive to FSH so your brain works a bit harder by releasing **more FSH** to help you ovulate. Ovarian response to FSH is inconsistent.



Without the consistent ovarian response to FSH, follicle development **decreases** so you don't make as much **estrogen. This is what is giving you the symptoms associated with low estrogen.**

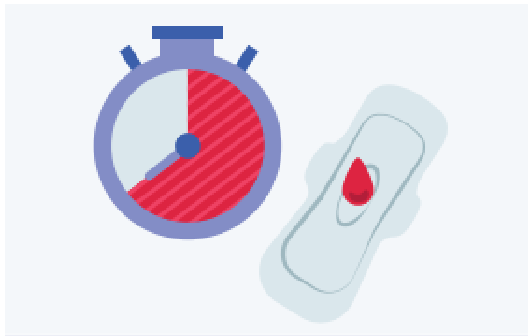
Because you aren't ovulating as much, you don't have a lot of **progesterone** circulating to stabilize your endometrial lining. **This is what may be giving you abnormal bleeding, usually referred to as anovulatory cycles.**

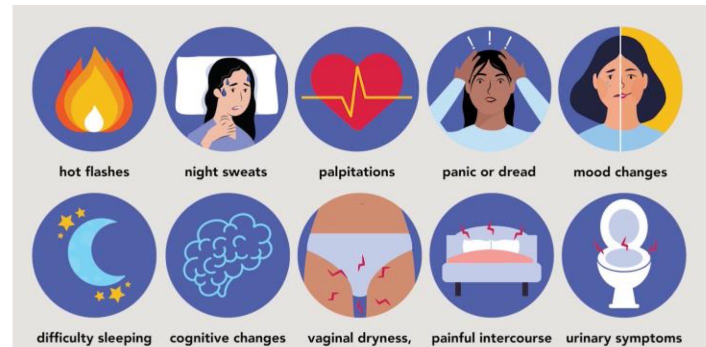
Toolkit Tips

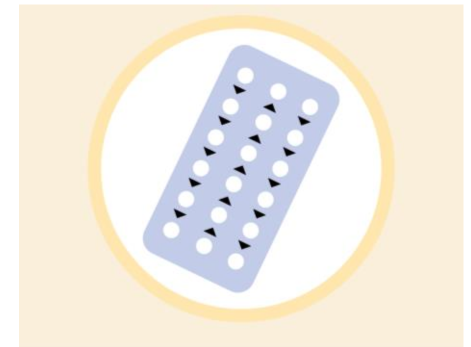
"Checking Hormones" or "Seeing Where you Are" isn't typically helpful.

Image Credit: Dr. J. Bitzer, IMS.

Question 4:
What are common gynaecologic considerations in perimenopausal patients?







Toolkit Tips

- ✓ Bleeding Pattern Changes
- ✓ Menopausal Symptoms
- ✓ Contraception

Illustration: Juliet Sweany

Question 5:

What's a NORMAL period?

REGULARITY

Periods occur every 24 – 38 days

DURATION

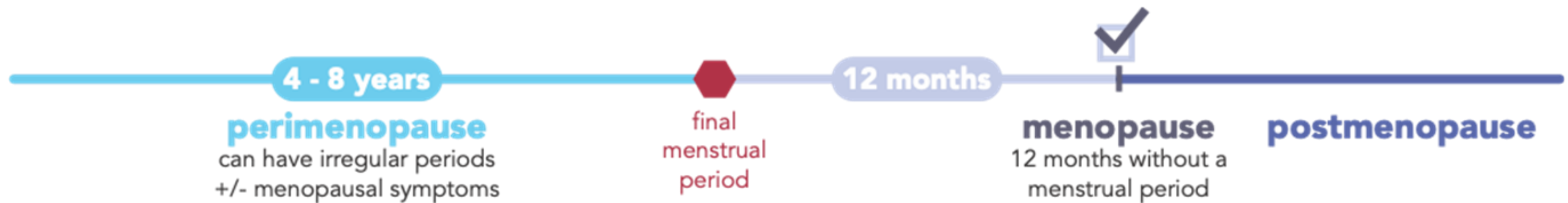
Periods last from 4.5 – 8 days

FLOW

Flow does not impact your daily life

Overall, normal menstruation exists on a spectrum with some people having lighter or heavier periods than others, and variation from cycle to cycle

Question 6:
What happens to bleeding in perimenopause?

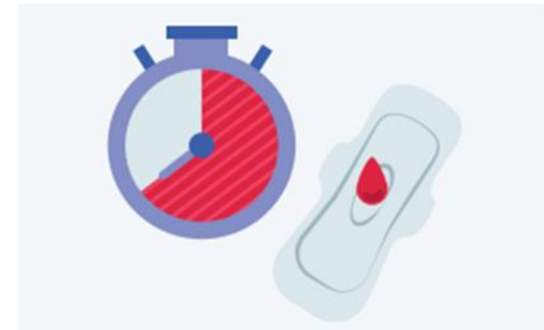


EARLY PERIMENOPAUSE

- **Variable length of flow**
- **Persistent difference of ≥ 7 day in length of consecutive cycles**

