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Why is Talking about Dyspareunia with our Menopausal Patients so Painful?

Announcer: Welcome to CME on ReachMD. This activity, entitled “Why is talking about dyspareunia with our menopausal patients so painful?” is provided by Omnia Education. This activity is supported by an independent educational grant from AMAG Pharmaceuticals.

Your host is Dr. Prathima Setty. Dr. Setty will speak with Dr. Sheryl Kingsberg, Chief of the Division of Behavioral Medicine in the Department of OB/GYN at University Hospitals Cleveland Medical Center and Professor of Reproductive Biology and Psychiatry at Case Western Reserve University School of Medicine in Cleveland, Ohio.

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Dr. Setty: Vulvovaginal atrophy is the loss of estrogen stimulation on vaginal and vulvar tissue, resulting in atrophy of these tissues. About half of the 64 million post-menopausal women in the U.S may suffer from vulvar vaginal atrophy symptoms, which include dyspareunia, or painful sexual intercourse. Dyspareunia can negatively impact a woman’s sexual function and sexual relationships as well as her overall quality of life. Research has demonstrated that both postmenopausal women and their healthcare clinicians want to engage in discussions surrounding the impact of dyspareunia on sexual functioning in relationships, but for a variety of reasons, these discussions do not take place. This interview will focus on identifying patient and clinician factors that inhibit discussion in the office setting and ways to open the dialogue surrounding dyspareunia. Dr. Kingsberg, welcome to the program.

Dr. Kingsberg: It is a pleasure to be here, and thank you for having me Dr. Setty.

Dr. Setty: So, Dr. Kingsberg, what is the actual prevalence of vulvovaginal atrophy in the U.S. population? How many women does this really impact?

Dr. Kingsberg: Well, Dr. Setty, you actually alluded to some of these numbers before. The fact is that at this point, we have about 64 million women that are postmenopausal in the United States, and we expect that at minimum, 50% are experiencing symptoms of vulvar and vaginal atrophy or genitourinary syndrome of menopause. If you can do the math, that is at minimum, 32 million, but we expect that there is probably more. A lot of that is because these women are going untreated and undiagnosed with only about 7% on any prescription therapies.

Dr. Setty: Why is vulvovaginal atrophy so under-recognized and underdiagnosed?

Dr. Kingsberg: Well, there are a lot of reasons to this. Let’s break down some of most common reasons. One is that women often do not recognize that vulvovaginal atrophy is related to menopause, so they do not know to actually speak to their healthcare provider about VVA – that is what we are going to call it – and also anything that is related to sexuality, because dyspareunia happens to be the most bothersome symptoms for women suffering from VVA that often goes sort of underground. Clinicians and patients really are still kind of uncomfortable talking about VVA. It is interesting; women would assume that their doctor is going to bring it up or their nurse practitioner and the clinician thinks that the patient is going to bring it up.

Dr. Setty: Following up to that, what are the patient barriers to discussing symptoms of VVA and painful sex – you alluded to some of this before – can you further discuss?

Dr. Kingsberg: Absolutely. You know, fair is fair. We have barriers on both sides of that consult room. So, we have patient-based barriers and we have clinician-based barriers. So, let's focus on the patient barriers first. One is, as I alluded to, the fact that women are not even recognizing that VVA, vulvovaginal atrophy, is related to menopause. One reason is because it happens sort of gradually and after they have had their last menstrual period, after they attended to the fact that they are menopausal, most women are well aware that hot flashes are sort of the key symptom of menopause. That is what they know. They know hot flashes and night sweats, and so they are not really paying attention to the fact that a few years after they have hit menopause they may show some gradual signs of vaginal changes, dryness, pain with sex, and so they are not attributing it to menopause. We have some research. In fact, one survey that I published called the REVIVE survey of over 3,000 postmenopausal women with VVA, most did not recognize that VVA was associated menopause, and a third of them had no idea what it was attributed to, so women do not know. Secondly, because VVA symptoms often relate to genital symptoms and particularly sexual problems, women are embarrassed and uncomfortable bringing it up with their healthcare professional. They think, "Oh, I don't know; is this something I should learn to live with? Is this an appropriate topic I should be asking my clinician about? It's sex. I don't know if that's appropriate," so they are very hesitant and they are hoping beyond hope that their clinician will bring it up. So, those are sort of the key features of why women are not addressing it.

Dr. Setty: Dr. Kingsberg, what about the healthcare professional? What are some barriers that healthcare professionals face in discussing painful sex in diagnosing vulvovaginal atrophy?

Dr. Kingsberg: Sure, well, it is not just the patients alone that are hesitant to bring up this topic. We have healthcare provider barriers as well, and one is that clinicians are not really aware of VVA. They are not thinking about it as sort of the most critical thing they should be evaluating, either in a well-woman's visit or even if a woman comes in for some other reason. Their assumption is that if a woman is suffering from symptoms, then she is going to bring it up. I am the trusted healthcare provider. I know that she knows that I will talk about anything; therefore, if she is having a problem, she will bring it up, but there we have that disconnect that sort of conspiracy of silence because the patient is thinking that the clinician is going to bring it up and the physician or clinician is going to assume that the patient is going to bring it up. Secondly, even women's healthcare providers, even clinicians who specialize in women's healthcare, despite the fact that they are comfortable doing a whiff test, they are comfortable talking about things that are coming out of your vagina, they still are not comfortable talking about sex; so, all things are okay except when it comes to talking specifically about sexuality, either because there is a bias that women of a certain age should not be or really are not interested in being sexual, which is a myth, or they are just uncomfortable talking about something specific like sex, and so that conversation often does not happen, so you have a disconnect on both sides. The trouble, though, is it is so sad because here is the disconnect from a simple conversation and we have such simple and effective and safe ways to treat this problem.

