Primary Care
Women's Health Society

Further reading

Genitourinary syndrome of the menopause (GSM)

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What is Genitourinary syndrome of the menopause (GSM)?

Many women notice changes in their vagina, vulva and bladder (the urogenital area) during and after the menopause. Genitourinary syndrome of the menopause (also known as urogenital atrophy, atrophic vaginitis or vulvovaginal atrophy) is a common and under-reported menopausal condition arising from decreased oestrogenisation of the vaginal tissue. This results in thinning and loss of elasticity of the lining with decreased vaginal blood flow and secretions.

GSM is a chronic, progressive condition, typically developing in the years after the last period, but it can affect some women during the perimenopausal phase. It is estimated that symptomatic GSM affects 50%-70% of all postmenopausal women[1].

One study found that 'many women request effective local treatment too late, when GUSM symptoms are already severe'[2]. GSM treatments should ideally be initiated when symptoms commence and cause distress, rather than later, when symptoms may have become a cause of intolerable distress for the woman.

Treatment for GSM can take up to three months to fully improve symptoms[3]. It is estimated that less than half of patients with GSM receive appropriate treatment[4]. This may be due to a lack of both public and healthcare professional awareness.

What are the symptoms of GSM?

- Vaginal dryness.
- Irritation/burning/pruritus/pain of the vulva or vagina.
- Vaginal discomfort, soreness or dyspareunia.
- Frequency, urgency and discomfort on urination
- Recurrent urinary infection
- Spotting after intercourse.

What is the impact on women?

Symptoms of GSM can have a severe impact on women's quality of life, sexual confidence and enjoyment.

What are the treatment options? (see the table below for more details).

- Non-hormonal topical preparations - vaginal moisturisers and/or vaginal lubricants for intercourse.
- Vaginal creams, gels, tablets or rings containing oestrogen. - vaginal oestrogens can be prescribed in addition to systemic HRT when needed.
- Dehydroepiandrosterone (DHEA) pessary.
- Oral tablet (ospemifene).

The goal of treatment in women with GSM is safe and effective restoration of urogenital physiology and alleviation of symptoms, to enhance quality of life.

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GSM Treatment Comparison Table

Brand names are given as examples – where more than one brand is available, the use of a particular brand name does not imply endorsement of that brand over any others. Clinicians should always refer to the BNF before prescribing.

Product	Active ingredient	Type	Strength	Recommended dose	Notes
Blissel®	Estriol	Vaginal gel	50mcg/g	Daily for 3 weeks then twice a week	• Clear gel containing low dose estriol which is mucoadhesive and highly hydrating. • Aqueous formulation – non-greasy (unlike creams). • Reusable applicator, which can be cleaned in water.
Generic	Estriol	Cream	0.01% w/w	1 applicator full per day for up to 4 weeks, then 1 applicator full twice a week.	• Can be applied with a finger externally as well as internally for vulval symptoms, particularly for urethritis and dryness at the introitus. Consider topical use in addition to other vaginal products (off licence). • Volume is often perceived as messy. • Cream base is oily and can damage condoms. • Contains peanut oil – not suitable for those with a peanut allergy.
Imvaggis®	Estriol	Pessary	30mcg	Daily for 3 weeks then twice a week.	• Very low dose but may be useful as the pessary base is lubricating and aids comfort of insertion. • No bladder data yet and may not offer UTI prophylaxis at this dose.
Ovestin®	Estriol	Cream	1mg in 1g (0.1%)	1 application per day for the first weeks (max. 4 weeks) then gradual reduction based on relief of symptoms, then maintenance dosage (e.g. 1 application twice a week).	• Can be applied with a finger externally as well as internally for vulval symptoms, particularly for urethritis and dryness at the introitus. • Consider topical use in addition to other vaginal products (off licence).
Estring®	Estradiol hemihydrate 2.0mg	Vaginal ring	7.5 mcg/24 hours	1 ring for 90 days (3 months)	• Equivalent to 5 x estradiol 10mcg vaginal tablets per week. • Women can self-fit or can be fitted by a clinician – if inserted far enough in, she will not be aware of it. • Useful with supportive pessaries for prolapse and for women who cannot use a daily pessary themselves. • May be useful for bladder symptoms even with no symptoms of dryness.

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Product	Active ingredient	Type	Strength	Recommended dosage	Notes
Vagifem®	Estradiol hemihydrate.	Vaginal tablet.	10mcg	1 vaginal tablet daily for 2 weeks then 1 tablet twice a week.	• Some women may need more frequent dosage; there is data to show that 50mcg/week does not need progestogenic opposition. No data exists above this dose. • Single-use applicator.
Vagirux®	Estradiol hemihydrate.	Vaginal tablet.	10mcg	1 vaginal tablet daily for 2 weeks then 1 tablet twice a week.	• Equivalent to Vagifem®, other than the fact that the applicator can be re-used.
Intrarosa®	Prasterone	Pessary	6.5mg	One daily	• NICE[5] – consider if vaginal oestrogen or non-hormonal moisturisers or lubricants have been ineffective or not tolerated. • Not first-line. • DHEA, converted by the vaginal epithelium first to testosterone and then potentially to oestrogen.
Senshio®	Ospemifene	Oral tablet	60mg	One daily	• NICE[5] – not first line. • Consider if the use of locally applied treatments is impractical, for example because of disability. • Selective estrogen receptor modulator (SERM) which acts as an oestrogen agonist in the vaginal mucosa, but as an antagonist in breast and endometrial tissue. • It can be considered in women with a history of breast or endometrial cancer, as long as they have completed their treatment – there is no data for women with current breast cancer. • There is limited data regarding long term use for GSM.

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Management of GSM in a woman who has had breast cancer

The following points are taken from the 2024 update of the NICE guidance on menopause[5]; it is always sensible to communicate with the woman's oncologist before starting any hormonal treatment.

- Use non-hormonal moisturisers/lubricants first-line.
- Consider vaginal oestrogen if non-hormonal options do not resolve symptoms, with the following caveats:
    - Vaginal oestrogen is usually not used in women taking aromatase inhibitors – discuss with her specialist.
    - Absorption of vaginal oestrogen is minimal, but not zero.
    - If the cancer was oestrogen receptor negative, vaginal oestrogen is unlikely to increase the risk of recurrence and is likely to be safe.
    - If the cancer was oestrogen receptor positive, it is not known whether vaginal oestrogen will increase recurrence risk; the use of tamoxifen will reduce any such impact.

Resources

- BMS. Urogenital atrophy.
- Women's health concern patient information leaflets on vaginal dryness and urogenital problems.

References

1) Angelou K, Grigoriadis T, Diakosavvas M et al. The Genitourinary Syndrome of Menopause: An Overview of the Recent Data. Cureus. 2020 Apr 8;12(4):e7586.
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3) BMS. Urogenital atrophy. March 2024.
4) Carlson K, Nguyen H. Genitourinary Syndrome of Menopause. [Updated 2024 Oct 5]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-
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