LATE PERIMENOPAUSE

- **Interval of amenorrhea of ≥ 60 days**

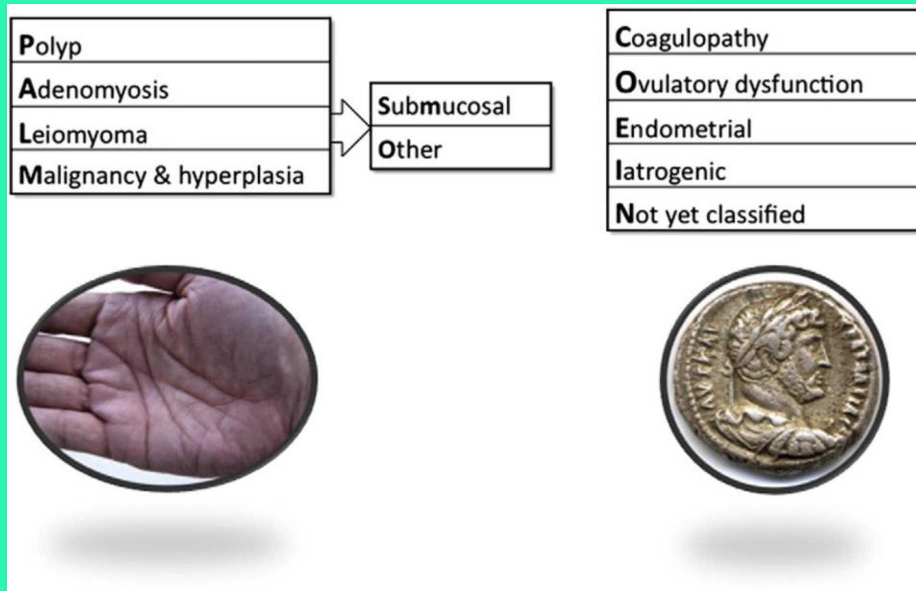


North American Menopause Society.

Question 8:
What is the DDx for abnormal uterine bleeding?

Toolkit Tips

✓ **PALM COEIN causes of abnormal uterine bleeding in nonpregnant, premenopausal women**



✓ **Bleeding caused by structural pathology measurable through imaging or histopathology**

versus

✓ **Bleeding unrelated to structural abnormalities**

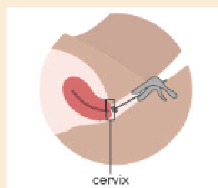
Munro MG, et al. *Int Gynaecol Obstet*. 2018; 143(3):393-408

Question 9:
What are initial steps for AUB work-up?

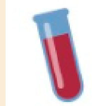
History

Physical Examination

Pap Test

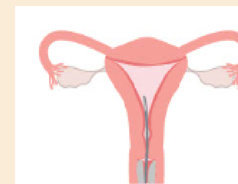


Labs



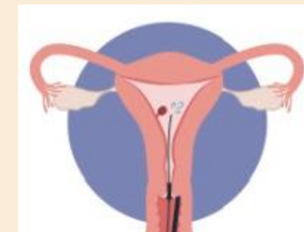
- CBC, ferritin, TSH, ß hcg, Prolactin, Vaginal C&S, Urine GC/Chlamydia, Bleeding disorder investigations

Endometrial Sampling (e.g., EMBx or D&C)



- *Age > 40*
- *Unexpected response to medical management*
- *Persistent AUB*
- *Family History of endometrial CA or Lynch Syndrome*
- ***Risk Factors**: Obesity, PCOS, Unopposed Estrogen, Bioidentical MHT, Tamoxifen use*
- ***If worried, you should do it or refer for one.***

Diagnostic Imaging



- *Pelvic/TVUS*
- *Sonohysterogram*
- *± MRI*

Johnston et al. J Obstet Gynaecol Can 2021;43(11):1301-1307.

Question 10:
What's Next?

Benign Conditions

- *Structural (GYN)*: Polyps, fibroids, adenomyosis, vaginal and cervical causes (polyps, lacerations)
- *Structural (non-GYN)*: GU, GI
- *Systemic*: Thyroid Dysfunction, Coagulopathy

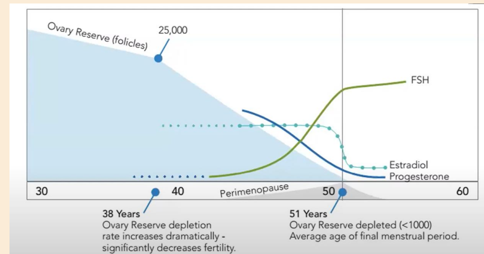
Pre-Malignant & Malignant Conditions

- *GYN*: Endometrial, Cervical, Synchronous Ovarian, Vulvar, Vaginal
- *Non-GYN*: GU, GI

