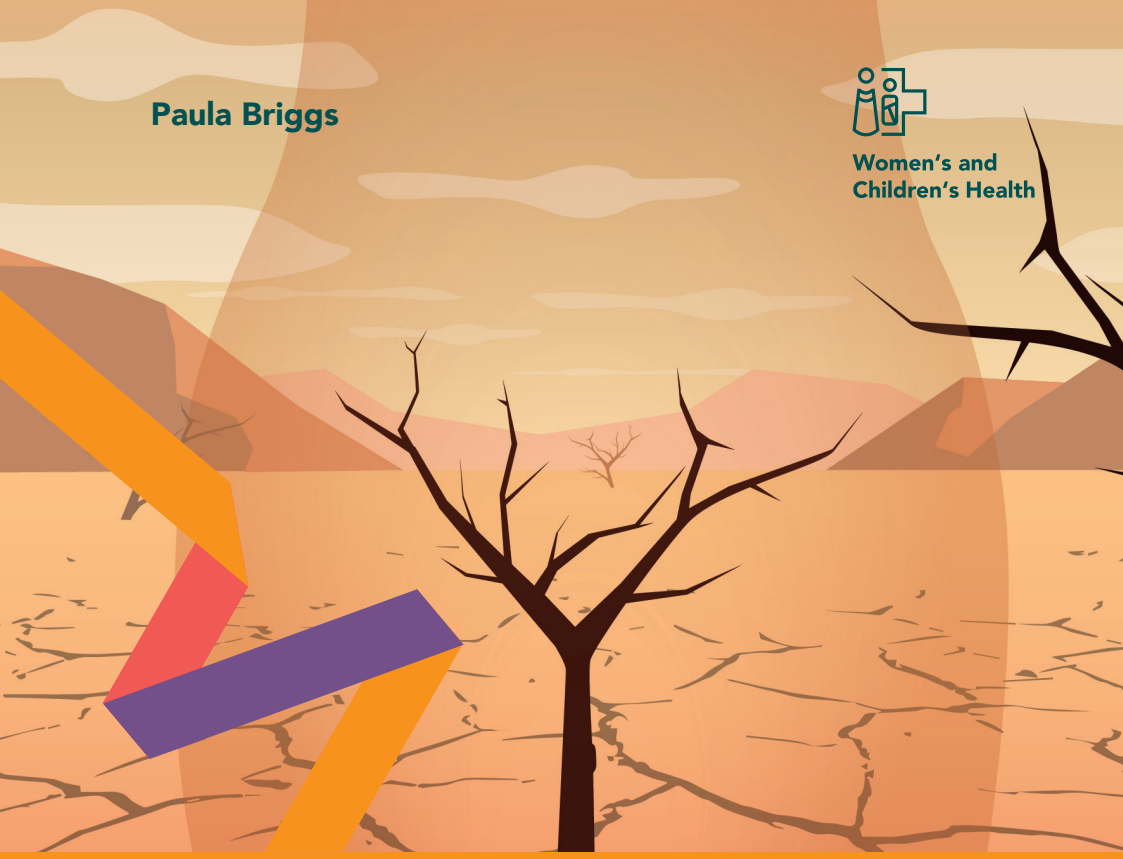
Paula Briggs



Women's and Children's Health

Fast Facts for Patients

Urogenital Atrophy

Karger HEALTHCARE

Important contacts

You can write the names and contact details of your healthcare team and other important contacts here…

Name .....

Role .....

Phone .....

Email .....

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Women's and Children's Health

First, the facts...

1. Urogenital atrophy is caused by low levels of oestrogen and is mostly associated with the menopause.
2. Symptoms can include a dry vagina and thinner vulval skin which leads to painful sex and bladder problems. Vaginal dryness may affect more than 50% of women after menopause. For some women, the symptoms of urogenital atrophy can be extremely disabling.
3. The condition is very common although many women mistakenly believe the symptoms are an inevitable part of ageing and do not seek treatment.
4. The symptoms of urogenital atrophy are often not recognised by healthcare professionals: the condition is underdiagnosed and undertreated.
5. A range of treatments are available that can alleviate many of the symptoms.

This booklet aims to help you understand your options, so that you can talk to your doctors, nurses and medical team about your symptoms and possible treatment.

You can use the spaces on the pages to organise your notes and questions. The information is general and if you have any concerns about your health you should speak directly with your doctor or healthcare team.

Karger HEALTHCARE

What is urogenital atrophy?

Urogenital atrophy (UGA) is a condition that affects the tissue quality of the vulva, vagina, urethra and bladder. It most often occurs around the menopause and is caused by reduced levels of the female hormone **oestrogen**.

Symptoms of UGA vary from one woman to the next, but vaginal dryness, itching and burning are common. Dryness can cause discomfort, itching and pain and affects more than half of all women who have gone through the menopause. Thinning of the lining of the vagina can also be a cause of bleeding and pain during sex. Left untreated, it can lead to problems in the **urinary tract**, like **cystitis**. You can read about the symptoms on pages 12–16.

Urogenital atrophy is a **chronic** condition, which means that symptoms can continue for many years and will likely progress. This means that without treatment the symptoms are likely to worsen with age.

