

## **MENOPAUSE MATTERS**

**JULY 2022**

### Vaginal rejuvenation with laser treatment

In April this year, the following summary appeared in the Journal Article Summary Service.

#### **Vaginal laser therapy – cure or con?**

The genitourinary syndrome of menopause (GSM) is a set of symptoms that affects up to half of postmenopausal women and is attributed to the decline of estrogen's effects on pelvic tissues. In particular, the vaginal epithelium becomes less pliant with fewer rugae and decreased elasticity, leading to histological changes. If accompanied by dryness, then women experience itching, pain, and dyspareunia, which can be substantive enough for medical treatment to be sought.

Purveyors of fractional carbon dioxide vaginal laser therapy have claimed rejuvenating outcomes following three treatment sessions over one year that have “no side effects” and last “just a few minutes”. The theory is that local “thermal necrosis in a fraction of the surface area of the vagina induces reparative changes, setting off a cascade of events that results in the remodelling of vaginal epithelium” – a process which purportedly increases collagen production and circulation leading, in the short-term at least, to a reduction of GSM symptoms.

Published proof of laser's efficacy is limited, with only three randomised trials, the pooled data of which (with fewer than 200 participants) showed no difference in symptoms, sexual function, or objective local health indices. A rigorous study from Australia is the first trial to use controlled sham treatment head to head with full standardised treatment and compared the long-term outcomes ([Li et al JAMA 2021;362:1381-9](#)). The results showed that symptomatic and objective parameters were not improved by “real” versus “sham” therapy over 12 months.

*Editorial comment – The literature over the last few years has been remarkably sparse on the proven effects of what was hailed as a major breakthrough in a field in need of progress. Small, short-term reports are quoted by those with financial interests in “laser success” and advertisements touting “regained femininity” do not ring true physiologically. This latest trial has finally called out those pushing a dodgy form of treatment, and it is time to heed scientists asking for reconsideration of the use of lasers for GSM symptoms ([Adelman & Nygaard JAMA 2021;326:1378-80](#)).*

#### **RCOG Scientific Paper**

Now (July 2022) a new Scientific Impact Paper from RCOG has appeared and is [available in full](#) but below is an excerpt from the Plain Language Summary:

“Lasers have been used in the cosmetic industry for collagen remodelling and repair of the skin. Therefore, it has been suggested that laser therapy may be used on the vagina as an alternative treatment for GSM.

A review of all the published studies assessing the safety and efficacy of laser therapy for GSM have shown promising beneficial results.

The majority of studies to date have been small, short-term, observational studies. However, there are randomised controlled trials underway.

Laser treatment may be beneficial for the symptoms of GSM but until more robust evidence is available it should not be adopted into widespread practice, and **should be used as part of a research study only.**”

*Menopause Matters editorial comment: The emphasis on the last 10 words is mine as I remain sceptical of the value of this therapy for the treatment of GSM symptoms. I am concerned that the evidence base for benefit is thin and the potential for harm, significant. We have done patients a huge disservice when we, as a profession, embarked on mesh surgery for prolapse without “due diligence” and long-term outcomes. I sincerely hope we are not going down a similar road with laser rejuvenation. See also Menopause Matters March 2022.*

## Menopause workplace policies

Another topic we have covered has been Menopause Workplace Policies (April 2022) when I questioned the “pathologising” of the menopause transition and whether other political matters were perhaps “more pressing”?

Much movement is occurring in the UK concerning the “[Women’s Health Strategy](#)” policy. The aim remains to promote women’s health across the lifespan, to redress sexual inequalities, to provide excellence in all aspects of care for women and protect women’s rights in law. The latest report being considered in their parliament is the appointment of a [Menopause Ambassador](#) “to keep women in the workplace” since there are more than 4 million women between the ages of 50 and 65 employed throughout the country. Indeed, there are some deficiencies in the legal system that do not assign the menopause transition to a “protected characteristic” and oblige women to “demonstrate their menopausal symptoms amount to a disability, to get redress.”

