Case 3

- Mrs Shanti, a 51 yr old housewife, post menopausal for 4 yrs
- Presents with vaginal dryness, local irritation and some urinary incontinence
- No other complaints
- On Examination vaginal walls dry and atrophic

- **How to approach?**
- **Preparations?**

Genitourinary Syndrome of Menopause

- **Genitourinary atrophy: inevitable changes in a postmenopausal woman.**

Symptoms	Signs
Genital dryness	Decreased moisture
Decreased lubrication during sexual activity	Decreased elasticity
Discomfort or pain during sexual activity	Labia minora resorption
Post-coital bleeding	Pallor, erythema
Decreased arousal, orgasm, desire	Loss of vaginal rugae
Irritation, burning, or itching of the vulva or vagina	Tissue fragility, fissures, petechiae
Dysuria	Urethral eversion or prolapse
Urinary frequency and urgency	Introital retraction

J Menopausal Med 2015;21:65-71

Indian Menopause Society 2020

- Urogenital symptoms respond well to estrogens.
- Vaginal route of administration correlates with better symptom relief by improving vaginal dryness, pruritis and dyspareunia
- Long-term treatment is often required as symptoms can recur on cessation of therapy
- **Systemic risks have not been identified with local low-potency/ low-dose estrogens.**

- **She can be offered vaginal CEE gel or Estriol cream**

Vaginal preparations available

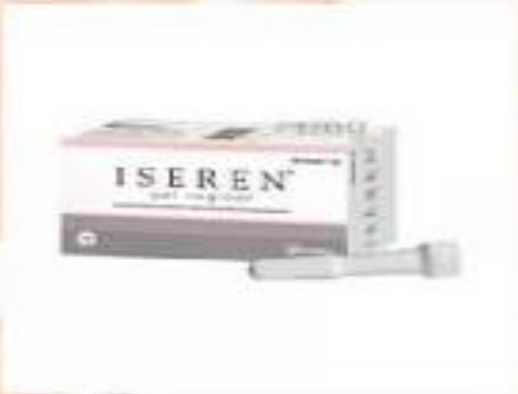
- **Estriol vaginal cream** - 0.5 mg in 0.5 gm
  - One applicator 0.5 gm daily for 2-3 weeks, then reduce to 2-3 times/week, can be given upto 1 year
- **CEE cream** - 1 gm contains 0.625 mg
  - 0.5 g/day

VAGINAL PREPARATION

Indications in postmenopausal women

- Vaginal symptoms
- Recurrent urinary tract infections
- Overactive bladder
- Vaginal surgery---Pre and postoperative
- Pap's smear---After a short course of therapy

- **Treatment should be started early and before irrevocable atrophic changes have occurred**
- **Delay in starting local treatment will reduce degree of response**
- **Initial loading dose to stimulate receptors followed by low maintenance dose once or twice per week**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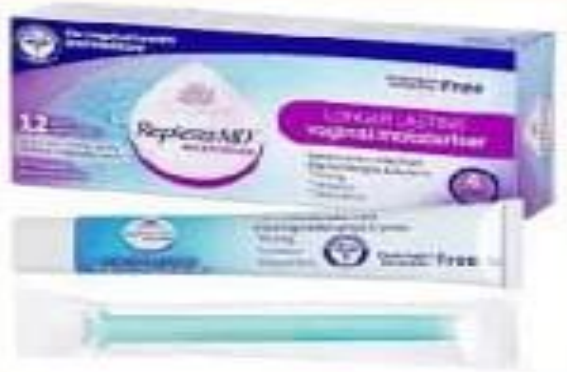
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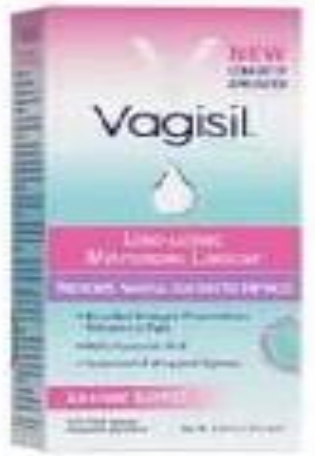
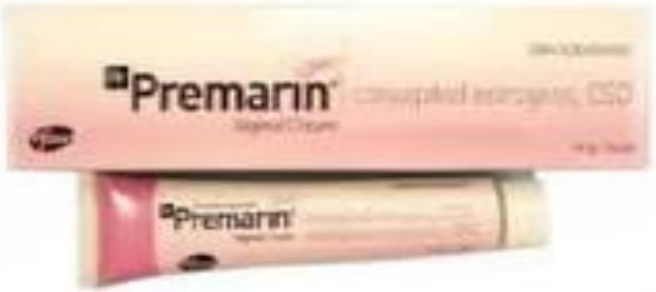

