

## Vaginitis, Atrophic (Urogenital) – GYN 7

### DEFINITION

Urogenital atrophy, now sometimes referred to as genito-urinary symptoms of menopause (GSM), is the most inevitable consequence of menopause. Women with low estrogen levels experience thinning and a decrease in the rugation and elasticity of the vaginal and vulvar epithelium due to estrogen deficiency. Hypoestrogenic causes of vaginal atrophy may include oral contraceptives, Depo-Provera, or other progestin-only method use; gonadotropin-releasing hormones (GnRH) agonists used for endometriosis; breastfeeding women; perimenopausal and postmenopausal (natural or surgical) women.

### SUBJECTIVE

May include:

1. No symptoms
2. Vulvar pruritus, dyspareunia, or vulvar / vaginal tenderness, or burning
3. Change in vaginal spotting/bleeding
4. Urinary burning, urgency, or frequency
5. Abnormal vaginal discharges or change in discharge and decrease in libido
6. Use of injectable contraceptives
7. Persistent genital symptoms despite systemic hormone therapy
8. Post-coital spotting

### OBJECTIVE

May include:

1. External genitalia: Sparse, brittle pubic hair; lax, wrinkled labia majora; thinning and shrinking of labia minora; fusing of labia minora with labia majora; atrophic clitoris; eversion of the mucosa of the urethral meatus
2. Vagina: Narrowed, stenotic or tender introitus; smooth, flat, thin rugae; dry, initially pale walls, later with diffuse erythema. Discharge may be odorous, thin, watery, thick, purulent, serosanguineous, or bloody, gray, yellow, or green; ecchymosis, petechial hemorrhages may be present; advanced atrophy may result in adhesions or occlusion (kraurosis)
3. Cervix: Small, pale, or erythematous; petechial hemorrhages may occur. The cervix may be flush with the vaginal wall
4. Uterus: Small or nonpalpable. WNL unless coexistent pathology
5. Adnexa, rectovaginal examination: WNL unless coexistent pathology
6. Spotty bleeding from mucosa after speculum or digital exam may require use of virginal speculum

Must exclude:

1. Vulvar lesions suspicious for lichen sclerosis, lichen planus, or serious dermatologic condition including malignancy

### LABORATORY

May include:

1. Pap smear report may note lack of estrogen effect. Cytologic exam (maturation index) reveals increased parabasal and basal cells and decreased squamous epithelial cells. (This test may be useful in women with vaginitis complaints who are using OCPs or are breastfeeding when the diagnosis is uncertain)
2. Wet mount microscopy (10x and 40x power) may be performed. Saline:
  - a. Increased WBCs
  - b. Intermediate/parabasal/basal cells, numerous bacteria identified
  - c. Absence of lactobacilli

KOH:

- a. WNL unless concomitant infection

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Last Reviewed: November 2024

Next Scheduled Review: November 2025

- b. Assess for amine color, hyphae, spores
  - c. Vaginal pH 5.5-7.0
  - d. Urinalysis with culture and sensitivities, as indicated
3. Vaginitis/cervicitis screening, as appropriate

#### ASSESSMENT

Atrophic Vaginitis (Urogenital)

#### PLAN

May include:

1. First-line therapies for less-severe symptoms focus on nonhormonal lubricants (KY Jelly) with intercourse and long-acting vaginal moisturizers, recommended to be used several times/week
2. Vaginal estrogen creams include one of the following if no contraindications to estrogen therapy:
  - a. Conjugated estrogens (Premarin vaginal cream 0.625 mg/gram) 0.5 - 2 gm vaginally for 21 days, then 7 days off OR twice a week
  - b. 17 beta estradiol (Estrace vaginal cream (0.01%) 2-4 gm vaginal daily X 1- 2 weeks. Maintenance: 1 gm vaginally 2-3 X/week. Reevaluate in one month
3. Vaginal rings if no contraindications to estrogen therapy:
  - a. 17 beta estradiol (Estring 2/90day ring) Place deeply in upper one-third of vaginal vault for 90 days and then remove. Reevaluate in one month
  - b. Estradiol acetate (Femring 0.05 or 0.1 mg/day ring) Insert vaginally for 3 months and then remove
  - c. Vaginal tablets (Vagifem or generic equivalent 10 mcg tablets) Start 1 tablet PV QD for 2 weeks. Reduce to one tablet twice a week. Re-evaluate in one month
4. Prasterone (Intrarosa) 6.5 mg vaginally insert nightly
5. Prolonged use of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. The lowest dose that controls symptoms should be chosen, and medication should be discontinued promptly. Assess the need to add progestogen to the patient's regimen for those who have not undergone a hysterectomy. The clinician should assess the need to discontinue or taper therapy with the client at 3 – 6-month intervals.
6. Concomitant progestogen therapy is not necessary with vaginal low-dose estrogen therapy

#### CLIENT EDUCATION

1. Provide the client with education handout(s) and may review the manufacturer's inserts
2. Provide education regarding danger signs of estrogen use that require immediate follow-up:
  - a. Abnormal vaginal bleeding (if any abnormal vaginal bleeding, stop estrogen immediately and contact the clinician)
  - b. Symptoms of thrombophlebitis or thromboembolism
  - c. Severe headaches, dizziness, or changes in vision
  - d. Breast lumps
  - e. Jaundice
3. Encourage sexual intercourse as tolerated and appropriate. Advise estrogen creams/suppositories may reduce the integrity of latex condoms, diaphragms, and cervical caps
4. Dilation of the vagina may be helpful for atrophy
5. Review safer sex education as appropriate
6. Avoid vaginal irritants (i.e., soaps, lotions, and scented panty liners)
7. Recommend client RTC in one month for evaluation or PRN for problems

#### CONSULT / REFER TO PHYSICIAN

1. As necessary to the individual case
2. Any abnormal vaginal bleeding or other danger signs of estrogen therapy

3. Endometrial biopsy in women > 40 years old with abnormal uterine bleeding or increased risk of endometrial hyperplasia
4. Any client with persistent or recurrent symptoms which are refractory to therapy who may need therapy with a non-estrogenic component
5. Any client with vulvar leukoplakia or suspicious vulvar, vaginal, or cervical lesions
6. Any client with a history of breast cancer with persistent GSM despite non-pharmacologic treatments
7. To HCP or PT for pelvic floor exercise treatment or dilator therapy.

## REFERENCES

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