Information for women

Urogenital problems

Women's Health Concern

Did you know…

- As women get older physical changes can lead to vaginal dryness which may affect sex life and lead to relationship difficulties
- Urogenital problems are common symptoms of the menopause
- Up to 40% of postmenopausal women experience vaginal dryness during the menopause (vaginal atrophy)
- Only 20% -25% of women with symptoms seek medical help
- Many women who experience incontinence link the time that it started with their final menstrual period
- 50% of people over 70 are sexually active
- Some women notice they have enhanced love life after the menopause!

Introduction

After the menopause many women may experience urogenital problems such as vaginal discomfort and urinary incontinence.

The information below will help to explain some of these problems.

Vaginal Atrophy: vaginal dryness, soreness and painful sex

Without the production of estrogen by the ovaries, the skin and support tissues of the vulva ("lips") and vagina become thin and less elastic. This is an inevitable consequence of the menopause and the majority of women will experience some form of symptoms. Vaginal dryness is commonly the first reported symptom. This is due to a reduction in the production of mucus by the glands of the vagina.

Thinning of the vaginal and vulval skin can follow, which in turn makes them more easily damaged. This damage can occur more so during sex, especially if lubrication is also poor and even quite gentle friction can cause pain and discomfort. If the vulval lips are thin and dry, they can often rub on underwear causing soreness. Many women also dislike the outward changes in the appearance of the vulva (lips) as they lose their plumpness. It is not unusual that for many women, sex becomes difficult, painful, and of course unwelcome!

Alteration in the normal vaginal discharge is something noticed by most women after the menopause and also rarely discussed. Without estrogen the pH (acidity) of the vaginal secretions changes and the normal discharge becomes more alkaline (like caustic soda!). This pH affects the balance of the micro-organisms in the natural secretions which in turn suppresses the normal levels of "good" bacteria (lactobacillus). The discharge changes in nature, becoming watery, discoloured and slightly smelly. This often leads to vaginal burning and vulval irritation.

Some seek advice from specialist clinics but most just worry and don't ask for help. Because of this relationships can sadly suffer and this is all completely unnecessary.

Management of vaginal atrophy

Some options that may help include:

- Avoidance of soaps to wash with (perhaps replacing with aqueous cream, available from most pharmacies).
- Treatment of underlying skin problems with topical creams , often after guidance by a specialist and perhaps skin-biopsy.
- Treatment of altered vaginal flora with appropriate antibiotics (often after an examination). This is short-term and may be administered by mouth or sometimes directly into the vagina. This treatment may need to be repeated.
- Local estrogen therapy. It is now well recognised that low doses of estrogen therapy, delivered locally in the vagina, can be effective (see below)

These treatments are effective and acceptable and unlike the conventional form of HRT, the effects are local therefore the risk of systemic side effects are reduced.

Local estrogen therapy

Vaginal dryness, soreness, burning, vulval irritation and chafing can all respond well to local estrogen treatments. This can also help greatly with discomfort, pain during sex, correcting the vaginal pH and stopping the overgrowth of abnormal vaginal flora.

Local low dose treatment with estrogen has been found to have significant effect on the postmenopausal urogenital symptoms related to atrophy.

Estrogen delivered locally can be in the form of:

- Vaginal tablets or pessary: initially taken daily, then twice weekly
- Creams: taken daily initially, then twice weekly
- Vaginal silica ring: changed 3 monthly

Pelvic floor changes and prolapse

Many postmenopausal women become aware of ballooning or bulging of the walls inside the vagina, or even of a feeling of descent of the neck of the womb. Others simply experience a generalised pelvic dragging sensation. About half of post-menopausal women are found to have weakening of the front wall of the vagina (anterior vaginal wall prolapse); about a quarter have similar problems with the back (posterior) wall, and one-fifth with the highest part of the vagina.

The muscles and ligaments of the pelvic floor (which should normally support the womb, bladder and other organs like a trampoline) are also estrogen-sensitive, and changes in collagen, due to estrogen deficiency, have a profound effect on the support mechanisms of the pelvic floor.

The protective covering of the clitoris is often affected by the changes in the collagen of the vulval skin, and the clitoris itself can become sore and traumatised. These skin changes are often so profound that genuine skin conditions emerge (“dermatoses”), and may need separate treatment.

Lower urinary tract symptoms

As they get older many women may find they have problems with their urinary tract (“water-works”).

Some suffer from genuine stress incontinence, which is leaking of urine on coughing, sneezing or jumping, for instance. There is still a lot of debate about whether this is direct result of the loss of estrogen after the menopause.