NEW
Vagisil


ESTRIOL CREAM BP
Ciplon


Premarin
Premarin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Recommendations for SSRI

- **Paroxetine, citalopram, or escitalopram as our first-line drugs (Grade 2B).**

Low-dose paroxetine (10 -12.5 mg/day) as the first choice since this is the only agent that has received approval by the US Food and Drug Administration (FDA) for the treatment of hot flashes

- Sertraline and fluoxetine not recommended because neither has a clinically important effect on hot flashes.

- **For women with predominantly night time symptoms: Gabapentin (Grade 2C).**

A single bedtime dose of gabapentin (300 mg, or as low as 100 mg if needed, titrating up to 900 mg until symptom relief or side effects), which takes advantage of the sedating effect of gabapentin while minimizing daytime sedation

- For women on tamoxifen for any indication : Citalopram, escitalopram, or **venlafaxine** to treat hot flashes, as they have minimal effects to block *CYP2D6* (NO PARAXOTINE)

Venlafaxine: sustained release preparation starting with 37.5 mg/day for one week, increasing to 75 mg/day after the first week to reduce the incidence of initial nausea

Case 4

- Mrs Jyoti, 53 year old postmenopausal comes with complaints of dyspareunia and loss of interest in sexual function.

What are the treatment options for her?

Sexual Function

- **Transdermal estrogens**
  - *If sexual function or libido are concerns in women with menopause symptoms, transdermal ET may be preferable over oral ET* because of less effect on sex hormone-binding globulin and free testosterone levels.
  - Estraderm MX (Novartis),17 beta estradiol
  - Dose: VVA- 0.025 mg/day once a week
- **Vaginal estrogens**
  - Low dose improves sexual function in postmenopausal women with GSM
- **Tibolone**
  - It improves mood and libido.

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Non oestogenic alternatives approved for dyspareunia

- **Ospemifene**- SERM derived from toremifene
  - Dose: 60 mg, Osphena
  - Indicated for the systemic treatment of moderate to severe dyspareunia associated with VVA in *women who are unable to tolerate or unwilling to take local or systemic oestrogens*

- **Intravaginal DHEA**- Prasterone, 6.5 mg suppository /cream
  - *Daily topical use* of DHEA is promising in the treatment of VVA and sexual associated symptoms, due to a favourable safety profile in women with contraindications to MHT.
  - *Efficacy appears to be lost with twice-weekly maintenance administration*

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- **Testosterone**- transdermal or intravaginal gels
  - *primary indication is diminished sexual desire that causes the affected woman to experience significant distress* (HSDD)
  - Androgenic side-effects of testosterone therapy are dose-related
  - Large, placebo-controlled RCTs transdermal testosterone in appropriate doses has no adverse cardiovascular or metabolic effects or effects on the endometrium
  - *Intravaginal testosterone administered alone or with vaginal oestrogen has been shown to improve dyspareunia, sexual desire, lubrication and satisfaction.*
  - Beneficial effects have been seen with administration three times/week
  - Dose: 1% gel 10 mg Androgel , Cernos gel, 5-10 mg rub in upper arm OD for 6 weeks

IMS 2020

“One size doesn't fit all when it comes to treating women with menopause,"

"Hormone replacement therapy (HRT) must be individualized based on a woman's age, time of onset of menopause, and other cardiovascular, metabolic, and genetic factors”