→ Manage Structural Pathology or Systemic Condition

Hormonal Changes

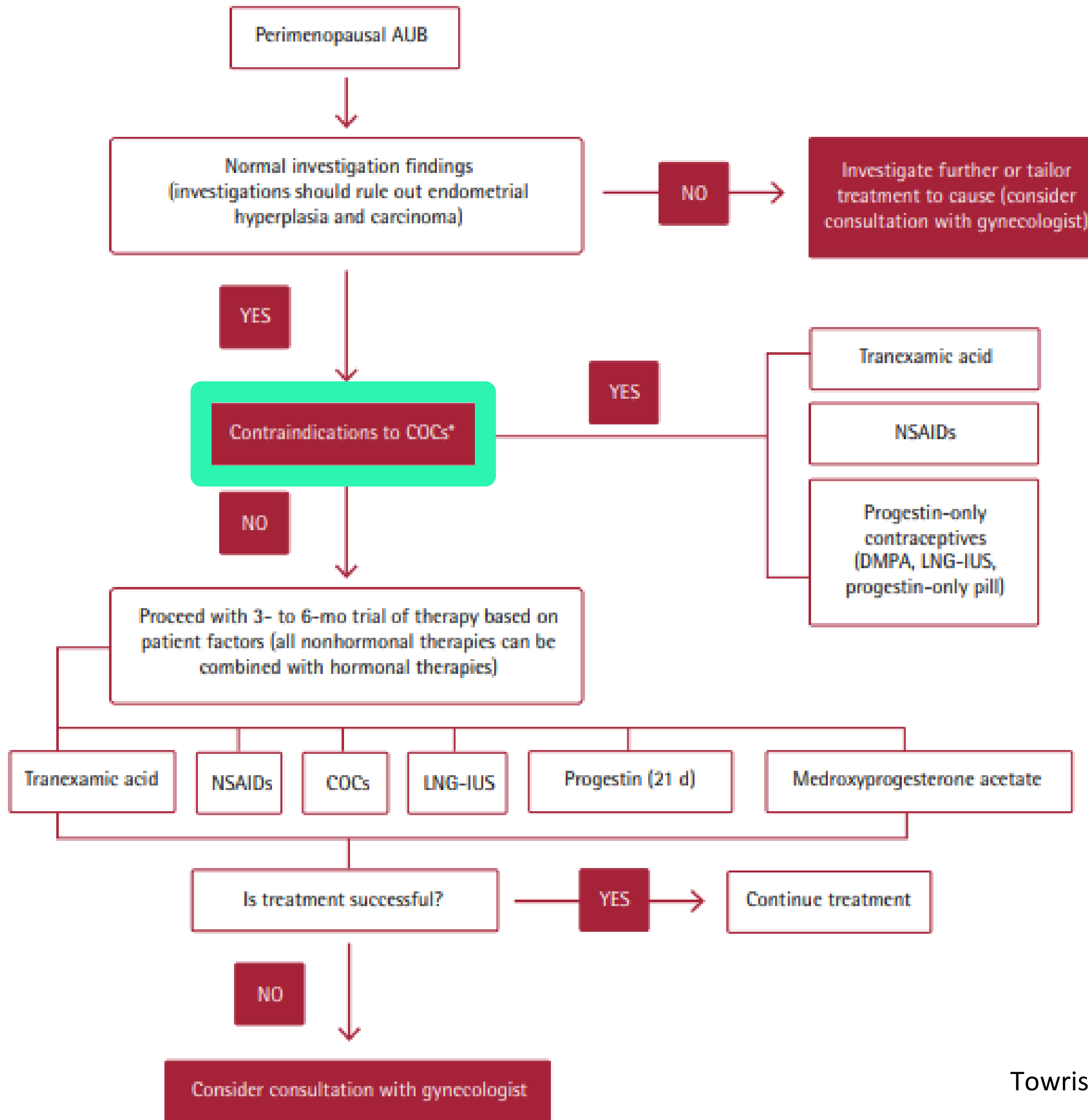
- Ovulatory Dysfunction



→ Manage Anovulatory Cycles

Question 11:

Some 'go-to' office medical management options?



Tranexamic Acid 1g po TID
"take while bleeding for up to 5 days per cycle"

Typical NSAID Dosing:
Naproxen 500mg po BID
Ibuprofen 600-1200 mg PO daily
Mefenamic Acid 500 mg daily
"start on first day of your period and take for 3-5 days"

First-Line Hormonal:

First Line: **LNG-IUS (52mg)**
Second Line: **Combined Hormonal Contraceptive**
***ANY** type of CHC will be effective*

Towriss K, Abnormal uterine bleeding summary chart. *RxFiles;* 2014.
McKee et al., Canadian Family Physician, 2015.

Question 11:

Some 'go-to' office medical management options?

Third-Line Hormonal:

Injected Progestins
i.e. Depot medroxyprogesterone acetate (DMPA)

150mg intramuscular injection every 90 days

Cyclic Oral Progestins
i.e. Norethisterone (or Norethindrone) acetate / NETA

5mg taken TID for 21 days monthly
(from day 5 to day 26 of menstrual cycle)

A note about oral progestins

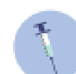
Taking lower dose NETA for 7-11 days per month (cyclic luteal phase progestins) is not effective for treating heavy menstrual bleeding; higher doses taken for 21 days per month is required to manage heavy flow (long-cycle progestin)

High Dose Oral Progestins
NETA 5mg po (OD to TID)
MPA 5-30mg/day

Fourth-Line Hormonal:

Danazol

100 – 400mg PO once daily



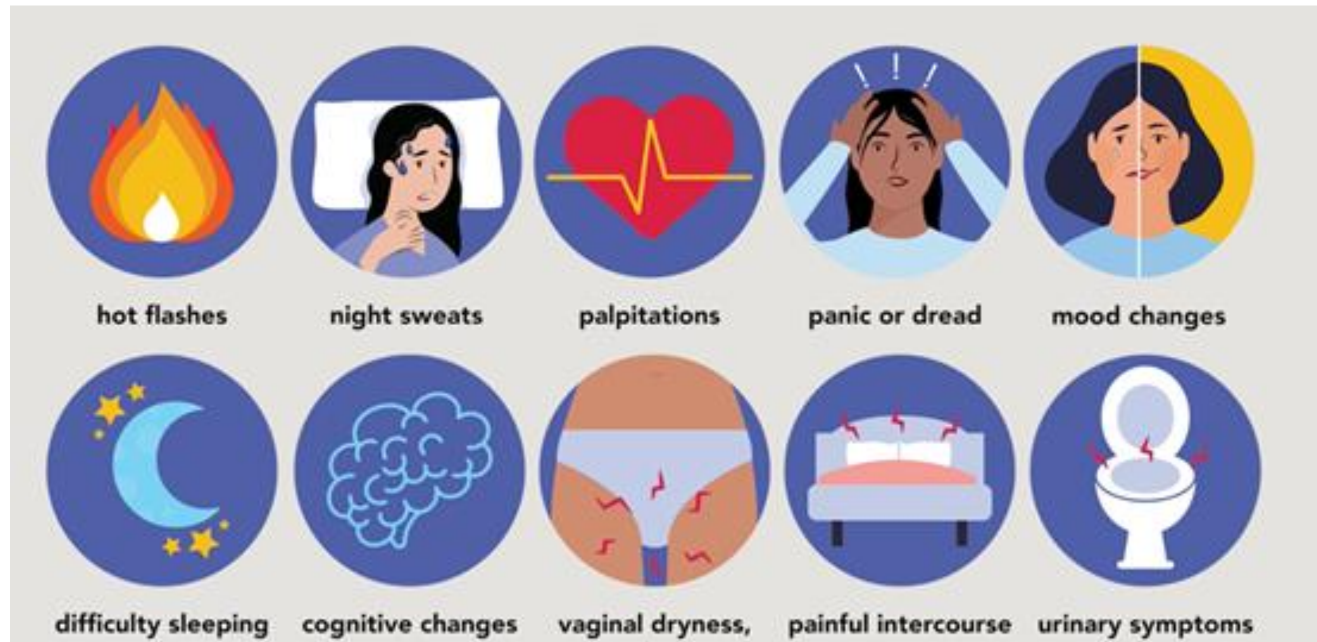
GnRH Agonists
i.e. Leuprolide acetate (*Lupron*)