Urge incontinence is even less commonly referred, some postmenopausal women have difficulty "holding on" once they sense that they need to empty their bladder. They may also leak and start to pass urine before they can get to the toilet.

Other associated symptoms of the overactive bladder include frequency (recurrent need to pass urine) and nocturia (need to pass urine at night leading to recurrent wakening). Some women also feel they need to pass urine, having only just done so. All these may be connected to over activity of the muscle surrounding the bladder.

Recurrent urinary tract infections (UTIs)

This is another form of "waterworks" problem that affects women of all ages, but increases with age with many elderly women being particularly troubled.

Management of urinary problems

Local estrogen

The role of local estrogen in the management of urinary problems is complex. Estrogen replacement therapy has been shown to alleviate urgency, urge incontinence, frequency, nocturia, dysuria (discomfort on passing urine) and reduce urine infections.

Genuine Stress Incontinence would not appear to be helped by estrogen alone, but it does seem to add to the action of other treatments currently used.

Pelvic floor exercises

Other strategies involve pelvic floor exercises. Many women have learnt these techniques for childbirth, but it is well worth revisiting them.

Pelvic-floor physiotherapists are the specialists in this field. They are able to fully assess a woman's pelvic floor function and teach appropriate techniques to strengthen it and train the bladder. They will then reassess and monitor improvements. They often use recording of pelvic floor muscle function, and various devices to help women perform appropriate exercises, such as weighted vaginal cones, or vaginal trainers. Often the practice nurse or GP can suggest referral to these practitioners.

Surgery

Sometimes assessment is needed using "urodynamics" in a specialist clinic, but only rarely is surgery needed. Modern surgical methods, however, are as non-invasive as possible, and very rarely is a hysterectomy needed.

Helpful vocabulary

Here are a few words that you may hear your doctor use:

Atrophic vaginitis – inflammation of vagina/vulva leading to discharge

Cervix – the neck of the uterus, at the top of the vagina

Dysuria – discomfort on passing urine

Dyspareunia – painful sex

Frequency – needing to pass urine often

HRT – hormone replacement therapy

Incontinence – involuntary leakage of urine

Local HRT – hormone replacement therapy applied in the vagina

Menopause – the last menstrual period

Nocturia – needing to pass urine at night leading to wakening

Perimenopause – the phase before the menopause takes place and can last from 5 to 15 years

Postmenopause – the time in a woman's life after the menopause

Premature ovarian insufficiency/ premature menopause – this is when a woman goes through the menopause before the age of 40. The average age of the menopause is 51

Prolapse – the descent of the uterus into the vagina cavity

STI – sexually transmitted infection

Stress incontinence – leaking of urine when coughing, sneezing or laughing

Systemic – circulating throughout the whole body

Thrush (candida albicans) – a fungal overgrowth especially in the vagina

Urethra – tube from bladder to outside through which urine is passed

Urgency – needing to pass urine urgently!

Urge incontinence – Involuntary leakage accompanied by, or immediately preceded by a strong desire to void

Urodynamics – the study of pressure and flow relationships in the investigation of functional disorders of the lower urinary tract (LUT)

Uterus – womb

UTI – urinary tract infection

Vagina – genital canal leading to the uterus

Vaginal atrophy – drying and thinning of the vaginal and vulval skin

Vaginal flora – the micro-organisms in the vagina

Vulva – the external lips of the vagina

This fact sheet has been prepared by Women's Health Concern and reviewed by the medical advisory council of the British Menopause Society. It is for your information and advice and should be used in consultation with your own medical practitioner.

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Discussing difficult problems with a healthcare professional…

Top tips for discussing "embarrassing" problems with a healthcare professional include:

- Make a list of what you want to discuss
- Discuss the most important or most difficult questions first
- Write down what the doctor tells you
- If there is anything that you don't understand, ask for clarification
- If you feel embarrassed take along some information with you. It can be difficult to discuss embarrassing problems face to face, but if you find information on the internet about your symptoms you can use this to help explain and avoid having to make eye contact with your GP whilst discussing the problem
- If you still feel unable to discuss the subject, write it all down and hand it to the doctor
- Don't wait to be asked, give the doctor any information that you may feel is relevant including a history of the condition, symptoms, the impact they are causing you, any lifestyle factors that may have contributed, any medication you are taking etc.

Women's Health Concern

Women's Health Concern is the patient arm of the BMS.
We provide an independent service to advise, reassure and educate women of all ages about their health, wellbeing and lifestyle concerns.

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