There are different names for this condition, depending on where you live. In the UK, 'urogenital atrophy' is used because the condition is now known to affect the urinary system as well as the vulva and vagina. In North America, the term 'genitourinary syndrome of menopause' is more common, and this name may end up being the preferred term. Your doctor may continue to use the name **(vulvo) vaginal atrophy.** Many women don't like any of the names, as 'syndrome' suggests an untreatable condition and 'atrophy' also has negative connotations. In this book, we use the term urogenital atrophy, and abbreviate it as UGA.

> *"The medical name for the condition is a barrier for some women – the term 'atrophy' suggests something that is no longer useful, is withering or not working properly."*

How common is urogenital atrophy?

Underdiagnosed

Urogenital atrophy is very common, but it is **underdiagnosed**. This means that doctors diagnose the condition less often than the condition really occurs. In fact, UGA is sometimes referred to as a 'silent epidemic' by clinicians who specialise in women's health, as there are many women who live with symptoms, but who are never diagnosed.

The symptoms of UGA can appear around three to five years after more common menopausal symptoms, so the link between the condition and the reduced levels of oestrogen is not obvious. This is one reason why underdiagnosis is common. Another reason is that doctors simply do not recognise the symptoms in their patients or do not wish to talk about common symptoms, diagnosis and management.

Underreported

Urogenital atrophy is **underreported**. Many women mistakenly consider the symptoms to be a normal part of ageing and believe that little help is available. Under-reporting means that it is not easy to get a full picture of how many women are affected by UGA.

Some studies suggest that women with UGA consult their doctors for some of their symptoms but do not mention others. This may be because they are self-treating with over-the-counter remedies, or they may not consider that their symptoms are important enough to 'bother' the doctor with. Because some women do not realise that their symptoms are connected to menopause, they are not aware that these symptoms may respond to vaginal oestrogen or other therapy options.

Some women may also feel uncomfortable or embarrassed about introducing the topic of their symptoms and are quietly hoping that their doctor will raise the topic and discuss potential treatment options.

Symptom relief

There are many things that can be done to help manage the symptoms of UGA. Products and treatments are readily available, from remedies you can buy that don't need a prescription, such as moisturisers, lubricants and vaginal hormonal treatment options, to prescription hormonal therapies and laser therapy (though in the UK this is currently only available in the private sector).

Lifestyle changes and pelvic floor physiotherapy can also help many women. You can read more about these on pages 26–29.

Talking to other women who are experiencing similar symptoms can be a great source of support and advice. It can be helpful to realise that the symptoms of the condition that you are experiencing are extremely common and that you are not alone. In the back of this book, we list support groups, websites and other helpful resources.

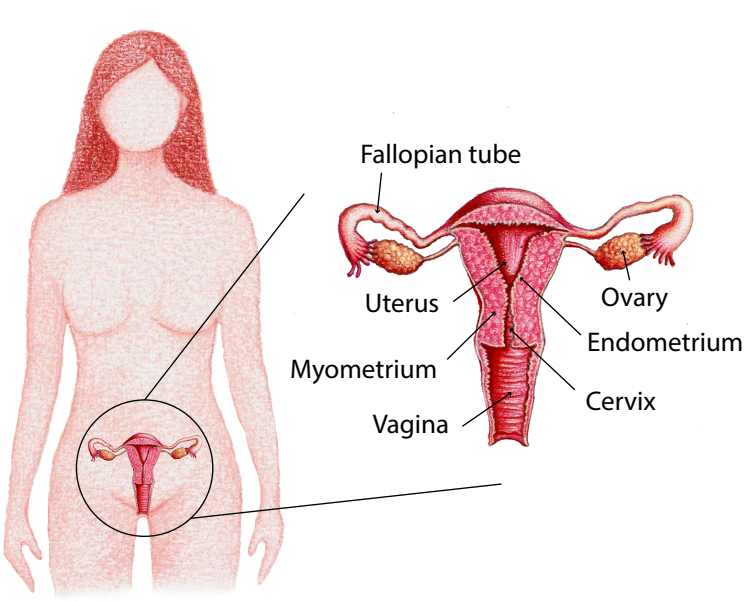
> *"I hope that over time urogenital atrophy will move up the list of the symptoms of menopause. Urogenital atrophy seems as common as hot flushes, but you hardly ever hear about it. We need more information."*

> *"I don't understand why this topic is kept 'secret' when apparently most women of a certain age suffer from the symptoms."*

How your body works

When you know more about how your body works, it can be easier to understand what UGA is and how it happens. It can be easier to talk about your symptoms with your healthcare team, too, and to ask questions about your treatment options.

The female reproductive system



Internal reproductive organs

Ovaries. The ovaries are small, walnut-sized organs, located in the pelvis (lower part of the tummy). Normally, you cannot feel them. The ovaries produce eggs for fertilisation in reproduction and the hormones **oestrogen**, **progesterone** and **testosterone.**

Uterus. The uterus is also called the **womb**. Usually, it is roughly the size of a pear and sits low in the pelvis, at the top of the **vagina**. It is formed of two parts: the upper thick part, called the body, and the lower thinner 'neck' called the **cervix**. The womb is held in place by many ligaments and muscles which are part of the **pelvic floor**.

