Genitourinary Syndrome of Menopause

Executive Summary for practitioners

REPORT	Case-Based Perspectives on the Management of Genitourinary Syndrome of Menopause
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DESIGN	Case-based narrative review · Mayo Clinic Menopause and Women's Sexual Health Clinic · 5 composite cases

OVERVIEW

This review provides a practical, case-based framework for diagnosing and treating genitourinary syndrome of menopause (GSM), a chronic and progressive condition affecting vulvovaginal, urinary and sexual health. Drawing on the 2025 AUA/SUFU/AUGS guideline, the 2024 NICE network meta-analyses, and current Menopause Society position statements, the authors present five composite patient cases spanning a low-risk postmenopausal woman, three breast cancer survivor scenarios, and a woman with recurrent urinary tract infections. The goal is a clinically actionable synthesis rather than a systematic review, and it does not follow PRISMA methodology.

KEY FINDINGS

- GSM affects an estimated **50–70% of menopausal women** and is progressive — it does not remit spontaneously without treatment.
- Nonhormonal lubricants and moisturizers are appropriate **first-line treatment** for mild symptoms, alone or alongside hormonal therapy.
- For moderate-to-severe GSM, low-dose vaginal estrogen, vaginal DHEA, and ospemifene are all FDA-approved and effective.
- A 605-woman randomized trial found ospemifene produced **significant improvement** in dryness, pain and sexual function versus placebo at 12 weeks.
- Large cohort studies show no increase in breast or endometrial cancer, or cardiovascular events, with low-dose vaginal estrogen in average-risk women.
- In late 2025 the FDA removed the boxed warning from estrogen products, including low-dose vaginal formulations, reflecting updated safety evidence.
- Breast cancer survivors require individualized, oncology-informed decisions; women on aromatase inhibitors specifically need maximal caution and shared decision-making.

CLINICAL IMPLICATIONS

The clinically useful takeaway is that GSM is both common and treatable, yet remains underdiagnosed largely because patients don't volunteer symptoms and clinicians don't routinely screen. A brief, direct question about vaginal dryness, discomfort, or recurrent UTIs at annual visits surfaces a condition most women are quietly

managing alone. The breast cancer survivor pathway deserves particular attention: general low-dose vaginal estrogen safety data does not automatically apply to women on aromatase inhibitors, and those decisions belong in a shared conversation with oncology.

PATIENT IMPACT

Many patients believe GSM symptoms are an unavoidable part of aging and don't realize effective, FDA-approved treatments exist. Others have tried a lubricant, found it insufficient for daily discomfort, and concluded nothing more could be done. The most useful message in consultation is that this is a named, common, progressive condition with multiple treatment pathways — and that waiting does not improve it.

IMPLEMENTATION CONSIDERATIONS

- **Clinical:** Proactively screen for GSM at routine visits rather than waiting for patients to raise it — direct questions about dryness, pain with sex, and UTIs.
- **Clinical:** For low-risk women, low-dose vaginal estrogen, vaginal DHEA, or ospemifene are all reasonable first discussions after nonhormonal options.
- **Clinical:** For breast cancer survivors, involve oncology in the decision, particularly for women on aromatase inhibitors.
- **Practical:** A mirrored pelvic exam can improve patient understanding and engagement with treatment decisions.

LIMITATIONS & CONTEXT

This is a narrative review built around composite illustrative cases, not a systematic review or meta-analysis, and does not follow PRISMA methodology. Clinical trial safety data for low-dose vaginal estrogen is limited to one year in duration, though large cohort studies extend reassurance further. Treatment decisions in breast cancer survivors are described as nuanced and requiring individualized, shared decision-making — the review does not offer a single protocol for that population.

RECOMMENDED NEXT STEPS

1. Add a routine GSM screening question to intake or annual visit templates.
2. Review current patient materials for language that treats GSM as an unavoidable aging change rather than a treatable condition.
3. Establish a clear referral or co-management pathway with oncology for breast cancer survivors with GSM symptoms.
4. Revisit patients previously told to simply use a lubricant if daily symptoms persist.

RESEARCH SOURCE CITATION

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