Administered as a monthly intramuscular injection for 3 to 6 months

A note about "add-back" therapy

If Lupron is used long term (> 6 months), **"add-back" hormone therapy** (estrogen with progestin OR progestin-only pill) should be prescribed for patients to protect against bone loss and manage the unwanted side effects

Question 12:
What are common menopausal symptoms?



Toolkit Tips

✓ Many symptoms arise during perimenopause. Important to screen for symptoms especially mood and vasomotor symptoms ***at the time of perimenopause***.

Question 13:
What are some important counselling points?

SYMPTOM	COUNSELLING POINTS
Vasomotor Symptoms	• **75%** of women will suffer from them with 20% of women rating flushes as severe and causing significant impairment. • **Risk factors** include smoking, obesity, physical inactivity. • 10% of women with have VMS for longer than 10 yrs. • MHT is most effective treatment but symptoms return in 50% of women who stop the medication.
Vaginal Dryness	• Proper term is Genitourinary Syndrome of Menopause (GSM). • It is very treatable, usually happens **later**.
Low Libido	• Multifactorial and affects up to 50% of people • Dyspareunia secondary to atrophy is treatable.
Weight Gain	• Average weight gain is 2.3kg (5lbs), usually related to aging and activity changes. Usually distributed centrally.
Sleep	• Affects 30% of menopausal people • *Causes*: night sweats, RLL, overactive bladder, etc.
Cognitive Changes	• Forgetfulness and difficulty concentrating ("brain fog") • Can worsen in the first year after LMP
Mood	• Depression affects women > men and depressive symptoms can **increase during the menopausal transition.** • CBT and antidepressants are first-line treatments. MHT may be helpful for people with both VMS and mood concerns.

Question 14:
What are treatment options for VMS?

1) **Lifestyle modification** — no harm and low cost

CBT | **Weight Loss** | **Paced Respiration**

2) **Nonprescription Treatments** — little potential for harm, but often ineffective

Soy (s-equol) | **Black Cohosh**

3) **Non-hormonal Prescription Drugs** — great choice when MHT is contraindicated

4) **Menopause Hormone Therapy** — most effective (90% effective)

Toolkit Tips
Treating Vasomotor Symptoms
Remember 4 broad categories of treatment. What has your patient tried and what do they want?

Question 15:

What are some non-hormonal prescription options?

Category Generic Name (Brand Name)	Dosages and frequency for vasomotor symptom management
Citalopram (*Celexa*)	10, 20 mg oral daily
Escitalopram (*Cipralex*)	10, 20 mg oral daily
Paroxetine (*Paxil*)	10, 20 mg oral daily
Desvenlafaxine (*Pristiq*)	100–150mg oral daily
Venlafaxine (*Effexor*)	37.5, 75 mg oral daily
Gabapentin (*Neurontin*)	300–900 mg oral once daily at night
Pregabalin (*Lyrica*)	150–300 mg oral daily
Clonidine (*Dixarit*)	0.05 mg oral twice daily
Oxybutynin Immediate-Release	2.5, 5 mg oral twice daily

Question 15:

What are some non-hormonal prescription options?

Toolkit Tips

SSRIs

Look at medications the patient is already on. Avoid Paxil in women taking Tamoxifen. High doses of SSRI medications can make vasomotor symptoms worse.

Toolkit Tips

Clonidine

Small dosing – *watch the decimal!* Discontinuing clonidine at higher doses can lead to rebound hypertension among other symptoms.

Toolkit Tips

Oxybutynin

Initial Prescription: 2.5mg po BID

Watch for **side effects**: dry mouth, eyes, nose or skin; nausea and urinary retention.

New warnings about cognitive impairment due to anticholinergic activity on the CNS leading to central side effects.

Toolkit Tips

1. Writing the first Rx for Gabapentin

Gabapentin 100mg po QHS

Increase by 100mg po QHS q3-4 nights until a maximum dose of 900mg po QHS is reached.

Mitte: 270 x 100mg tablets (1 month)

2. FDA Warning

Respiratory depression can occur when Gabapentin or Pregabalin is taken with other medications that depress the CNS (ie. Opiates), women who have respiratory issues or in the elderly.

Question 16:
What about Menopausal Hormone Therapy (MHT)?

1. Bothersome vasomotor symptoms (VMS)
2. Significant sleep or mood disturbances
3. Genitourinary syndrome of menopause (GSM)
4. Prevention of bone loss in postmeopausal women at high risk of developing or have osteoporosis
5. Hypoestrogenism caused by hypogonadism, premature surgical menopause or premature ovarian insufficiency (POI)

Toolkit Tip
GSM is typically treated with **LOCAL** therapies. Other indications are managed with **SYSTEMIC** MHT.

