CLIMACTERIC 2014;17:29–36

Attitudes and approaches to vaginal atrophy in postmenopausal women: a focus group qualitative study

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Key words: VAGINAL ATROPHY, POSTMENOPAUSAL WOMEN, SYMPTOMS, TREATMENT, PERSONALITY, COUNSELING

ABSTRACT

Objective The impact of postmenopausal vaginal atrophy and women's coping strategies were evaluated through international focus groups.

Methods Three-hour focus groups of three to five postmenopausal women who had symptoms of vaginal atrophy but had not sought treatment were conducted in Canada, Sweden, the United States, and the United Kingdom. Participants were asked about their experience with menopause and vaginal atrophy, including use of non-prescription treatments and their interactions with health-care providers. Women were classified as one of five personality types, based on their interaction with the world (individualism or belonging) and strategies for coping with stress (control or liberation).

Results Vaginal atrophy was not recognized as a medical condition by focus group participants, and women had not used treatments for vaginal atrophy apart from non-prescription lubricants. Women who had discussed vaginal atrophy symptoms with their doctor felt their concerns were dismissed as a normal part of aging, and they did not receive counseling about treatment options such as low-dose estrogen therapy. Those whose coping strategy involved dominance, combatting, or individualism were more likely to seek treatment than those whose strategy involved submission, acceptance, or belonging. Women who used control to cope with menopausal changes were more likely to respond to information validated by perceived experts than were those who used a strategy of release.

Conclusions Women's reactions to their vaginal atrophy varied according to personality. Use of a personality-based approach to patient counseling may encourage patients to discuss vaginal atrophy with their health-care provider and seek treatment.

INTRODUCTION

The menopausal stage of a woman's life may bring a number of changes, especially with regard to her family life, relationships, and work and financial status. During the menopausal transition, vasomotor symptoms such as hot flushes occur due to hormonal fluctuations[1]. Decreased estrogen levels in tissues of the genitourinary tract can also lead to vaginal atrophy (VA), a progressive, chronic condition[2,3]. Symptoms of VA include dryness, soreness and burning or itching of the vagina, dyspareunia, and bleeding following sexual activity[2–4]. These symptoms can be detrimental to a woman's quality of life, including her relationships, sexual satisfaction, and self-esteem[4–6].

Despite the distress caused by symptoms of VA, the majority of menopausal women do not seek treatment[6–8]. The reasons for this reluctance have been surveyed in large cohorts of postmenopausal women and include embarrassment, lack of awareness that VA can be treated, and a failure of health-care providers (HCPs) to initiate conversation about sexual health issues, including VA[8,9].

Human strategies for coping with change can be classified according to two dimensions of personality: a social dimension based on Adlerian individual psychology principles

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ORIGINAL ARTICLE

DOI: 10.3109/13697137.2013.850480

Received 23-07-2013
Revised 25-09-2013
Accepted 26-09-2013

(combatting versus acceptance) and a personal dimension based on Freudian psychoanalytic principles (liberation versus control). Likewise, a woman's individual reaction to the negative changes associated with menopause and VA can be predicted based on her general coping strategies.

This international focus group study classified women by personality type and examined their attitudes toward menopause, VA, and barriers to seeking treatment for VA. Recommendations for a personality-based approach to treatment were also generated based on focus group data; the recommendations included preferred sources of information and aspects of ideal treatment for each personality type.

METHODS

Focus groups took place in March and April of 2010 in Montreal, Toronto, and Calgary in Canada; Stockholm, Sweden; London, Birmingham, and Manchester in the United Kingdom; and New York, Chicago, and San Francisco in the United States, and were held in the national language of the respondents. Three groups were held in each US city and four were held in the other cities; all groups comprised three to five women for a total of 70 women. All participants were postmenopausal (aged between 40 and 75 years), had experienced symptoms of VA, and had not sought treatment for VA. Sessions were held in a non-traditional setting (incorporating living-room-style seating, for example) to encourage creativity and free expression, and women were encouraged to remove their shoes to indicate that this would be an informal atmosphere. Women were also invited to bring an item along which reflected well what being a woman means to them. This allowed them to speak very personally and intimately about what matters for each individual. After thanking the women for participating, each group's moderator was instructed to reassure them that their answers would be kept confidential and that there were no right or wrong answers.

