Therapeutic Pearls

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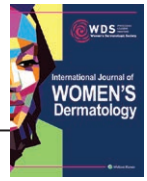

Treating co-existent genitourinary syndrome of menopause in patients with lichen sclerosus improves symptoms

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Clinical problem

A 60-year-old female with history of biopsy-proven lichen sclerosus (LS) returned for follow up after induction of halobetasol ointment twice daily for 2 months. She had resolution of her initial hypopigmented patch on the left labium minus and of the white hyperkeratotic plaques along the perineum. No hypopigmentation, erythema, or erosions were noted on examination. Despite clinical resolution of LS, she experienced an ongoing burning sensation of the vulva with numerous parabasal cells on saline microscopy. With lack of clinically apparent LS, the patient was transitioned to a maintenance regimen for her LS. To address the burning sensation, she was prescribed estradiol cream nightly for 2 weeks followed by twice weekly thereafter. At 3 months follow-up, she reported complete resolution of symptoms and described the estradiol cream as "life-changing."

Therapeutic solution

Genitourinary syndrome of menopause (GSM) stems from a deficiency of estrogen at menopause resulting in symptoms and physical changes to the vulva, vagina, urethra, and bladder.[1] GSM affects 13 to 87% of postmenopausal women and may present with symptoms of dryness, burning, pruritus, and dyspareunia.[2] GSM has a similar symptom constellation to LS. If LS is treated without addressing co-existence of GSM, this may lead to ongoing patient discomfort despite clinical control of LS.

GSM care involves symptom management and the approach to treatment varies with severity of symptoms. First line therapy for GSM includes non-hormonal vaginal moisturizers. However, there are limited data to support symptom improvement with these interventions.[1] For patients with persistent GSM symptoms despite use of non-hormonal moisturizers, estrogen treatments may be prescribed. Vaginal estrogen (VE) is available as a cream, an intravaginal ring, vaginal tablet, and dehydroepiandrosterone insert. Use of low-dose VE in these formulations is associated with minimal absorption.[1]

Estradiol 0.01% cream is typically prescribed as 2 to 4 g nightly for 2 weeks and then tapered to 1 g twice weekly per vagina and applied to the introitus.[1] Since symptoms will recur once therapy is discontinued, it should be continued if symptoms are present.[1] The addition of progesterone is not recommended in women who are low risk.[1] VE treatments carry the same black box warning as systemic estrogen therapy.[1,3,4] However, the Women's Health Initiative study showed no increased risk of cancer, including breast and endometrial cancer, and no increased risk of cardiovascular disease, which includes stroke and venous thromboembolism with VE.[3]

Undiagnosed vaginal bleeding warrants further workup and is an absolute contraindication to starting estrogen therapy.[1] Relative contraindications include estrogen-dependent breast or endometrial cancer in which case, discussion with oncology regarding risks and benefits is recommended and it is recommended to use with caution in patients with increased risk of thrombosis.[1,5] Discussion of health maintenance items such as mammography and close monitoring of VE therapy in patients with increased risk of thrombosis is recommended.[1] Physicians must be knowledgeable about the potential co-existence of GSM with LS in postmenopausal women to effectively manage LS. Management of GSM can be led by the dermatologist or co-managed with the patient's gynecologist or primary care physician.

Conflicts of interest

None.

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Study approval

N/A.

Author contributions

SBC established the concept and outline for the therapeutic pearl. SBC and SD drafted, revised, and prepared the manuscript. Both the authors reviewed the final version of the manuscript and responded to provided edits.

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