Question 17:
Who <u>cannot</u> take SYSTEMIC MHT?

Contraindications to estrogen	Contraindications to progestogen
• Undiagnosed abnormal vaginal bleeding • Known, suspected, or history of breast cancer • Known or suspected estrogen-dependent cancers (i.e., endometrial, ovarian) • Coronary heart disease • Active or history of venous thromboembolism • Active or history of stroke • Active liver disease • Known or suspected pregnancy	• Undiagnosed abnormal vaginal bleeding • Current or history of breast cancer

Toolkit Tips

NOT on this list:

migraines, controlled hypertension, smoking

Wolfman *et al*. J Obstet Gynaecol Can. 2021 Oct;43(10):1188-1204.

Question 18:

How do I start my perimenopausal patient on MHT?

Estrogen Generic Name (Brand Name)	Typical Estrogen Starting Doses	Continuous Progesterone Regimen	Cyclic Regimen Progesterone Regimen
Conjugated Estrogen (***Premarin***)	0.3 mg OD 0.625 mg OD	Medroxyprogesterone Acetate (***Provera***) 2.5mg OD **OR** Micronized Progesterone (***Prometrium***) 100 mg PO or PV OD **OR**	Medroxyprogesterone Acetate (***Provera***) 5 mg PO OD for 12-14 consecutive calendar days each month **OR** Micronized Progesterone (***Prometrium***) 200 mg PO or PV for 12-14 consecutive calendar days each month
17ß Estradiol (***Estrace***)	0.5 mg OD 1 mg OD		
17ß Estradiol (***Estradot***) *Patch changed twice/week*	25 mcg 37.5 mcg 50 mcg 75 mcg*		
17ß Estradiol (***Estrogel***)	1 ppd OD 2 ppd OD		
17ß Estradiol (***Divigel***)	0.25 mg sachet OD 0.5 mg sachet OD	Levonorgestrel IUD (***Mirena***)	

*Typically requires more progesterone than listed in far column

Estrogens

Toolkit Tips
Oral Estrogens
Many patients prefer once daily dosing.
ODSP will cover generic
Premarin (0.625mg tablet) and
Estrace (0.5mg, 1mg and 2mg tablets).
Downsides: VTE/stroke risk, first-pass at liver

Toolkit Tips
Transdermal Estrogens
Best option for women who are smokers or have migraines, hypertriglyceridemia, malabsorption syndromes, metabolic syndrome or hypertension.

Toolkit Tips
Gels
***Estrogel* (80g canister): 64 actuations**
Daily application to >2000 cm^2 and let dry for 2 minutes after application.
***Divigel* (30 sachets in a box)**
Consider when the Rx will need a refill.

Estrogen Generic Name (Brand Name)	Typical Estrogen Starting Doses	Continuous Progesterone Regimen	Cyclic Regimen Progesterone Regimen
Conjugated Estrogen (***Premarin***)	0.3 mg OD 0.625 mg OD	Medroxyprogesterone Acetate (***Provera***) 2.5mg OD **OR** Micronized Progesterone (***Prometrium***) 100 mg PO or PV OD **OR** Levonorgestrel IUD (***Mirena***)	Medroxyprogesterone Acetate (***Provera***) 5 mg PO OD for 12-14 consecutive calendar days each month **OR** Micronized Progesterone (***Prometrium***) 200 mg PO or PV for 12-14 consecutive calendar days each month
17ß Estradiol (***Estrace***)	0.5 mg OD 1 mg OD		
17ß Estradiol (***Estradot***) *Patch changed twice/week*	25 mcg 37.5 mcg 50 mcg 75 mcg*		
17ß Estradiol (***Estrogel***)	1 ppd OD 2 ppd OD		
17ß Estradiol (***Divigel***)	0.25 mg sachet OD 0.5 mg sachet OD		

Toolkit Tips
Patches
i.e. *Estradot* (8 patches/box)

Change patch twice per week with lower abdomen or buttock application. Check patch site for irritation in patients with ongoing symptoms.

Estradot is a matrix patch, which can be cut in women wanting to wean off hormone therapy.
(ie. 25 mcg patch → 12.5 mcg patch)

Progesterones

Toolkit Tips

Progesterones

This can be the hardest to 'get right.'

A good 'go-to' option is a micronized progesterone (*Prometrium*) because it can be given orally or vaginally. Orally is great for women with sleep concerns. Vaginally can be helpful for patients with mood dysfunction.

<table>
<tr><th>Estrogen Generic Name (Brand Name)</th><th>Typical Estrogen <u>Starting</u> Doses</th><th>Continuous Progesterone Regimen</th><th>Cyclic Regimen Progesterone Regimen</th></tr>
<tr><td>Conjugated Estrogen (Premarin)</td><td>0.3 mg OD
0.625 mg OD</td><td rowspan="5">Medroxyprogesterone Acetate (Provera) 2.5mg OD

OR

Micronized Progesterone (Prometrium) 100 mg PO or PV OD

OR

Levonorgestrel IUD (Mirena)</td><td rowspan="5">Medroxyprogesterone Acetate (Provera) 5 mg PO OD for 12-14 consecutive calendar days each month

OR

Micronized Progesterone (Prometrium) 200 mg PO or PV for 12-14 consecutive calendar days each month</td></tr>
<tr><td>17ß Estradiol (Estrace)</td><td>0.5 mg OD
1 mg OD</td></tr>
<tr><td>17ß Estradiol (Estradot)

Patch changed twice/week</td><td>25 mcg
37.5 mcg
50 mcg
75 mcg*</td></tr>
<tr><td>17ß Estradiol (Estrogel)</td><td>1 ppd OD
2 ppd OD</td></tr>
<tr><td>17ß Estradiol (Divigel)</td><td>0.25 mg sachet OD
0.5 mg sachet OD</td></tr>
</table>

Toolkit Tips

Message to your patient about Progesterone:

Estrogen is going to help your symptoms the most. However, if you still have a uterus and you have been prescribed a stand-alone estrogen, it is important you take a progesterone to protect the lining of the uterus from developing precancer or cancer cells.