This focus group study was conducted according to the standards of the Market Research Society (http://www.mrs.org.uk/standards/#standards). Women were recruited to participate via various sources, including contacts based on existing consumer panels, placing adverts on online forums, and word of mouth in some cases. Women's attitudes toward menopause, VA, and the treatment of VA were explored using a variety of techniques, including associations, projections (such as selecting pictures to describe a concept), and creating collages. Based on their statements within the focus groups, participants were categorized using the Censydiam approach, a market research analytical method that has been used for 25 years in more than 70 countries. This methodology was validated across 11 countries in four different categories in a PhD thesis conducted in 2007 by a leading Belgian university[10]. The Censydiam approach uses extended interviews in a casual setting using a questionnaire along with a wide range of projective techniques (i.e. fantasy, projections, allegories) in order to elucidate individual patient feelings and motivations. The focus group leaders had a psychology degree and were trained in the Censydiam methodology prior to this study. Further, a Censydiam expert team observed the research and supervised recruitment, development of the discussion guide, preparation of the questions to the participants, and the interviews. Following the research, trained and certified Censydiam executives analyzed the results. Because the discussion is focused on each individual woman's personal feelings, influence from other respondents is minimized. The Censydiam segments are based on motivations, which are universal, and therefore the same personality types are seen all over the world. Two dimensions were used to place the women on a continuum based on their mode of interaction with the world: a social dimension based on Adlerian individual psychology (individualism/dominance versus belonging/acceptance) and a personal dimension based on Freudian psychoanalytic principles (liberation versus control). Women who display individualism/dominance may see change as inconvenient because it can affect their social status and appearance, but they also see it as a chance to show competence and fight back. These people may be described as proactive and resolute. Women who interact with their environment by belonging/acceptance look for protection and guidance and are passive toward change, which they see as neutral or overwhelming. These women often seek solutions that are caring and non-threatening. Individuals who use liberation as a coping strategy view change as constructive and as renewal; they embrace change to cope. In contrast, individuals who cope by attempting to control a situation may feel threatened by and fearful of change. Together, these dimensions define five personality types based on outside interaction and coping strategies (Table 1): (1) *adventurers* (individualism/liberation), (2) *happy-go-luckies* (belonging/liberation), (3) *nurturers* (belonging/neutral), (4) *submissive security seekers* (belonging/control), and (5) *fighters* (individualism/control) (Figure 1).

RESULTS

Personality types

All five personality types were found in each location, although groups in the cities of the United States (Figure 2a), London (Figure 2b), and Sweden (Figure 2c) had more happy-go-luckies and adventurers and fighters, while groups in Canada (Figure 2d) and Manchester and Birmingham (Figure 2e) had more nurturers and submissive security seekers.

Attitudes toward aging and menopause

Focus group participants were asked to select images of women from paintings to describe how they felt about growing older and were asked to describe the meaning of their chosen images. Though some women found a strength and pride in their accomplishments, they also described feeling faded, androgynous, and insignificant or unnoticed in this stage of life. A common theme was the disconnect between a woman's mental sense of self, which had not changed with age, and her physical self, which she sometimes perceived as

Table 1 Coping strategies for menopausal women with vaginal atrophy

Grouping	*Characteristics*	*Exemplary quote*
Adventurers	• Do not want to be limited by responsibilities; freedom and spontaneity are important • Sexuality is important; experimental and more daring • VA limits ability to do what they want to do when they want to do it, including sex • Actively seek solutions to enable them to live life the way they want to	Getting older is OK, but I want to get older and still feel hot
Fighters	• Maintain and control independence; do not want to display a fragile side • Very independent and individualistic; may be perfectionists or compensate by being very individual and eclectic • Sexuality is about being whole as women; want to be in charge • Try to master menopause; may actively seek a solution to VA • Suffer because they are not in control, especially if not prepared for symptoms of VA	I still tell my children, 'Your mother is a woman and a person also'
Happy-go-luckies	• Positive outlook; at ease with themselves • Focus on opportunities that menopause brings; embrace the newfound freedom and maximize life by living it to the fullest • Sexuality is a way to have fun, explore new sensations, and feel close and connected with their partners • Able to find ways around the problem of VA and have open communication with partner • May use humor to cope	I might be going through all this, but it's not the end of the world. I have the hope [that] things will sort themselves out in the future
Nurturers	• Fulfilment comes from helping others; being in a partnership and at the center of the family (e.g. as mother and grandmother) is key • Sex is a way to maintain a close and harmonious connection with a partner, but friendship is more important • VA is less impactful because connection and intimacy are more important than penetration	I was quite sad when my periods ended, but my grandchildren gave me the continuity that helped me to move on
Submissive security seekers	• Feel like their aging bodies have betrayed them • Hold traditional values and think being a woman means making sacrifices and is a burden • May have a victim mentality • Sex is a duty rather than something to be enjoyed; may never have been sexually satisfied • VA is another part of aging to be suffered in silence	I feel limitations of my body more than I used to. My body is letting me down. I am in an irreversible decline