Fallopian tubes. The fallopian tubes extend from the uterus to the ovaries. Fertilisation of an egg takes place in the fallopian tubes. The fertilised egg then travels to the inside of the uterus, where it potentially develops into a baby.

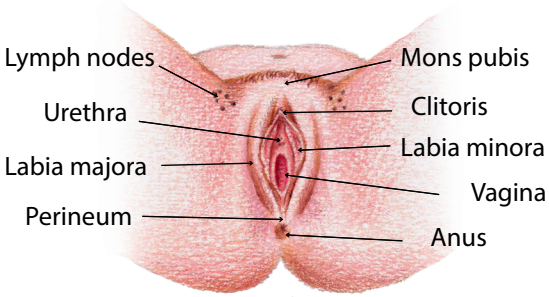
Peritoneum. The peritoneum is a thin sheet of tissue that wraps around and supports the ovaries. The peritoneum also covers the internal organs in the abdomen (tummy), such as the liver and stomach, and lines its muscular walls.

Cervix. The cervix sits in the upper vagina behind the bladder and in front of the rectum.

Endometrium. The endometrium (womb lining) responds to the hormones oestrogen and progesterone. The womb lining is usually shed every month if there is no fertilised egg (your monthly period).

Myometrium. The muscular layer of the uterus wall.

External reproductive organs



Vagina. The vagina is the passageway that runs from the vulva to the cervix.

Vulva. The vulva is the part of the female reproductive system that is on the outside of the body. It includes the mons pubis, the **labia majora** (big lips) and **minora** (small lips) and the **clitoris** (important for sexual pleasure and orgasm). During perimenopause and menopause, the drop in oestrogen can affect how your vulva looks. You may notice a change in colour, or appearance of the labia. These changes can be upsetting but are common.

The **urethra** is a thin tube that connects to the bladder and empties urine from the body.

The **perineum** is the area between the vagina and the anus.

Hormones in menstruation and menopause

A woman's reproductive years are those when she is most fertile and most likely to become pregnant – on average this is between the ages of 14 and 45.

Menstrual cycle

Your **menstrual cycle** is calculated from the first day of your period to the first day of your next period. The average cycle in a woman who is menstruating regularly is around 21–35 days. The menstrual cycle is regulated by the hormones oestrogen and progesterone.

Perimenopause

The period before menopause occurs is called the **perimenopause**. This can last for a number of years, during which time periods can become irregular and eventually stop. The levels of oestrogen begin to fall at this time, which can lead to menopausal symptoms.

Symptoms of UGA can appear in the perimenopause but are more likely to occur a few years later, and can even occur when a woman is taking systemic hormone replacement therapy (HRT).

Menopause

The **menopause** is specifically your last menstrual period. However, the word menopause is also used to describe the time around this event when many women experience symptoms.

Oestrogen and urogenital atrophy

When the ovaries stop producing oestrogen, this can have a significant impact on the health of the vulva, vagina, urethra and bladder.

The ovaries naturally produce significantly less oestrogen at menopause, and levels vary widely during perimenopause. Low levels of oestrogen can also occur for other reasons and at other points in a woman's life.

Certain treatments called 'gonadotrophin releasing hormone agonists' and contraceptive choices such as the contraceptive injection can affect production of oestrogen from the ovaries. Low body weight and eating disorders, such as anorexia, can also result in UGA because of a drop in oestrogen, while women who have recently given birth or who are breastfeeding will also have low levels of oestrogen. Cancer and its treatment, for example chemotherapy, can also cause oestrogen levels to fall.

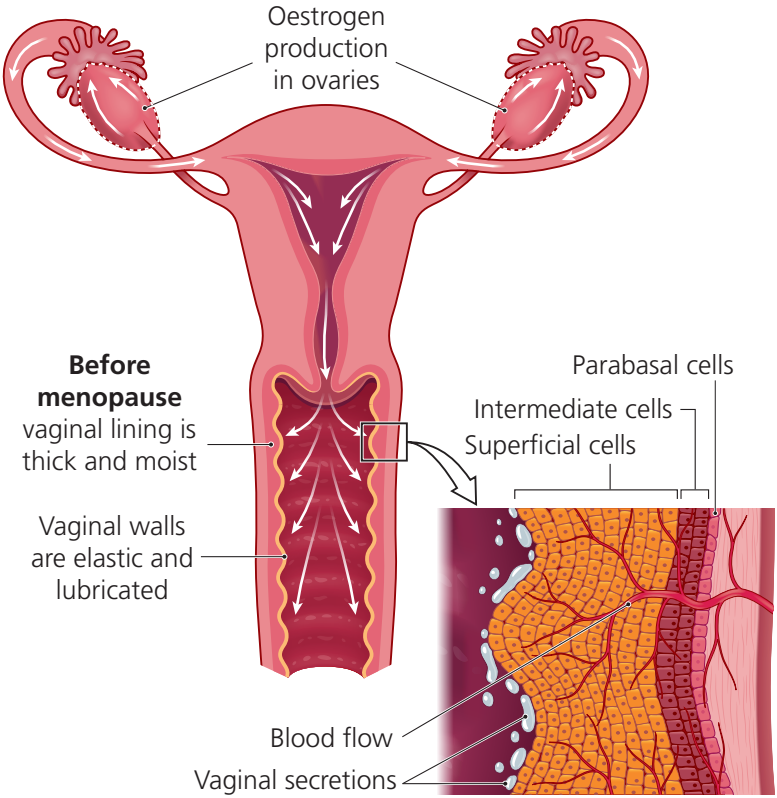
Irrespective of the cause, if levels of oestrogen are low, some women can experience symptoms of UGA.