Toolkit Tips

Medroxyprogesterone Acetate

All strengths of the generic tablets are covered by ODSP.

Medroxyprogesterone acetate was the same progesterone in the WHI trial.

Question 19:
How do I explain risks of systemic MHT?

There was a large study published in 2002 called the WHI Trial that made women very nervous. However, a **closer look at the data showed hormone therapy isn't as harmful as was initially thought** and several studies have shown significant benefit with respect to systemic hormone therapy, meaning hormones given by mouth or through the skin as a patch or gel. While every patient has individualized risks and every regimen carries different risks, generally:

Breast Cancer: Risk of breast cancer among the average patient is 63 cases per 1000 women. If we have you a combined estrogen and progesterone regimen, we increase that risk by approximately 1 case per 1000 women with each year of use. This is the same risk brought on by being obese or drinking 1-2 glasses of wine per night.

Stroke: Risk of stroke increases after the age of 60. If you start HRT before the age of 60, your risk of stroke is not really increased. Our counselling may be slightly different when speaking to patients with a history of migraines.

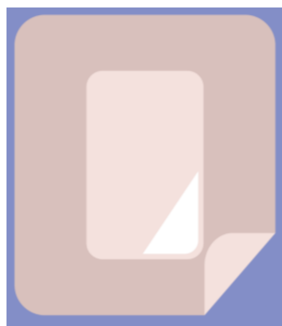
Heart Attack: As long as you are starting systemic hormone therapy within 10 years of your final period and before the age of 60, your risk of heart attack is not increased. In fact, starting estrogen in that time period likely offers cardiovascular protection in a healthy patient. However, we are not prescribing estrogen for that indication at the moment.

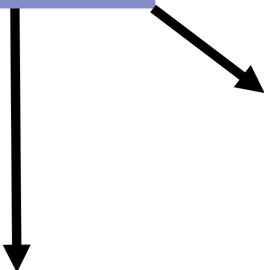
Blood Clot: Your absolute risk of blood clot is very low. Starting systemic estrogen increases that risk in the first 1-2 years of use. If you are a smoker or overweight, it is reasonable to consider an estrogen through the skin as risks of blood clot are lower in those using transdermal estrogens.

Question 20:

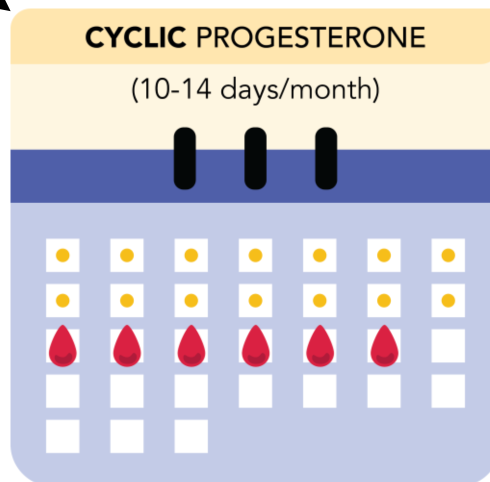
What progesterone components of systemic MHT is best for perimenopausal women?

Estrogen (pill, patch, gel)

