Dyspareunia in Menopause Is Undertreated

Overall, 22%-45% of women who are not using hormone therapy experience dyspareunia.

BY DOUG BRUNK

SAN DIEGO — The prevalence of dyspareunia in menopausal women ranges from 11% to 45%, according to the best estimates in the medical literature.

However, "the literature [on this topic] is terribly flawed," Dr. Andrew T. Goldstein said at the annual meeting of the North American Menopause Society.

"Age alone is often used instead of menstrual status, there's a failure to indicate surgical versus natural menopause, and there's a failure to indicate if women are on hormone replacement therapy, and if so, what types. Also, the use of validated questionnaires is sorely lacking," said Dr. Goldstein, an ob.gyn. practicing in Annapolis, Md., who specializes in the treatment of vulvovaginal disorders.

If anything, he continued, the prevalence of dyspareunia in menopausal women seems to be increasing because of a variety of factors, including the fact that fewer women are taking hormone therapy; overall, 22%-45% of women not on hormone therapy have dyspareunia. In addition, "changing attitudes of postmenopausal women and their sexuality [are factors]. They expect to have sex later in life."

Another contributing factor is the proliferation of phosphodiesterase type 5 inhibitors in recent years, which allow the partners of these women to resume or increase sexual activity.

"Changes in the types of [hormone therapy] are also contributing, going from systemic [HT] to such things as vaginal estradiol tablets or rings which do not treat the vulva," he said.

Dr. Goldstein cautioned clinicians not to assume that the cause of dyspareunia in menopausal women is always atrophic vaginitis. "There are many different causes of postmenopausal dyspareunia," he said.

Many premenopausal women have dyspareunia that is never adequately treated, Dr. Goldstein added. A study by other researchers showed that 40% of women with vulvar pain never sought primary treatment (J. Am. Med. Womens Assoc. 2003;58:82-8). "In addition, at best, only 75% of women given adequate estradiol treatment are cured of their pain," Dr. Goldstein said.

Postmenopausal women 'expect to have sex later in life.'

DR. GOLDSTEIN

However, with a thorough history, physical, and differential diagnosis, "the specific disease process can be determined, and this will determine the correct diagnosis and treatment," he noted.

Evaluations should include an assessment of when the dyspareunia started, the location of the pain, and the nature of the symptoms. "Different symptoms point us in different directions," Dr. Goldstein said. "A throbbing, dull, or stabbing pain can often suggest a pelvic floor dysfunction, whereas dryness or tearing can suggest an estrogen deficiency or vulvar dermatoses. Symptoms such as hesitancy, urgency, frequency, or incomplete emptying, constipation, and rectal fissures can also suggest hypertonus pelvic floor muscles."

He recommended that the physical exam include a careful inspection of the vulva, as at least 75% of dyspareunia cases are vulvar in origin. Special attention should be paid to the vulvar vestibule, "but we have to look at all of the structures," he said.

The exam also should include vulvoscopy to look for areas of erythema, lichenification, fissures, erosions, ulcerations, scarring and architectural changes, evidence of atrophy, hypopigmentation and hyperpigmentation, and evidence of vulvar intraepithelial neoplasm, he said.

Another component of his exam is the "Q-tip test." Begin by touching a moistened Q-tips swab lateral to and then just medial to Hart's line. Touch the vestibule at 1 o'clock and 11 o'clock adjacent to the urethra at the ostia of the Skene's glands. Then touch the vestibule at 4 o'clock and 8 o'clock at the ostia of the Bartholin's gland.

"Frequently there will just be pain posteriorly and not anteriorly," Dr. Goldstein said. "I believe that if you just have posterior pain and not anterior pain, that's almost always a sign of hypertonus of the pelvic floor musculature, and that's often the cause of the dyspareunia. If you have diffuse pain at the entire vestibule, that [points to] an intrinsic problem within the vestibular tissue."

Evaluation of the pelvic floor muscles is also warranted for all women who present with dyspareunia. For this, he said, insert one finger through the hymenal ring. Press posteriorly toward the rectum, and tell the patient "this is pressure." Then palpate the pubococcygeal, transverse perineal, and internal obturator muscles. "For each muscle," he said, "ask, 'Is this pressure or pain?' Are there trigger points? Is there hypertonicity? Can she relax the muscles?"

Next, palpate the urethra and bladder. This "should cause urgency but not burning or pain," Dr. Goldstein said. "If there is intrinsic pain of the bladder, this may suggest interstitial cystitis/painful bladder syndrome."

