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Unmet needs in vulvovaginal atrophy (VVA)

Alessandra Graziottin, MD
Director, Center of Gynecology and Medical Sexology
H. San Raffaele Resnati,
Via Santa Croce 10/a, 20122 Milan, Italy
President and Founder, Alessandra Graziottin Foundation
for the cure and care of pain in women Onlus

Vulvo-vaginal atrophy, also called atrophic vaginitis, is a chronic, progressive condition that results from the decrease in oestrogen levels in the vagina that commonly occurs after the menopause. Symptoms include vaginal dryness, dyspareunia, vulvar and vaginal irritation and itching, soreness, vaginal discharge, post-coital bleeding etc. [1]. It is estimated that between 69%[2] and 98%[3] of postmenopausal women have signs of vaginal atrophy, with worsening features with increasing age after the menopause. In cross sectional surveys, around 50% of postmenopausal women complain of symptoms of vaginal discomfort attributable to VVA[4]. VVA has a significant impact on the personal and sexual lives of women and their partners. Vaginal discomfort had a negative impact on many aspects of women's self-esteem and emotional well-being[5]. 75% of postmenopausal women surveyed admitted it had a negative impact on quality of life[6] and relationships with more than 70% of men noting that their partner avoided sexual intimacy because of vaginal discomfort[5]. Despite the impact on quality of life and relationships, the fact that 62% of women complain of moderate or severe symptoms and 55% had the symptoms for 3 or more years[6], vulvar and vaginal atrophy remain an underreported, underdiagnosed and therefore also an undertreated condition[7] for a number of different reasons.

Underreported: Although embarrassment, related to the intimacy of the complaints, is holding women back to seek professional advice, in the VIVA survey among 3520 postmenopausal women, 53% of participants said that they would feel comfortable discussing vaginal discomfort with their doctor. However, 37% would not raise the subject or hesitate to do so[6]. A third would not even tell their partner[5]. A pervading "*collusion of silence*" that translates into a substantial diagnostic neglect is preventing effective communication, both in the high and low income world . In addition, general ignorance about the condition also plays a major role in the underreporting, with only 4% of women attributing their symptoms to vaginal atrophy, and 63% failing to recognize vaginal atrophy as a chronic condition that requires ongoing treatment of the underlying cause[6]. Few women attributed symptoms to menopause (24%) or hormonal changes (12%)[8]. Many women expect their doctor to start the discussion about postmenopausal vaginal health, but 50% of the total survey population claimed that their doctor had not raised the subject[6].
A major educational effort, directed to both physicians and women, is therefore needed to reduce the gap between disabling unmet vaginal needs and the many therapeutic opportunities available today.

Underdiagnosed: The diagnosis of VVA is commonly based on a combination of symptoms, gynaecological history and clinical findings of vulvo-vaginal atrophy during examination (atrophy of the introitus and labia, disappearance of the rugae and a dry, thin, friable mucosa which can be reddened or pale with petechiae), sometimes supported by pH testing (pH>5) and the Vaginal Maturation Index (e.g. < 5 % superficial cells)[1]. It is a clinical diagnosis, but requires the doctor to have an interest in the vaginal health of the patients with 40% of patients expecting the doctor to initiate the discussion[8]. The recent REVIV EU survey revealed that only 2/3 of postmenopausal women with VVA discussed the condition with their doctor and in only 10.3% the doctor initiated the discussion[9]. Women who did discuss symptoms received a VVA diagnosis in 14% of cases[8]. It is

important for physicians to have an interest in the sexual function and erotic value of the vagina of their patients, even if these do not specifically and clearly ask for help.

Undertreated: The underreporting and underdiagnosing of VVA itself leads to undertreatment of the condition. The REVIVE US survey among postmenopausal US women with VVA revealed that only 40% was using any form of treatment, with those who discussed the condition with their doctor being twice as likely to have treatment than those who did not[8]. In the VIVA survey, just under half (49%) of all women with VVA complaints had tried lubricants and moisturizers, but these do not treat the underlying condition[6] and the efficacy on vaginal symptoms is lower than that of topical oestrogen therapy in the trials published thus far. Systemic HRT on the other hand relieves vaginal atrophy in about 75% of women, but is usually not recommended in women with vaginal symptoms only[10]. The mainstay of treatment for VVA has been local vaginal oestrogens. However, in the VIVA survey, 30% of women said that they would not consider taking local oestrogen therapy, even if they knew it to be effective[6]. In the REVIVE EU survey, less than half (45%) of the participants were satisfied with their current treatment. For OTC products the concerns were mainly about efficacy and for local oestrogens they were about safety[9]. Many women, up to 46% in REVIVE US, dislike the messiness of local treatment and nearly a quarter cites lack of efficacy of local oestrogens as an issue. In addition, 9% of women did not fill their prescription for local oestrogens and 38% lapsed on treatment. Most vaginal treatments require a degree of dexterity to self-administer with nearly 20% of women complaining of the inconvenience of the method of administration. Among those who expressed a preference for treatment administration, 55% indicated they would prefer an oral product[8]. Finally, the labels of all local oestrogens exclude women with a history of breast cancer and other hormone dependent cancers as systemic absorption has been demonstrated for these treatments[11,12].

Conclusion: Vulvo-vaginal atrophy in postmenopausal women can lead to symptoms that significantly impact self-esteem, quality of life and relationships. There is a dire need to educate such women about the potential for effective treatment. Doctors and other healthcare providers should be willing to open up the conversation about vaginal health to assist in diagnosing and treating all those women who come to seek help. And finally, since current treatments are limited in their efficacy and convenience, leading to considerable non-compliance with treatment, the range of treatment options needs to be extended so that a suitable treatment can be found for all those women who need it.

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