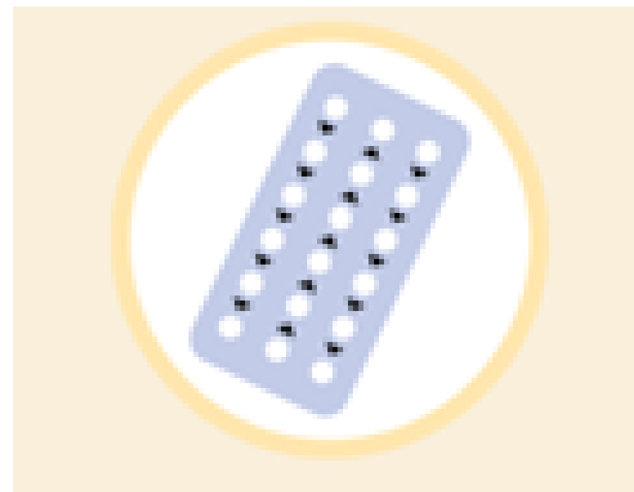




Levonorgestrel IUD



Cyclic Progesterone

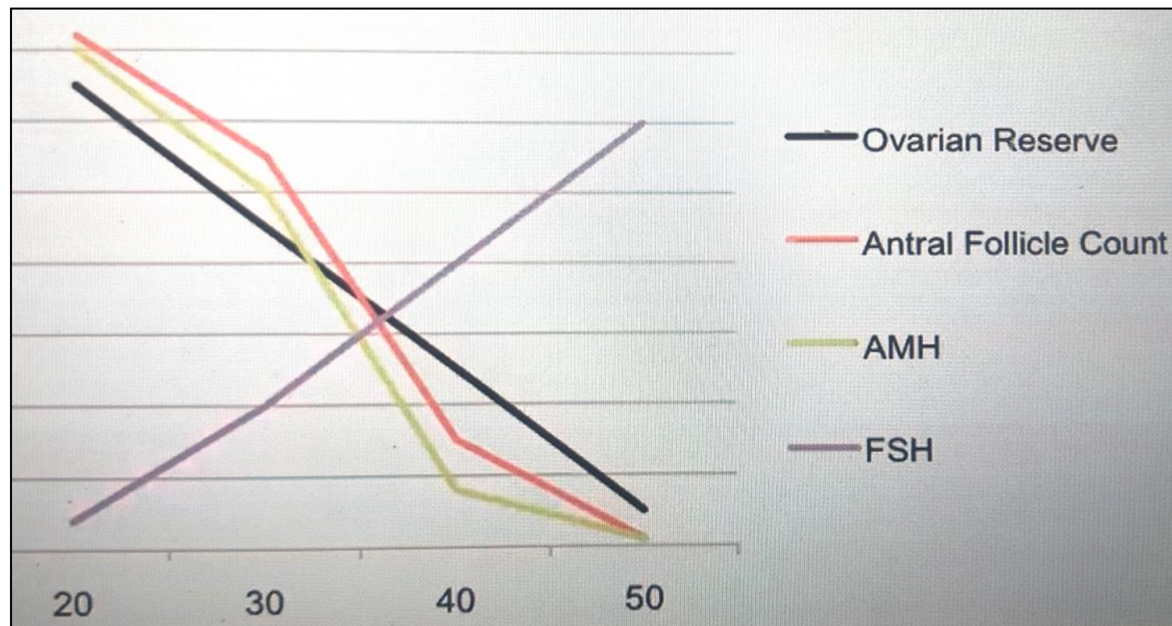


Toolkit Tip

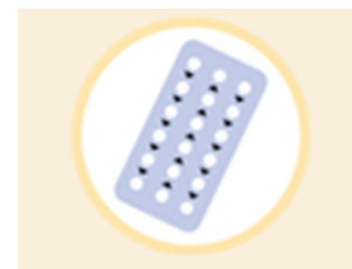
OCP may also be an option

e.g., LoLo OCP

Question 21:
What about contraception?



Age (years)



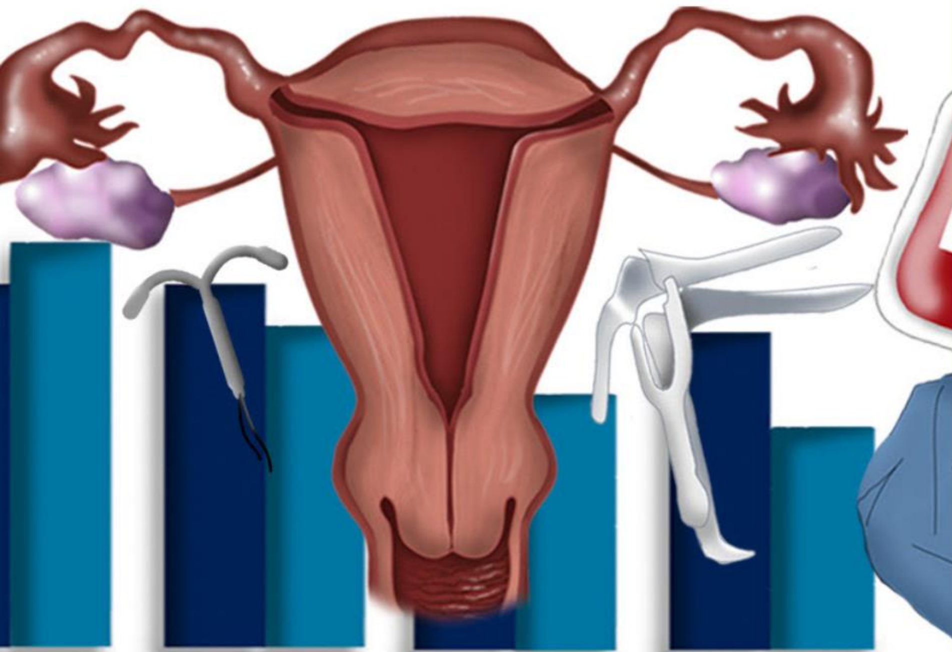
"You need to use an effective, safe, and appropriate method of birth control until menopause is confirmed if you don't want to get pregnant at midlife."

Toolkit Tip

In real life, coital frequency and ovarian reserve decrease as women age. Therefore, contraceptive methods with lower inherent efficacy may be acceptable to your patient.

Question 21:
Any new resources available?

Home · About the Project · For Surgeons · For Patients · QI Projects · Publications · Project Funding · Who We Are



GYNAECOLOGY QUALITY IMPROVEMENT COLLABORATION

Hysterectomy Complication Prediction Tool

Patient Handout Project

Toolkit Tip

www.GYNQI.com

Question 22:

Any new resources available?

Patient Handout Project

We wanted to create a place for patients to access reliable, evidence-based information related to gynaecologic care. We also hope gynaecologists can use these resources as they counsel patients in the clinic or hospital setting.

In this collaboration, Staff Gynaecologists have partnered with Obstetrics and Gynaecology residents and University of Toronto medical students to create a unique collection of patient handouts. We look forward to building and updating these resources over time. You can search your topic of interest and click the image to view your desired handout.

GENERAL GYNAECOLOGY | COMMON GYNAECOLOGIC CONDITIONS | MENOPAUSE

VULVA | GYNAECOLOGIC SURGERY | PREPAR

Search here...

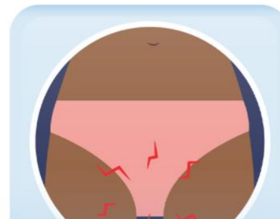
General Gynaecology

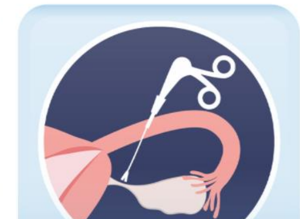
Menopause

Introduction to Menopause

Vasomotor Symptoms of Menopause

Cost of VSM Treatments





Question 22:

Any new resources available?