It can take several years for the effect of a lack of oestrogen on the tissue quality of the vulva, vagina, urethra and bladder to be noticed. For this reason, many women – or their doctors – do not realise that the vaginal dryness, the bleeding and pain during sex and the urinary problems that they experience are due to lack of oestrogen.

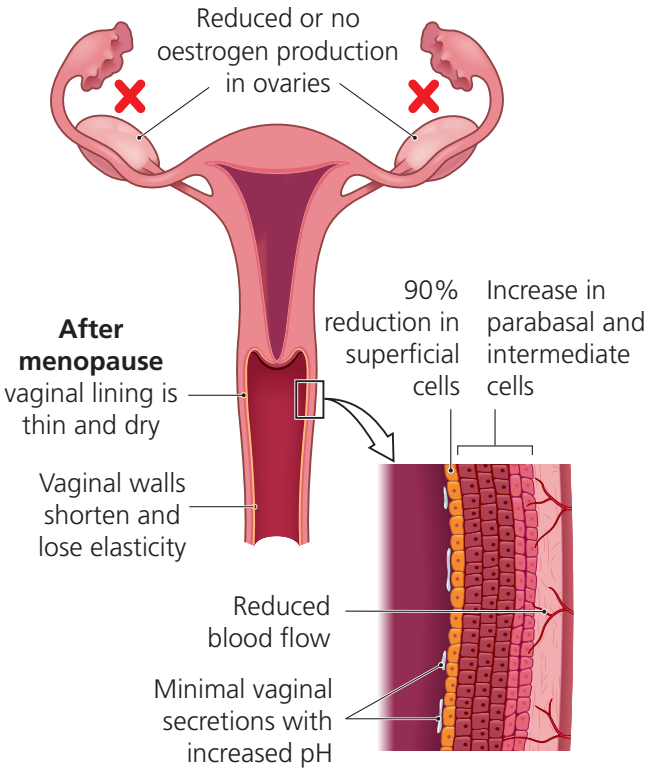
What causes urogenital atrophy?

The premenopausal vagina

The lining of the vagina, called the **epithelium**, is made up of many layers of different types of cells. When oestrogen is produced normally by the ovaries, the lining of the vagina is thick and moist, and the vaginal walls are elastic and lubricated.



The menopausal vagina



Falling oestrogen levels cause changes to occur in the cell layers. So-called **superficial cells** reduce by up to 90%, while the **relative percentage of parabasal** and **intermediate cells** increases. The walls of the vagina become thinner as a result and less elastic. Blood flow to the tissues of the vagina reduces. The drop in oestrogen also results in less lubrication in the vagina, leading to the dryness and irritation that many women experience.

What are the symptoms of urogenital atrophy?

How you experience UGA is individual and will vary from woman to woman. We include a checklist on page 15 of the recognised symptoms. You may find it helpful to show it to your doctor. Below you can read about the most common symptoms in more detail.

Vaginal/vulval symptoms

Vaginal dryness is a very common symptom of UGA. It may well be the first symptom you notice. The dryness can affect the vulval area, too. It may be a mild irritation, a burning sensation in the vagina or it may cause intense discomfort in the vulval area. This can result in scratching, which then makes the skin more likely to itch. An itch/scratch cycle follows which can be difficult to break. Tight clothing can make the discomfort worse. Vaginal dryness leads to painful sex, a symptom many women experience. See pages 16–17.

Vaginal discharge is also common in women experiencing UGA. This is because there is a reduction in healthy vaginal bacteria (lactobacilli) which allows other organisms to overgrow.

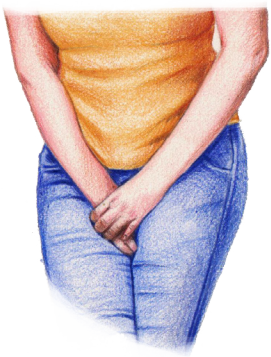
IMPORTANT: Vaginal discharge and bleeding after sex are common but there can be many reasons for these symptoms. It is important to speak to your doctor when you notice either a significant change in discharge and/or blood in your urine. Your doctor may organise an ultrasound scan or a referral to rule out any serious condition.

Bladder symptoms

Bladder symptoms are very often experienced by women with UGA. Painful urination, urge incontinence and stress incontinence are all common.

Painful urination. You may find that it is painful to pass urine. The medical term for this is **dysuria**. Dysuria can be felt as a sharp pain in the urethra, or a stinging sensation.

Overactive bladder is caused when the bladder contracts to empty despite only being partially full. This causes problems during the day and also at night, which disrupts sleep. The medical term for needing to pass urine at night is **nocturia**.



> *"I wee… then immediately need another wee… then it's the anxiety wee. Endless weeing."*

Urge incontinence is a common problem and also occurs with, or is made worse by, UGA. Women who are affected have little warning about the need to pass urine and generally don't go far unless they know where there is a toilet.

