Transcript Details
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Having the Talk: Painful Sex Due to Menopause

Narrator:
Welcome to ReachMD. This medical industry feature titled: “Having the Talk: Painful Sex Due to Menopause” is sponsored by AMAG.

We’re first going to hear from Traciee, a patient with dyspareunia.

Traciee:
We are the women who have gone through menopause who have dyspareunia, and there are millions of us, but no one seems to talk about it.

Narrator:
After speaking with her doctor, Traciee had a hysterectomy due to uterine leiomyomas.

Traciee:
I remember him saying something like, “This will induce surgical menopause, so you may have some sexual side effects.” Then in 2013, I realized, Oh my gosh! The sex was agonizing. It literally felt like shards of glass was stabbing me, and it wasn’t just when we were having sex. It was also this external irritation that I was experiencing. I had to know where that tube of lube was at all times. Lube only took the edge off. The sex was still so incredibly painful.

Narrator:
Traciee then met with her hysterectomy surgeon about the pain.

Traciee:
He never mentioned the word dyspareunia or gave my condition a diagnosis. He told me about some prescription treatments, then he told me to go home and think about it. Months and months went by. Sex was still extremely painful. My relationship with my husband was already strained, but this was really making it toxic. The marriage just did not work out. So, I moved on.

Narrator:
Following her move to Portland, Traciee made an appointment with a new primary care physician.

Traciee:
I told her about my hysterectomy. I told her about my surgical menopause, and then I also told her about the pain that I was having with sex. She just had this huge, like ah-ha look on her face. She had just come back from a Women’s Sexual Health Conference. They were actually talking about dyspareunia due to menopause, and she recognized it as something that I had. I’d like to thank you

for listening to my story. I feel like I told it for the millions of postmenopausal women who are experiencing pain with sex. So, please have that conversation with your patient who has gone through menopause and is having trouble with sex. You'll enable her to have the best life that she possibly can. Thank you.

Narrator:
You'll now hear insights on vulvovaginal atrophy, or VVA, from Dr. Sheryl Kingsburg, Brooke Fought, DNP, Dr. Risa Kagan, and Dr. James Simon. VVA is part of the genitourinary syndrome of menopause, or GSM. Here's what they have to say.

Dr. Kingsburg:
Wasn't Tracy so brave? But, unfortunately, this story is not uncommon. We think about the fact that there are 64 million postmenopausal women in the United States. About half of them, at the least, suffer from symptoms of vulvovaginal atrophy or VVA, which is, I can do the math, about 32 million women, and one of the most common symptoms of VVA is dyspareunia. As you all know, VVA is chronic and progressive, and so without treatment, VVA symptoms will worsen over time in most women. Unpublished data from the Reveal Survey, which stands for Revealing Vaginal Effects at Midlife, which I was involved with many years ago, found that about one-third of the women who reported experiencing dyspareunia were still having intercourse at least once a week, despite pain, okay? They were suffering in silence. They had learned to live with these symptoms because they thought it was a natural part of aging, and so there was nothing that could or should be done about it. They didn't know that it was related to menopause. This is so unfortunate because we now know that a third of our lives are going to be spent postmenopausally. That's a very long time to go with either painful sex or no sex. Now dyspareunia may also have an impact well beyond sex. It may impact how a woman feels about herself. In the Closer Survey, some of the women experiencing vaginal discomfort reported feeling upset that their body didn't work the way it used to, or they made them feel old or sexually unattractive, and then they lost their sense of self-confidence, particularly as a sexual partner.

Brooke Faught:
We're very familiar with the anatomic changes of GSM. They include thinning vaginal epithelium, which you see illustrated here. Other vaginal changes include decreased vascularity and increased pH. The most commonly reported VVA symptoms by postmenopausal women in the Revive Survey were vaginal dryness, reported by over half – so 55% of women – and dyspareunia, reported by 44% of women. GSM encompasses changes beyond those affecting the vagina. Other symptoms include pelvic floor disorders, recurrent urinary tract infections due to changes in pH, overactive bladder, urinary incontinence, and constipation. It's not just the vagina. Of course, as women's healthcare professionals, we know that these symptoms are a result of the reduced circulating sex hormones as a part of menopause and as a part of aging.

Dr. Kagan:
I think that most people know, because they know the hallmark of menopause is hot flashes, and that's totally related to estrogen levels, our patients often know that they're declining in estrogen, so, you know, they're having hot flashes. But what they really don't know is that there are other hormones that are also declining. There's other sex steroids, including testosterone and the pro-hormone DHEA, are also declining for women at this age as well. And so I try to explain that to patients, and this decline in the sex steroids in general, postmenopausally, may create and cause dyspareunia, painful sex, dryness – and I tell every patient about this – there are effective treatment options available besides what you can get over the counter.

Narrator:
Despite its prevalence, the mechanism of disease for VVA is not fully understood, and Dr. James Simon will now discuss some theories as to why that is.