VA, vaginal atrophy

being in decline. Symptoms of menopause that were most concerning to participants were hot flushes and weight gain, while vaginal dryness, a symptom of VA, was moderately bothersome. VA symptoms were considered more serious, however, than disrupted sleep and a loss of skin elasticity. The impact of VA was described in terms of its symptoms (itching and burning, dry inside and out), its effect on relationships (reinforced decreased libido, limited spontaneity), and its emotional effects (reminded women of their age, decreased feelings of femininity, increased embarrassment).

Behavioral adaptations to vaginal dryness included avoiding harsh or drying soaps, showering less often, and wearing breathable fabrics. For women who were sexually active and comfortable communicating with a partner, increased foreplay was cited, whereas women with decreased libido were more likely to choose abstinence. The most common treatment strategy used by focus group participants was application of lubricants. These non-prescription treatments included brands associated with sexual activity as well as oils, moisturizers, and creams. These were used routinely by sexually active women in the United States; however, women in the United Kingdom had more negative associations with lubricants, including the misperception that they are used only by sex workers. In addition to their embarrassment caused by associating lubricants with sex, women had additional complaints related to lubricant use. For example, participants did not like the fact that they were often messy or greasy, were not long-lasting, and needed to be applied directly prior to sexual activity, which decreased spontaneity.

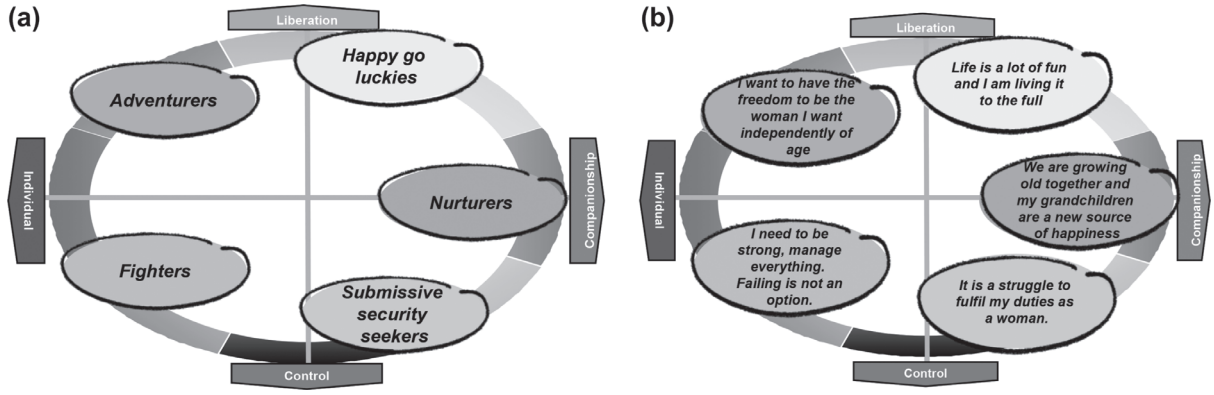

Figure 1 (a) Personality types based on social (*x*-axis) and personal (*y*-axis) dimensions; (b) motivation by personality type

Common barriers to treatment

The focus group participants were selected partly because they had not previously sought treatment for their VA. Their reasons for this included a lack of information about the disorder. The women were less familiar with VA symptoms than they were with other symptoms of menopause, such as hot flushes. Because VA symptoms may occur gradually, women saw them as a natural part of aging. This, coupled with a lack of knowledge of VA treatments and a lack of discussion among their peers, meant that some women were not aware of prescription treatment options. When women were aware of estrogen therapy, they were concerned about an increased risk of breast cancer and of heart disease. These women did not differentiate between the risks of systemic hormone replacement therapy and local estrogen therapy (LET), because they believed that LET still gets into your system.

