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A pioneer in menopause research, Dr. Utian founded the world's first menopause clinic in Cape Town, South Africa, in 1966 and established the Cleveland Menopause Clinic in 1983.

Recipient of many research grants and awards, he is the author of more than 150 scientific publications and five books. He is the Honorary Past-President of the International Menopause Society and Honorary Founding President and Executive Director of The North American Menopause Society. He is also Chairman of the Council of Affiliated Menopause Societies (CAMS) of the International Menopause Society.

## The Neglected Symptom: Vaginal Dryness

Other than the cessation of menstruation itself, the two most specific early symptoms associated with menopause are hot flashes and vaginal dryness. The former are the usual reason for women to seek help during the perimenopause; vaginal dryness, on the other hand, is frequently not addressed.

I have pondered the reasons for this. In 2002 we certainly cannot credit this lapse to the inability of physicians to open discussion on issues relating to sexual activity. Perhaps some patients are still too embarrassed to raise the subject. Yet vaginal atrophy can be one of the most detrimental changes associated with menopause, resulting in reduced frequency of intercourse and major coital dysfunction, including dyspareunia and postcoital bleeding. Indeed, in keeping with the old adage "use it or lose it," women who reduce sexual activity may have heightened risk of developing even more atrophic vaginal changes.

Another reason vaginal dryness often is not recognized is the misconception by both physicians and patients that current estrogen therapy (ET) or hormone therapy (HT) users are protected. Vaginal dryness is not automatically alleviated by systemic hormone treatments. The mechanism is unclear.

Local vaginal estrogen therapy often is not prescribed for women with "contraindications" to ET or HT. The woman with a treated breast cancer is a case in point.

The atrophic vagina responds rapidly to low-dose applications of estrogen, even in the patient on systemic hormones. This can now be administered in cream, tablet or vaginal ring form, with the choice based on patient preference. The cream or the tablet might be preferable, in that dosage can be intermittent and reduced. For example, one-fourth of an applicator of a vaginal estrogen cream about three times a week invariably provides an excellent response, with extremely low, and probably insignificant, systemic absorption. For this reason, I personally prescribe this to women after breast cancer therapy, even though this is not an FDA-approved indication, provided of course that patients consider vaginal dryness to be problematic enough to need treatment and that they are counseled thoroughly about risks and benefits.

The amount of systemic absorption is quite variable if therapy is prolonged and administered in full dosage, when absorption may be enough to cause systemic effects. Under these circumstances, in women with an intact uterus, progestogen may become necessary, or at least the endometrium may need to be measured by ultrasound. The vaginal route is not generally recommended as the only one for systemic indications.

Women who are averse to using hormones can be advised to use a standard water-soluble vaginal lubricant or one of the nonhormonal moisturizers immediately before intercourse.

The bottom line is to query all patients about vaginal symptoms, including those on ET/HT. Vaginal dryness and dyspareunia should be regular components of a comprehensive gynecologic history.

A handwritten signature in black ink that reads "Wulf H. Utian".

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Honorary Founding President  
The North American Menopause Society*