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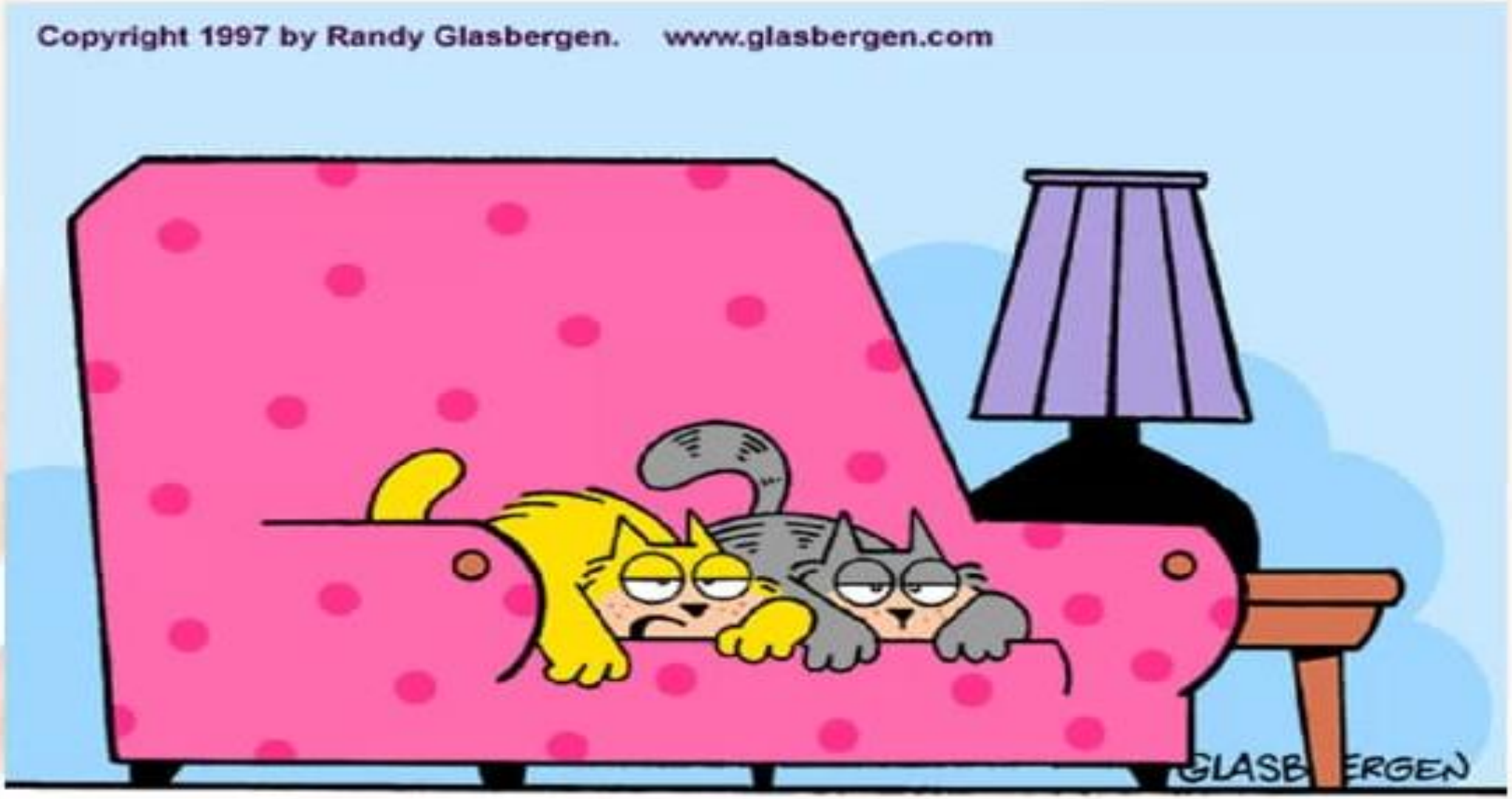
Assess The Profile Of The Woman To Individualize Treatment

Type and stage of menopause

- Surgical menopause-E only/Tibolone
- Perimenopause-Cyclical Progesterone/OCP/HT cyclical
- Early Menopause <12 months-EPT (More estrogens) sequential
- Late Menopause <12 months-EPT continuous combined/tibolone (Lowest estrogens/transdermal)



"Having nine lives is cool, but if I have to go through menopause again, forget it!"