Although participants may have been uninformed about VA, their HCPs failed to supply this information. The systemic barriers to HCP interaction mentioned by European participants were an appointment structure not conducive to discussion, lack of direct access to specialists, and a low percentage of older female HCPs. A woman in Manchester explained, 'I would like to not be rushed in and out when I go to my GP [general practitioner]. I can only go in with one problem at a time; otherwise I have to make two appointments. I just want to be listened to.' HCPs often did not ask about symptoms associated with VA and, when women broached the topic, displayed a lack of sensitivity to the impact of VA on their quality of life. Another focus group member from Manchester said, 'I did speak to my GP about my symptoms, but he was young. I felt [silly]. I know they have to learn all these things, but honestly I don't think he had a clue. He said [my symptoms will] pass with time [and that I'd be OK]. I felt I'd just wasted my time.' Contrary to the recommendations of the North American Menopause Society (NAMS) and the International Menopause Society (IMS), HCPs did not typically suggest vaginal low-dose LET to women with VA[11,12]. One member of the Stockholm, Sweden, focus group was told by her doctor, 'Just use [lubricant] and your imagination; there's no miracle product.'

Personality-based approaches to vaginal atrophy

Along with the challenges that were experienced by most women in the focus groups, each personality type displayed different approaches to managing VA, concerns regarding treatment, influences, and characteristics of ideal treatment (Table 2). Each personality type was categorized by predominant characteristics. For example, women whose coping strategy involved combatting/dominance (fighters and adventurers) were generally more likely to seek treatment than those whose strategy involved belonging/acceptance (nurturers, happy-go-luckies, and submissive security seekers). Women who used control to cope with menopausal changes (submissive security seekers and fighters) were more likely to respond to information validated by perceived experts, including their HCP, than were those who used a strategy of release (adventurers and happy-go-luckies).

DISCUSSION

This series of international focus groups revealed a variety of attitudes toward menopause that could be characterized according to a woman's coping strategies. The women in these groups also described the detrimental emotional and physical effects of VA. Other studies of postmenopausal women have detailed the negative effects of VA on their quality of life[5,7,8,13]. More than half (52%) of respondents in the Women's Voices in the Menopause study described one or more negative effects of VA; these included effects on their sex lives (40%) and feeling old (32%)[8]. Women who participated in the VIVA (Vaginal Health: Insights, Views, and Attitudes) study said that vaginal discomfort would complicate their relationship with a partner (39%), affect a loving relationship with a partner (32%), and affect feelings of attractiveness (21%)[6]. In a UK-based survey, 42% of women with vaginal discomfort reported making excuses to avoid intercourse and 60% thought it had affected their confidence[7]. In the Clarifying Vaginal Atrophy's Impact on Sex and Relationships (CLOSER) survey of approximately 4000 women with symptoms of VA and approximately 4000 male partners of women who suffered from symptoms of VA