Dr. Simon:
Some of our patients know that estrogen plays a role in their menopausal symptoms, but there are other sex steroids involved in the process. Before menopause, the ovaries secrete estrogen. There's also a second source of estrogens, as well as androgens, dehydroepiandrosterone, or DHEA. DHEA is from the adrenal glands. In postmenopause, adrenal DHEA becomes the primary source of estrogens and androgens in the vagina via steroidogenesis. This is the process of specific enzymes transforming the

DHEA intracellularly into androgens and estrogens. By the time a woman reaches menopause, the DHEA levels in her body may have decreased about 60%. This contributes to decreasing levels of sex steroids in her vagina, which may result in dyspareunia. This is a good time to consider the role of androgens in maintaining vaginal health. It is important to remember that the vestibule and its glands have widely distributed androgen receptors, which make urogenital tissues receptive to androgens as well as estrogens. Androgens may further modulate sexual responses that include vaginal lubrication. So, let's take a closer look at the conversion of DHEA into sex hormones. This occurs via steroidogenesis, a process in which a series of steroidogenic enzymes convert that DHEA into androgens and estrogens. There's a theory about how this process is regulated in various tissues. It's called intracrinology. Yes, I said intracrinology, not endocrinology. According to intracrinology theory, DHEA conversion is completed within target peripheral tissues, producing sex hormones to support those tissues. Sex hormones are predominantly inactivated intracellularly through glucuronidation and a few other pathways.

Narrator:
Next, we're going to look at the diagnosis and treatment of VVA, the challenges that practitioners face, and how practitioners can potentially combat those challenges.

Dr. Kingsburg:
Another survey I conducted with some of my colleagues, called the Revive Survey, which stands for the Real Women's Views of Treatment Options for Menopausal Vaginal Changes, about 90% of postmenopausal women with VVA symptoms did not receive a VVA diagnosis. So, if we think that 32 million women, at least, have VVA symptoms, that means about 28 million women in the United States may be living with VVA that haven't even been diagnosed. That happens to be about the population of Texas. And even a diagnosis doesn't translate into adequate treatment. Many women with VVA are not treating their symptoms at all.

Brooke Faught:
One main barrier to the diagnosis and treatment is that women and healthcare professionals – we just don't bring up the conversation about VVA and GSM. 56% of women who responded to the Revive Survey Dr. Kingsburg spoke about, reported they discussed VVA symptoms with a healthcare professional, but only 13% of the healthcare professionals were the ones to bring up that conversation. The Empower Study, which is a survey of over 1,800 women, at least 45 years old, who are experiencing or had experienced symptoms of VVA, found that fewer than half of them had discussed with their vaginal symptoms with their healthcare provider. The conversation is not being had. Other studies provided similar data. Not many women are having these conversations with their healthcare professionals about VVA, and fewer healthcare professionals are bringing up the conversation.

Dr. Simon:
So, I start asking my patient about these changes that they may have with their vagina or sexual activity. I do it long before menopause. Actually, I ask every patient at every visit about their breasts, their bowels, their bladder, their vagina, and their sex life. So, it becomes just part of a routine conversation. Direct, more productive conversations follow, and everything is really quite straightforward.

Dr. Kingsburg:
I think that many women will talk about dryness before they'll talk about pain, and that's sort of the euphemism for saying please ask me more about my sexual life. And asking as an open-ended question, sort of normalizing it, most of my patients have some sexual concerns. What concerns do you have? Instead of hand on the door, you don't have any sexual concerns do you? Makes – gives a different impression.

Brooke Faught:
And I think we can all agree that having patients clothed to have these really intimate conversations is really important to develop that rapport. If patients are sitting there in a very vulnerable state, no matter if it's a man or a woman healthcare provider, I really think it's important to have those conversations while they're clothed.

Dr. Kagan:

And one other thing is that if your hand is on the door, oh my god, that's the last thing – you come back in and you could talk a little, but you really can – this is really impressive. You say to them, this such an important topic. I really want you to come back in a week, two weeks, we're going to sit together and have a consult just specifically about this whole area.

Dr. Kingsburg:
I promise you, if you ask an open-ended question – because we have done the data – and you ask, what sexual concerns do you have? A. You look like the hero. They're going to see you and not go to somebody else, and B. You can answer that question in less than two minutes. They will give you information in less than two minutes, and if it's important, you bring them back. Or if you don't want to address it, you refer them to somebody who can. And the North American Menopause Society has the NCMP. You can find menopause practitioners. You can go to ISWISH and find sexual health practitioners. You don't have to do it. If you only open the door, you're already the hero, and refer them out. Now, we've just seen that many women who suffer from dyspareunia, very few women are actually getting treated, getting diagnosed, they're not talking about it with their healthcare providers. So, we looked at some of the reasons why they're not having this discussion, such as low awareness of the condition among women, embarrassment talking about sex or vaginas, and a resigned acceptance of getting older for many of our women. And, finally, we looked at the biology behind dyspareunia, including the role of DHEA and sex hormones. So, on behalf of all of us, we thank you for coming, and remember to keep having the talk about dyspareunia. Thank you.

Narrator:
This program was sponsored by AMAG. If you missed any part of this discussion, please visit ReachMD.com/dyspareunia. This is ReachMD. Be Part of the Knowledge.