> *"Leaking urine is very disturbing, as it takes away your self-confidence in daily activities."*

> *"The first time it happened I was at a music festival, having a great time with my husband. I started to jump up and down like everybody else in the audience – and wet myself. I was absolutely mortified."*

Stress incontinence. Many women find that they leak small amounts of urine during exercise or when laughing or coughing. This can become more problematic as they get older. The medical term for this is stress incontinence.

Stress incontinence is not necessarily caused by UGA, but the lack of oestrogen can be associated with weakening of the pelvic floor muscles, which are important for continence. We talk more about pelvic floor muscles on pages 27–29.

Bladder infections

Symptoms suggestive of **urinary tract infections (UTI)** are common in women with UGA and many women find that after menopause they are treated for recurrent infections. Recurrent means the symptoms keep coming back. To diagnose a UTI, a urine sample needs to be sent to the laboratory to analyse whether excess bacteria are present and to check for antibiotic sensitivity.

A UTI can cause painful urination, a high temperature, cloudy and smelly urine or urine that looks bloody. If you have any symptoms of a UTI, make sure you see your doctor. Treatment is usually with a course of antibiotics. If a UTI isn't treated, it can lead to a kidney or blood infection, which can be very serious.

> *"I have recurrent urinary tract infections and use antibiotics repeatedly. But I also suffer 'frequency of urination' and the continual urge to go. This leads to disturbed sleep, difficulty leading a normal life, fatigue and continual visits to the GP."*

Symptom checklist

My symptoms You can use this table to keep track of your symptoms over 2–3 weeks. Make a note of the severity of your symptoms – mild: 1, moderate: 2, severe: 3 – and how long the symptoms last.			
Vagina & vulva			
Burning			
Discharge			
Itching			
Change in the appearance (vulva)			
Urination			
Burning when urinating			
Urgency			
Frequency			
Leaking urine			
Signs of urinary tract infection			
Pain when urinating			
Cloudy or smelly urine			
Bloody urine			
High temperature			
Repeated infections			
Sexual intercourse			
Discomfort			
Pain			
Bleeding			
Less vaginal lubrication			
Other... (write below)			

Urogenital atrophy and your sex life

Painful sex

Painful sex is a very common symptom of UGA, yet, while it is very common, it is also one of the symptoms that women are less likely to mention to their doctors. This can mean that the symptom is never treated and gets worse with time.

> *"The worst symptom? A dry vagina leading to painful sex. It's like someone is rubbing sandpaper internally."*

Why is sex painful?

As the lining of the vagina thins and becomes dryer because of the reduced levels of oestrogen, any kind of penetration can cause pain. The medical term for painful sex is **dyspareunia.**

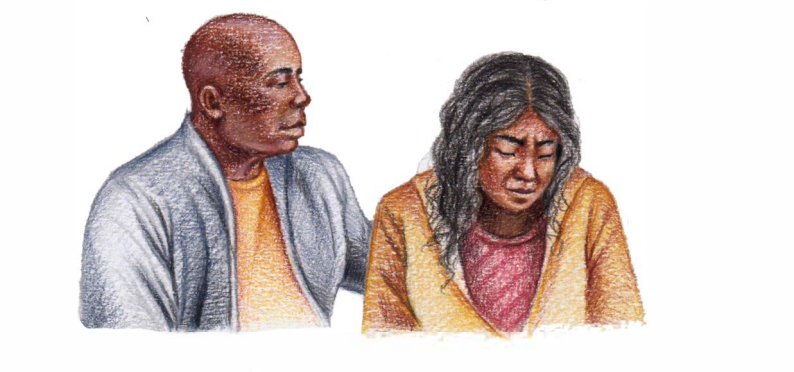
IMPORTANT: A regular pelvic health check and smear test can also cause significant discomfort and may even be impossible to do. It is important to tell the healthcare professional doing the vaginal examination or smear that sex has been painful before they begin the examination.

Bleeding after sex can also happen because the lining of the vagina is thin, with fragile blood vessels close to the surface, and so is more likely to be damaged by friction. This can be frightening, although it is relatively common. However, you should always see a doctor to rule out anything more serious.

How can urogenital atrophy affect your relationships?

Sexual health and wellbeing are very important aspects of your physical and mental health. When it is not diagnosed and not treated, UGA can have a devastating impact on your sex life.

> *"Urogenital atrophy has a big effect on women who are sexually active and may inhibit them or even stop them being sexually active altogether."*



When sex hurts, it is natural to want to avoid it. If you have a partner, they may feel worried about hurting you, which can also make them feel anxious. They may also avoid initiating sex.

For many peri- or postmenopausal women and their partners, sex just doesn't feel the way it used to. A common response for many women is to distance themselves physically and emotionally from their partners.

Information and support

It can be a huge relief for many women to learn that what they're experiencing has a name and is common to many, many other women. Talking to others can be a great source of support and information.

While it's not easy to find a support group specific to UGA, there are many groups relating to the menopause. Many of these groups are online or on social media platforms such as Facebook. We list some recommended support groups at the back of this book.

> *"Painful sex was the worst symptom for me. At one point it affected my relationship with my husband – I thought I was allergic to him! It never occurred to me there was a name for what I was experiencing. It was a huge relief when I found out that it wasn't unusual, and I wasn't alone."*

My notes

You can use this space to make notes

How is urogenital atrophy diagnosed?