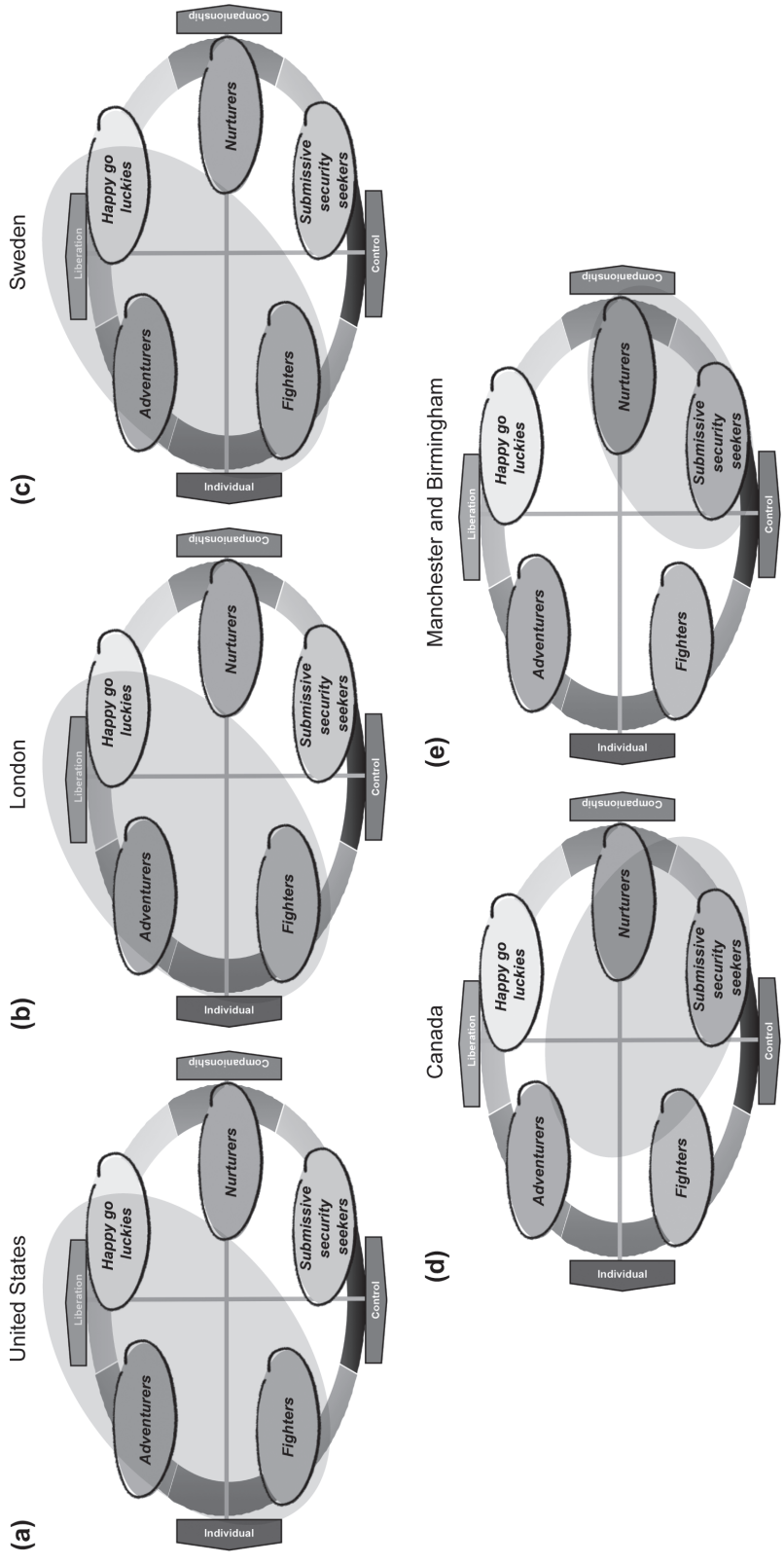

Figure 2 Predominant personality types by location

Table 2 Personality-based approaches to vaginal atrophy treatment

Type	*Behavior*	*Treatments used*	*Barriers*	*Influences*	*Characteristics of ideal treatment*
Adventurers	• Actively seek solutions to ensure they can fulfill their needs, including sexual	• Pharmaceutical and non-pharmaceutical • Sex aids	• Might not be aware of all the options • HCP may be a gatekeeper	• Friends • Internet (websites, media, social networks)	• Long-lasting • Does not eliminate spontaneity or interrupt the moment
Fighters	• Seek empowerment through information • Weigh the risks and benefits	• Anything proven in scientific study	• Lack of options or information	• Physician as primary source • Internet (high-end medical resources rather than social media)	• Scientifically validated • Efficacious
Happy-go-luckies	• Live in the moment; do not dwell on symptoms	• Minimum required to keep them going • Lubrication	• Focus on the positives leads to lack of urgency	• Friends • HCP (if HCP-initiated)	• Easy to remember • Not too complex
Nurturers	• Maintain an intimate relationship with partner, not necessarily involving sex but rather emotional dependency	• Familiar sexual aids (lubrication and saliva) • Foreplay	• Acceptance • Feeling that VA is inevitable • Partner's understanding	• Partner • Friends and family	• Efficacious • Safe for their partner • Does not affect spontaneity
Submissive security seekers	• Avoidant strategy – abstinence is common • Suffer in silence with VA	• Typically none	• Embarrassment • Lack of self-confidence • Not comfortable with their sexuality	• Limited due to poor acknowledgement that they are suffering	• Doctor-recommended • Not applied in front of partner; discreet • Does not require much exploration of vaginal area

VA, vaginal atrophy; HCP, health-care provider.

in North America and Europe, 62% of women reported that vaginal discomfort caused them to avoid intimacy[13,14]. The major reasons for this avoidance were loss of libido, finding sex painful, and concerns that sex would be painful[13,14]. Qualitative results from the focus groups were supported by data from quantitative surveys such as CLOSER and VIVA which confirmed the distress that women feel regarding VA and the urgent need to initiate the dialogue to improve postmenopausal women's quality of life.

Like any study, this focus group-meeting study has both strengths and weaknesses. The strengths include the opportunity for topic exploration and indirect questioning to obtain greater insights into the attitudes of women about VA in a setting conducive to an interchange of ideas. This setting also allowed for ideas to be generated and feelings to be explored by encouraging interaction among the group. Alternatively, the limitations of this qualitative study include small sample sizes and lack of power for statistical analyses, but the purpose of the study was to provide guidance for individualized discussions about VA.