Last, palpate the pudendal nerves at the ischial spines. Are the nerves more painful than the muscles, or is one side more tender? Tender nerves can indicate pudendal neuralgia or entrapment.

Lab tests should include a wet mount, "which is absolutely essential"; cultures for speciation and sensitivity; tests for gonorrhea, chlamydia, and herpes simplex virus types 1 and 2; and serum tests of estradiol, total and free testosterone, and sex hormone–binding globulin.

"I'm a big proponent of vulvar punch biopsies," Dr. Goldstein added. "I always send my punch biopsies with a differential diagnosis to a dermatopathologist, and I always close the biopsy with one or two interrupted Vicryl sutures."

Atrophic vulvovaginitis is the most common cause of dyspareunia in menopausal women, he said, followed by pelvic floor dysfunction and vulvar dermatoses. Less common causes include vulvar granuloma fissuratum, desquamative inflammatory vaginitis, and interstitial cystitis.

He said he believes the addition of low-dose testosterone to estradiol helps to treat atrophy at the vulvar vestibule, but he acknowledged that this belief is based on his clinical experience and lacks evidence-based studies.

Dr. Goldstein disclosed that he serves on the advisory boards of Boehringer Ingelheim Pharmaceuticals Inc. and Wyeth. He has also received research funding from Novartis. ■

Increased Risk for Depression Remains After Menopause

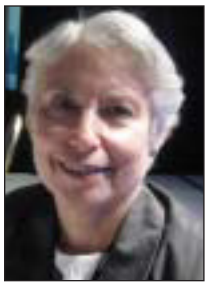
BY DOUG BRUNK

SAN DIEGO — The risk of a major depressive episode more than doubles for women during and after the menopausal transition, compared with when they were premenopausal, results from a 9-year follow-up study showed.

The finding suggests that clinicians "need to pay attention to depressive symptoms during this time in a woman's life, and perhaps do a more extensive assessment both in terms of the current presentation and a history of depression, so they have a better understanding of what the overall risk is for a major depressive episode and how they might intervene to prevent it," the study's principal investigator, Joyce T. Bromberger, Ph.D., said in an interview at the annual meeting of the North American Menopause Society.

She and her associates analyzed 9 years of follow-up data from 221 premenopausal women enrolled at the Pittsburgh site of the Study of Women's Health Across the Nation, a multisite epidemiologic study designed to examine the health of women during midlife. The researchers used the Nonpatient Structured Clinical Interview for DSM-IV Axis I Disorders at baseline to determine lifetime history of major depression and annually to assess current and past-year major depression. They classified the women's status according to self-reported bleeding criteria as premenopausal, perimenopausal, postmenopausal, and postmenopausal on hormones.

Covariates included race, history of major depression at baseline, time-varying age, stressful life events such as the loss of a spouse or a job, use of psychotropic medications, and hot flashes/night sweats. Women who reported a bilateral oophorectomy or hysterectomy were not included in the analyses after the procedure.



The literature has suggested that the increased risk is during the menopausal transition, and not after it.

DR. BROMBERGER

At baseline the women were between the ages of 42 and 52, reported Dr. Bromberger, associate professor of epidemiology and psychiatry at the University of Pittsburgh. Of the 221 women, 129 (58%) transitioned to post menopause over the 9 years and 69 (31%) experienced at least one major depressive episode. Nearly half of women with a history of a major depression at baseline (47%) met criteria for current or past-year major depression, compared with 23% of women without a history of major depression at baseline.

Univariate analyses demonstrated that the greatest risk for having a major depressive episode occurred when women were postmenopausal (odds ratio 3.52) or when they were perimenopausal (OR 2.13), compared with when they were premenopausal.

In the fully adjusted multivariate analyses, women remained significantly more likely to have a major depressive episode when they were postmenopausal (OR 3.79) or perimenopausal (OR 2.05). Odd ratios were also significantly greater for African American women (OR 2.10), women with a history of depression (OR 2.97), and women who reported stressful life events (OR 2.90).

"I was surprised by the increased risk during the postmenopause, because the majority of the literature on depressive symptoms has suggested that the increased risk is during the [menopausal] transition, and not after it," Dr. Bromberger said.

The study was funded by the National Institute on Aging, the National Institute of Mental Health, and the National Institute of Nursing Research. ■