Who you see for a clinical diagnosis will depend partly on your symptoms. You may have made an appointment with your GP, a gynaecologist, a urologist, a dermatologist, a specialist nurse or a sexual health practitioner. Some of these people may be able to give you a diagnosis of UGA or, if they suspect this is what you have, a referral to a specialist who can make a diagnosis.

At the moment, however, not every healthcare professional is fully aware of the symptoms and signs of UGA and there is no single, standard test to diagnose it. What this means is that different assessments may be used in the consulting room.

Generally, diagnosis may include some or all of the following.

Patient history. Your doctor should ask you questions about your symptoms. You can give your doctor a clearer picture by not leaving any symptoms out, even if you feel uncomfortable talking about personal or sexual matters. This is vital to reach an accurate diagnosis and to get appropriate treatment.

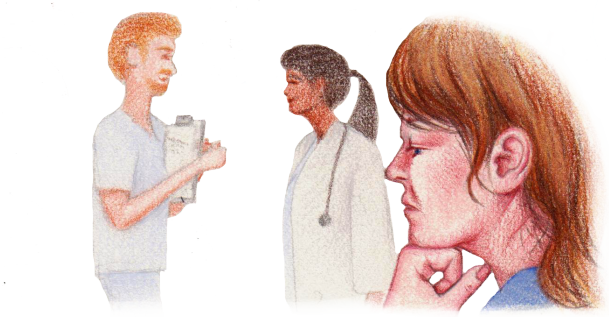
Pelvic exam. A physical examination usually includes a pelvic examination. Along with a detailed list of all your symptoms, a pelvic examination can help to provide your doctor with a potential diagnosis. A speculum test is not always needed as many of the clinical signs can be seen during the examination. A speculum is a medical tool that helps the doctor widen the vaginal walls for examinations.

Vaginal pH. In UGA, the pH level of the vaginal secretions is likely to be 5.5 or higher. The normal pH level is somewhere between 3.8 and 4.5. The pH level is a measure of how acidic or alkaline something is.

Urine dip test if you have bladder symptoms.

What can I do if I don't get a diagnosis?

Urogenital atrophy is underdiagnosed and undertreated. Some doctors are unaware of the link between your symptoms and oestrogen or that treatment is readily available. And some people – both doctors and patients – simply believe that there is little that can be done.



And while your doctor may be sympathetic, they may not offer any treatment. This can be very disappointing.

> *"I had all the symptoms. It was devastating, emotionally, on a private and a professional level. Now it's all under control because I found a new gynaecologist."*

> *"It was only after I had visited several doctors that I got the advice that helped me."*

If you have not been diagnosed with any other condition, and you feel that your symptoms have been dismissed by your doctor, consider finding another doctor to talk to. Local menopause support groups – even those online – are often good sources of names and recommendations.
If you have a good relationship with your doctor, it may be useful to show them a copy of this booklet.

Treatment options

A range of treatment options are available for UGA, both prescription and non-prescription, hormonal and non-hormonal. Vaginal oestrogens are the best form of treatment.

Women using regular HRT for symptoms like hot flushes and night sweats may still develop UGA so are also likely to benefit from the addition of vaginal oestrogen. What you can use will generally depend on your symptoms and how disturbing (serious) they are, as well as your medical history.

Oestrogen, oestradiol, oestriol and oestrone – what's the difference?

Oestradiol, oestriol and oestrone are all forms of oestrogen.

Oestradiol is the dominant form of oestrogen during reproductive years, oestriol is dominant during pregnancy, and oestrone is dominant following the menopause.

Oestradiol is the more potent form of oestrogen. Oestradiol is available in 10 microgram vaginal tablets and an impregnated vaginal ring (7.5 microgram daily).

Oestriol is much weaker: it has only 8% of the potency of oestradiol. Oestriol is available as a cream, pessary or an oily gel.

Oestrone is considered the "weakest" form of oestrogen and is predominant following the menopause. It is not used in any of the treatments for menopausal symptoms including UGA.

Estrogen, estradiol, estriol and estrone are US spellings.

Vaginal dryness and painful sex: how your doctor can help

Vaginal oestrogen. You may be eligible for a prescription treatment with low-dose oestrogen delivered directly to the vagina. Vaginal oestrogen preparations are available as pessaries (vaginal tablets), creams, gels or a vaginal ring. Product names vary between countries. They are equally effective and what you are prescribed will depend on your preference.

Can everybody use vaginal oestrogen?

Vaginal oestrogen is not suitable for everyone. Women who have had a hormone dependent cancer may not be eligible for this kind of treatment, depending on their individual circumstances and ongoing treatment.

Reassuringly though, even women who have had breast cancer may be eligible following a discussion with the specialist teams looking after them. Where women have a significant past medical history, communication with their specialist is important.

Vaginal moisturisers. Your doctor may suggest vaginal moisturisers, which you generally use twice a week to reduce vaginal dryness. They are easily available in a pharmacy or online. Your doctor may also give you a prescription.

Vaginal lubricants. These are available in different formulations and can be used as often as needed. They are particularly important in reducing friction associated with penetrative sex. This may make the difference between being able or unable to have sex. Some water-based lubricants are available on prescription.