Menopause Patient Handouts

Introduction to Menopause

Vasomotor Symptoms of Menopause

PRESCRIPTION TREATMENT OPTIONS FOR VASOMOTOR SYMPTOMS AVAILABLE IN CANADA*

Genitourinary Syndrome of Menopause

Menopause Hormone Therapy

Surgical Menopause

PATIENT HANDOUT PROJECT

Fibroids: Evaluation

History and Physical Examination

Your doctor may wonder if you have fibroids based on symptoms you report. Furthermore, they may be able to feel your fibroids during a pelvic and/or abdominal examination. These findings may prompt your doctor to order further imaging or other investigations.

Imaging

Further Investigations

Apart from imaging, other tests may be suggested based on your symptoms and physical examination.

Pap Test
A pap test is an office procedure that involves a speculum examination. Your doctor will use a small brush to gently sample cells from the cervix so they can be checked for any precancerous or cancerous changes.

Endometrial Biopsy
A short office procedure during which a speculum is inserted into the vagina and a small pipelle is placed through the opening of the cervix, and into the uterus to take a sample of the lining of the uterus. Some people find this procedure uncomfortable and cannot tolerate having it done in the office. Your doctor may recommend a short procedure in the operating room under anesthesia instead.

Bloodwork
- **CBC (complete blood count) and Ferritin** – People who present with heavy or abnormal bleeding will likely have bloodwork to check iron levels and hemoglobin.
- **Creatinine** – This test

www.GYNQI.com

Postmenopausal Bleeding: Evaluation

If you have postmenopausal bleeding, it is important for your doctor to rule out worrisome causes. Your doctor will likely recommend completing various investigations. You may not need all of these tests. Management of postmenopausal bleeding depends on the cause of the bleeding.

Your physician may order a **pelvic and/or transvaginal ultrasound** (TVUS) to assess the thickness of the endometrial lining.

A pelvic ultrasound uses an external probe on your lower abdomen to provide images of your pelvic structures. A transvaginal ultrasound may be completed at the same time, with your consent. In a TVUS, a probe is inserted into the vagina to better delineate the female reproductive organs.

2 Sonohysterogram
In some cases, a more advanced type of ultrasound, called a **sonohysterogram**, may be required to better characterize the cavity of the uterus.

Fibroids: Fertility and Pregnancy

Fibroids are benign tumors (*not cancerous*) of the smooth muscle of the uterus. Up to 70% of women have fibroids. Some fibroids are small and people don't even know they have them because they have no symptoms. Other fibroids can cause significant symptoms.

There are four different types of fibroids depending on their location.

Symptoms of Fibroids

Vulvar Lichen Sclerosus

Grade 1 Endometrioid Adenocarcinoma: Treatment

Definitive treatment of Grade 1 Endometrioid Adenocarcinoma involves surgically removing the uterus, fallopian tubes, and ovaries (+/- lymph nodes in certain patients). Depending on several factors, removal of these structures can be achieved in a variety of ways.

LAPAROSCOPIC APPROACH

Frequently, surgery can be performed through a minimally-invasive approach called "laparoscopy". This involves the surgeon inflating the abdomen with carbon dioxide gas, introducing a camera into the abdomen in order to be able to see, and introducing surgical instruments through 2-3 small (usually less than 1 cm) incisions into the abdomen and completing the procedure. This approach may not be appropriate for all patients.

ABDOMINAL APPROACH

Many patients require surgery to be performed through an abdominal incision (which may be horizontal or vertical).

A quick note on fertility...

In menstruating women diagnosed with endometrial cancer who wish to maintain their fertility potential, a hormone called **progesterone** may temporarily treat endometrial cancer.

In well-counselled patients, it may be offered as an option until a patient has completed their family planning after which they may undergo surgery. This usually involves taking progesterone orally (by mouth) or through a hormonal intrauterine device (IUD).

All treatment options must be discussed with your doctor in order to determine which are right for y

The operation is done through the vagina, without requiring any abdominal incisions. The uterus is removed through this vaginal opening. No scars will be visible on the abdomen.

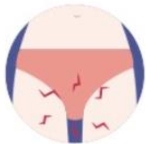
The procedure is started laparoscopically and completed through the vaginal approach. Scars from this surgery will be similar to that of a laparoscopic hysterectomy.

Question 22:

Any new resources available?

Genitourinary Syndrome of Menopause

Genitourinary Syndrome of Menopause (GSM) is caused by low estrogen levels in the tissues of the urinary tract and the female gential tract. The symptoms of GSM can vary between patients and may affect the vulva and vagina, urinary function, and sexual function.



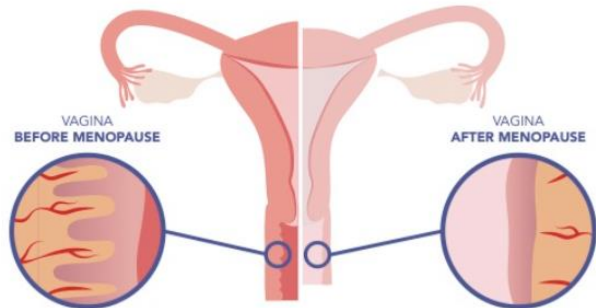
Genital Symptoms
Dryness, burning, and irritation of the genital area (vulva and vagina)

Sexual Symptoms
Lack of lubrication, discomfort or pain, and impaired function during sex

Urinary Symptoms
Urgency, burning, and recurrent urinary tract infections

GSM is very common and can impair quality of life, sexual function, and relationships with partners

Without adequate and timely treatment, GSM can become a chronic concern with longstanding functional and structural changes in the urogenital tissues that can be difficult to reverse.



Prior to menopause, the vagina is

After menopause, vaginal tissues

Have this document emailed to you

Enter your email address below and submit to have this handout emailed to you. If you are a physician emailing this handout to a patient, you can use the message field to add additional information.

Email *

Message

Submit