These anomalies do need resolving, in exactly the same way that legislation in the United States fails to recognise maternity leave as a right, and other countries fail to grant equality or protection of women’s reproductive rights. The ambassador will also be tasked with raising the status of “Clinical Commissioning Groups” to be regional, for fertility facilities to be standard services across the country and menopause hormone therapy to be supplied to any woman in need without extra payment.

Antiquated legal loopholes and preferences for matters other than menopause care, are being brought to the fore. As such the British are pushing other nations to give priority to aspects of the menopause that have not been receiving the profile they deserve.

Again, the question is asked “Whose job is it to champion these causes?”

## Patient wellbeing

Once your patient’s pathology has been dealt with, do you enquire about their general wellbeing? There is evidence that broaching broader subjects can give insights into the reason a person presents herself for consultation or what could be aggravating her symptoms.

“Are there things that are troubling you? are there issues at home? are you making an effort to keep yourself healthy? or simply is there anything else you would like to ask about?” can be rewarding starting points.

The matters of domestic unrest, substance use, gender roles and menopausal concerns are difficult to raise unless given the opportunity. So is obesity.

The international journals are filled with articles about physical activity and proof of its benefits. This has been passed on to *Menopause Matters* readers with regularity and hopefully this trickles down to those who present themselves to you. The classical ½ an hour of brisk exercise 5 times a week remains the basic advice to be given and it rewards participants with better cardiovascular health, less metabolic pathology and improved mental health as well as “lower all-cause and cause-specific mortality rates.” ([dos Santos](#) et al *JAMA Intern Med* 2022;182:840-8).

But what if it is not feasible to take exercise so regularly? Is it acceptable to do more demanding work-outs less frequently? It appears that whether physical activity is spread out or done in bursts, it is equally beneficial. These data are from a cohort of more than 350 000 people followed for at least a decade and the conclusion was the accrual of “similar health benefits whether the sessions are spread throughout the week or concentrated in a weekend.”

This has given rise to the catch-phrase “a weekend warrior” which describes someone who concentrates their activities to the times that are available to them. There is also evidence that short bursts of activity – 10 minutes or less – really do improve your health, mental wellbeing, and fitness” ([Kuzma](#) *Medscape* 2022). It seems every effort is worthwhile, and the bogey is a sedentary lifestyle ([Wendling](#) *Medscape* 2022).

## Painful sex & the menopause transition

Do women experience painful sexual intercourse when they transition the menopause? This is not a topic that is frequently addressed in the international journals, but it may be of interest to women as they approach their menopause.

The SWAN research (Study of Women’s Health Across the Nation) prospectively followed a large group of women for at least 10 annual visits when they answered questions about their sex lives before, during and after their menopause transition. They were asked if they experienced pain with sex (dyspareunia) and the frequency of their sexual activity ([Waetjen et al](#) *Obstet Gynecol* 2022;139:1130-40).

The participants’ patterns of sexual frequency did not appear to change because of pain with intercourse. Where there were changes in frequency, the reasons volunteered were other than dyspareunia. It seems that variations in patterns do not depend on when the woman last had sex. The interpretation was that when pain did occur, it was “not due to less frequent sex” ([Rushton](#) *Medscape* 2022).

Cohort data showed that half of 2 000 women who did not have sexual pain at baseline, did subsequently developed pain at least “sometimes” over the course of their interviews. Those experiencing pain said it was not related to the length of time since they last had intercourse. Frequency of activity was related to other factors such as lack interest and postmenopausal vaginal dryness. A quote from a [discussion about the paper](#) was that: “It will be very reassuring for women to know there’s a study that shows sexual pain doesn’t increase with a decline in sexual intercourse.”

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Menopause Matters is a monthly review of matters menopausal that have recently appeared in the journals. It is produced for the South African Menopause Society and the summaries concentrate on clinical issues although some underlying patho-physiology will be included to ensure a scientific basis for the work. These summaries and opinions do not necessarily reflect the views of the S A Menopause Society. Any clinical decisions made on the data presented are at the reader's discretion.