Prasterone is another treatment option for UGA. It is a pessary inserted into the vagina daily. It releases a precursor hormone called **DHEA**. A precursor hormone has little effect on its own but converts into another hormone in the body. DHEA is converted in the lining of the vagina to oestrogen and testosterone. There is virtually no absorption into the bloodstream.

Ospemifene is a drug that you take by mouth (orally). Your doctor may suggest it if the treatments above do not work. Ospemifene should be used alone, not taken if you are already using a different HRT and cannot be used by some women with certain cancers or a history of blood clots or stroke.

Dilator therapy may also be proposed by your doctor. A vaginal dilator is used to gently stretch and stimulate the muscles in the vagina. You can use it along with vaginal oestrogen therapy. It may be preferable to use a tapered vibrator.

What you can do

Vaginal oestrogen. A non-prescription vaginal oestrogen product called 'Gina' is available in the UK. It contains 10 micrograms of oestradiol. It is only recommended for women who are post-menopausal (women who have not had a period for at least one year). The pharmacist will check that the product is suitable for you by asking questions about your medical history.

Some women may not be eligible to buy this without a prescription but might be able to access the same thing via their doctor.

Vaginal moisturisers are available from pharmacies or online and can make a world of difference to a dry vagina! They can be used every couple of days and will last longer than a lubricant.

Lubricants are used just before sexual activity and can help reduce pain and discomfort. These are also widely available in pharmacies or online, though it is always better to choose products with a pH level as close to the natural level of the vagina as possible (between 3.8 and 4.5). Cheaper products may contain ingredients that can irritate an already-irritated vagina.

Dilator therapy including use of a tapered vibrator is also something that you can do, even if your doctor hasn't suggested it.

Other types of intimacy. Explore other types of stimulation and intimacy with your partner. Sex does not have to include penetration to be enjoyable. Alternative ways to show affection and share intimacy with your partner are important. Even if you do not feel like having sex, affection is important and can help you both feel better.

My questions

You can use this space to write questions for your doctor about treatment options

Bladder problems: how your doctor can help

Vaginal oestrogen (see pages 21–23) improves urogenital tissue quality, which can help with some bladder symptoms.

Pelvic health physiotherapy. If you are eligible, your doctor may be able to refer you to a specialist pelvic floor physiotherapist. You can read more about this on pages 28–29.

Medication is also available for overactive bladder, though it may not be suitable for everyone.

What you can do

Watch what you eat. Try to avoid spicy foods and artificial sweeteners, as these may irritate the bladder.

Watch what you drink. Have your last drink at least one hour before going to bed. Reducing your intake of fizzy drinks, caffeine and alcohol can help.

Acupuncture uses needles to stimulate pressure points around the body. Electroacupuncture, where a small electric current is passed between two needles, is also used. There is some evidence that acupuncture can help relieve urinary incontinence and frequency.

Work on your pelvic floor. A few sessions with a specialist pelvic floor physiotherapist can be very helpful. If your doctor doesn't refer you, you can make your own arrangements privately. You can read more about this on pages 28–29.

Yoga. There are different aspects to yoga – physical, breathing and meditation to name three – and many different styles of yoga. If you are reluctant to do more intensive sport because of urinary incontinence, yoga is an excellent alternative. It's particularly effective for strengthening the pelvic floor. Yoga can be done in a class or at home – there are many online yoga teachers offering free or low-cost classes. Pilates and Tai chi are also very effective.

More about your pelvic floor

Pelvic health relates to the best possible function of the bladder, bowel and reproductive organs.

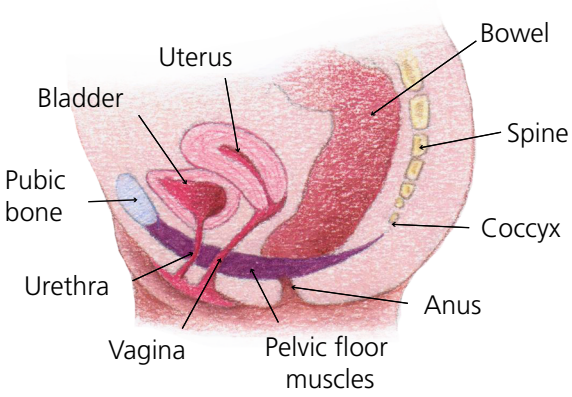
Why is the pelvic floor important?

Your pelvic floor includes not only muscles, but ligaments, nerves and other connective tissues in the pelvic region. Your pelvic floor is key to supporting the pelvic organs and to promoting good bladder, bowel and sexual health.

How can the pelvic floor be weakened?

There are many causes of a weakened pelvic floor. These include the hormonal changes that occur with the menopause, childbirth, heavy lifting, constipation and the resulting straining, and by being overweight and ageing. Poor posture can also contribute.

Where are the pelvic floor muscles?



What is pelvic physiotherapy?

Pelvic physiotherapy is specialist physiotherapy for any problem that relates to the pelvis.

Problems that a pelvic physiotherapist can help with include bladder issues such as urge incontinence, bowel issues such as incontinence or constipation, and other problems caused by weak pelvic floor muscles. Pelvic physios can also help with painful sexual intercourse and pain in the pelvic joints.