Dr. Setty: The REVIVE study also examined women's current use of VVA therapy, what they liked and disliked about these, and their preference for vaginal versus oral therapy. Can you summarize some of these key findings?

Dr. Kingsberg: Sure, and as a reminder, the REVIVE survey was actually the largest survey of women in the US with vulvovaginal atrophy with almost 4,000 women surveyed, so this really is quite the representative sample. What we saw was that 40% reported that they used some sort of therapy, but that includes both prescription and over-the-counter, or OTCs. So about 27% of them who are using therapies said they were using vaginal estrogen therapies. But the 62% who had actually talked to their HCP about symptoms - and remember that's not very many anyway – really talked about the fact that they mostly used over-the-counter therapies, and very few were actually using some combination.

Now the REVIVE survey examined how satisfied women, or dissatisfied women were with their current treatments and many of them were very dissatisfied. First of all, OTCs - lubricants and moisturizers -certainly can only sort of can only give them a little bit of comfort and certainly doesn't resolve the problem and so many of them really felt like they weren't doing the job. Only about 35% actually said that they were satisfied with their treatment – so a lot of them felt if they're using, for example, local estrogen cream or moisturizers or lubricants, they found them very messy.

In terms of oral versus vaginal therapies, really it's an individual process. And the message to me was that clinicians should be asking what is the best option for you because what patient preference does is it drives adherence. So, if you find a therapy that works for your patient, you're more likely to have them adhere.

As to the preference of oral versus vaginal therapy, 39% noted a preference for an oral pill, while 31% noted their preference for a vaginal therapy. And for those women currently using any type of therapy, vaginal therapy was preferred, about 41%, over oral therapy, which was about 35%.

Dr. Setty: Another large survey examined the impact of dyspareunia on women, particularly as it related to their self-esteem, their sexuality, and their relationship with their sexual partner. It also examined the therapies being utilized to treat their dyspareunia. Again,

could you provide some of the key findings?

Dr. Kingsberg: Sure, you know there have been several studies that have looked at women suffering from vulvovaginal atrophy and three of them have been done in the US in particular. One of them is the CLOSER Survey, which stands for the Clarifying Vaginal Atrophy's Impact on Sex and Relationships, and Jim Simon was the first author on the publication of that. And that was really designed to understand, as many of these were, the physical and psychological impact of VVA, of discomfort and pain on women and in the case of the CLOSER, on women and their partners. The study was done in both North America and several countries in Europe, with over 4,000 women with VVA and 4,000 male partners of women with VVA. So they weren't necessarily matched up to be the same, but this was an unusual study in that they were also able to include males. And in the North American survey, there was 500 women in the US, 500 women in Canada and 500 men in the US and 500 in Canada. So they were able to really get a sense of what both women and their partners felt.

And what the survey and the CLOSER survey showed was that not only does VVA cause pain and discomfort during sexual activity, but the impact goes well beyond the bedroom. One third of women reported that they no longer felt sexually attractive and they had lost sexual confidence simply as a result of VVA, and men noticed that in their partners. So it wasn't just the women themselves, but men were sort of noticing the impact on their partners.

Fifty-eight percent of the women reported that vaginal discomfort had led them to avoid intimacy, not just sexual activity, but all intimacy, 64% showed that they lost their sexual desire, and their partners also noticed these differences. Almost 8o% of men said that their partners VVA had caused them to avoid intimacy, so they clearly notice it and 52% had said that they noticed that their partners had lost their sexual desire. And as far as pain goes, almost 80% of both the men and the women responded that it impacted their willingness to engage in intercourse, or penetrative sex. And that downstream effect led to avoidance of all intimate relationships. Thirty percent had actually stopped being sexual altogether simply because of VVA. So we know based on these large surveys that the impact of VVA goes well beyond the bedroom and causes tremendous distress for both women and their partners.

Dr. Setty: And Dr. Kingsberg, could you describe some of those easy and efficient ways for healthcare professionals to open the door to a discussion about painful intercourse and diagnosing VVA?

Dr. Kingsberg: Sure. The first thing to think about is the fact that it should be brought up in almost every annual visit or visit anyway, because as clinicians now know, patients are not going to bring it up. So the simplest thing to do is to normalize it. We assume that since we've got 64 million postmenopausal women and at least 50% have symptoms, that we should be asking, and so the way to do it not to give them an out of a yes/no, but to really invite that opportunity by asking open-ended questions, which I promise does not take long. A lot of clinicians are afraid to ask an open-ended question because they think that is going to lead to a 45-minute answer, but the fact is that you will get a lot more information effectively, efficiently without having to do rapid fire yes/no's if you just ask an open-ended question. In this case, it would be to give a ubiquity statement to normalize to say, "Most of my postmenopausal women have noticed that they have some changes in their vagina as they have aged; what changes have you experienced?" Then, you can follow up with "Do you feel dryness or pain with sexual activity," and women will then absolutely resonate which then leads you right into, "There are a number of safe and effective treatments that with shared decision making, clinicians and patients can find something that will actually lead to greater adherence. We now have local estrogens, which have been around for a long time, which include creams, a vaginal pill and a ring, but we also now have an oral SERM, which is ospemifene. We also have vaginal DHEA prasterone and the CO2 lasers are showing some promise as well – all for safe and effective treatment of VVA. With 32 million at minimum suffering from vulvovaginal atrophy and only 7% on prescription therapies, we certainly have much room for improvement.

Dr. Setty: Well, thank you very much Dr. Kingsberg for taking the time to speak with us about dyspareunia and the issues surrounding this condition.

Dr. Kingsberg: It was my pleasure.

Announcer: This has been a CME activity on ReachMD. This activity is provided by Omnia Education and supported by an education grant from AMAG Pharmaceuticals.

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