What does a pelvic physiotherapist do?

A pelvic physiotherapist will:

- assess the condition of your pelvic floor muscles by seeing how well you can contract and relax them
- assess the support of your pelvic organs, to make sure everything is as it should be
- evaluate your breathing and your posture and explain how to optimise them, if necessary
- work with you to develop a programme of exercises for your pelvic region. These exercises can help existing problems and also reduce the chance of any future problems happening.

Who can see a pelvic physiotherapist?

Specialist pelvic physiotherapy services can be found privately and within the National Health Service (NHS). They can be accessed via your GP or by self-referral.

Other treatments for urogenital atrophy: laser therapy

Laser treatment is another approach to restoring urogenital tissue quality. A probe is inserted into the vagina to apply laser energy to the vaginal wall. Vulval treatments are provided using a different attachment and both treatments are provided in one appointment. The recommendation is for treatments to be delivered every 4–6 weeks, three or four times at baseline, followed by a single annual treatment.

Laser therapy may be useful for women with UGA who cannot use oestrogen, though it isn't yet clear whether it can offer long-term benefits. Like all procedures, there may be some side effects. In the UK, it isn't approved yet for use in the NHS but is an option in the private sector. In future, it will have greatest impact in women failing to respond to vaginal oestrogen or alternative second line options such as DHEA, or in women with a history of a hormone dependent cancer, who cannot have hormonal therapy.

Urogenital atrophy can be a challenging and distressing condition for many women, but there is hope. From hormone therapy to topical treatments and lifestyle changes, there are effective solutions that can alleviate the discomfort and improve the symptoms associated with this condition. Many women have experienced great success in managing and overcoming urogenital atrophy. We hope this booklet has given you the confidence and knowledge to discuss your symptoms and treatment options with your doctor.

Guide to words and phrases

Abdomen: The tummy area between the lower ribs and pelvis.

Bladder: The organ that collects and releases urine from the body.

Cervix: The entrance or 'neck' of the womb, near the vagina.

Chronic: Long-lasting.

Cystitis: A common urinary infection caused by a type of bacteria.

Dyspareunia: Pain during or after sex.

Dysuria: Pain or discomfort when passing urine.

Endometrium: The lining of the womb (uterus).

Fallopian tubes: The pair of hollow tubes leading from the womb to the ovaries.

Fertility: The ability to conceive a baby (become pregnant).

Hot flush: A sudden feeling of intense heat, reddening (of face and chest) and sweating. Often a symptom of menopause.

HRT: Hormone replacement therapy.

Incontinence: Not having full control over the bladder and/or bowel.

Kegel exercises: Well-known exercises for strengthening the pelvic floor.

Labia: The lips of the vulva (majora and minora/big and small).

Libido: Sex drive.

Menopause: When your periods stop due to lower hormone levels. This usually happens between the ages of 45 and 55, but can happen earlier, including because of medical treatments.

Menstrual cycle: The monthly process in which an egg develops and is released and the lining of the womb is prepared for possible pregnancy.

Nocturia: Needing to urinate during the night.

Oestrogen: Estrogen (US). A female sex hormone produced by the ovaries.

Ovaries: A pair of organs (each about the size of a walnut) in a woman's pelvis. They produce follicles from which eggs develop.

Ovulation: When an egg is produced and released as part of a monthly menstrual cycle (a period).

Pelvic floor muscles: Layers of muscle, which support the bladder and other organs in the pelvis.

Pelvis: The lower part of the trunk, between the abdomen and the thighs.

Perimenopause: The time before your periods stop completely. It can last for a few years.

Perineum: The area of skin between the anus and the vagina.

Peritoneum: The tissue that lines the abdominal wall and covers most of the organs in the abdomen.

Postcoital bleeding: Bleeding from the vagina after sexual intercourse.

Progesterone: A hormone produced following ovulation.

Stress incontinence: Leaking urine when abdominal pressure is increased e.g. when jumping or coughing.

Urethra: The tube connecting the bladder to the outside, through which urine passes when it is released from the body.

Urge incontinence: A sudden need to pass urine (wee).

Urinary tract: Also known as the urinary system. The human body's system for removing urine and other waste. It consists of the kidneys, ureters, bladder and urethra.

Urinary tract infection (UTI): Infection in the urinary tract caused by bacteria.

Uterus: The part of the body where a baby develops. Also called the womb.

Vagina: The canal leading from the vulva to the cervix.

Vaginal atrophy: Another name for urogenital atrophy.

Vaginal dilator: Used to gently stretch the vagina when it has become narrowed.

Vaginal oestrogen: A treatment used in the vagina to relieve some of the symptoms of urogenital atrophy.

Vulva: The area around the opening of the vagina.

Womb: Another name for uterus.

Useful resources

Menopause (will include information about UGA)

Daisy Network
daisynetwork.org

Menopause Matters
menopausematters.co.uk

Menopause Support
menopausesupport.co.uk

Menopause Now
menopausenow.com

Pelvic health

Easy Kegel App
easykegel.app

NHS Squeezy App
squeezyapp.com

POGP (Pelvic, Obstetric and Gynaecological Physiotherapy)
thepogp.co.uk

APTA Pelvic Health
aptapelvichealth.org

Women's and Children's Health

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Urogenital Atrophy

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