Women in the focus groups had symptoms of VA but had failed to seek treatment for a variety of reasons, including failure to recognize VA as a treatable condition. Similarly, in the VIVA study, only 4% of participants recognized dryness, itching, burning, or soreness in the vagina, or pain during intercourse as VA, and more than half (63%) did not realize that VA was a chronic condition[6].

Clinical practice recommendations

HCP attitudes and practices also discouraged treatment-seeking. Focus group participants reported that HCPs did not initiate discussions of VA and, when these women described VA symptoms to their doctors, they were told that these were a natural part of aging and should be endured. Only 36% of HCPs in the REVEAL (Revealing Vaginal Effects at Mid-Life) survey said they had asked their patients about their vaginal health[9]. Including questions about vaginal health as a routine part of the postmenopausal well-woman examination has the potential to greatly increase the awareness and treatment of VA. In particular, GPs should be mindful that older women may not be receiving care from a gynecologist and should consider asking brief, open-ended questions that include a 'ubiquity' statement describing VA as a common condition of postmenopausal women[15].

Women in the focus groups were asked for their reactions to the term *vaginal atrophy*. Vaginal atrophy was viewed negatively because it sounded medical, overly intellectual, and somewhat frightening. Participants were then given a definition of VA that included a medical explanation of the hypoestrogenic state, a list of common VA symptoms, and a statement that VA is experienced by up to 40% of all women. This definition resonated with many of the women, who thought it described their symptoms, was straightforward, and validated their concerns with a scientific explanation. This experience was echoed by women who participated in the VIVA study; only 2% of respondents thought that vaginal atrophy was a suitable term for dryness, itching, burning, soreness in the vagina, or pain during intercourse[6]. Clinicians may therefore wish to use alternate language to describe VA, such as vaginal health following menopause, vaginal discomfort, or vaginal dryness.

The NAMS and IMS both recommend the use of LET to relieve symptoms of VA that do not respond to non-prescription therapies or where symptoms are severe[11,12]. The options for LET include a conjugated estrogen cream, an estradiol cream, a vaginal estradiol ring, and a vaginal tablet[16,17]. Each of these formulations has been shown to be efficacious, safe, and well-tolerated[12,18–21].

Personality-based approach to patient needs

The women who participated in focus groups were separated into personality types based on their strategies for coping with change. These groups exhibited different behaviors associated with VA and related barriers to seeking treatment. HCPs may similarly incorporate a personalized approach to discussing VA depending on behavioral cues provided by their patients. Women who could be described as adventurers respond best to messages about treatments that can maximize their opportunity for pleasure while also allowing for spontaneity. Adventurers draw information from many sources, particularly those on the Internet. HCPs can help adventurers, who were generally receptive to treatment, connect with scientifically sound resources. Fighters respond best to scientific evidence presented in a straightforward but detailed manner and may therefore be persuaded to seek help by a well-informed HCP. Happy-go-luckies preferred simple, convenient, and easy-to-use treatments. Because these women may cope well with the adversity associated with VA, it is particularly important that their HCP initiate the conversation about VA. Nurturers seek solutions that will bring them closer to their partners while remaining safe for both members of the relationship. Nurturers may feel most comfortable speaking to friends or family; however, an HCP may also provide information in the form of pamphlets that can be shared with a partner. Finally, submissive security seekers can be persuaded by treatment options that are safe and discreet. This latter group was considered the least likely to initiate treatment, but they should not be considered a lost cause as they were among the most likely to respond to HCP recommendations.

CONCLUSIONS

The 70 postmenopausal women who participated in this series of focus groups reacted to the challenges of menopause, including symptoms of VA, in many different ways. These focus groups contributed to a growing body of work showing that menopausal women are often unaware that VA is a medical condition and that it has prescription treatment

options. Based on their patient's personality and their level of comfort and engagement with vaginal health, HCPs may use some of the insights described here to encourage the appropriate use of LET and improve their patient's quality of life.

ACKNOWLEDGEMENTS

Editorial assistance was provided by Amy Troy, PhD, ETHOS Health Communications, Newtown, Pennsylvania, with financial assistance from Novo Nordisk, Inc, Princeton, NJ, in compliance with international guidelines on Good Publication Practice. The authors received no remuneration of any kind for the development of this manuscript.

Conflict of interest Dr Utian has no competing financial interests. Dr Maamari is an employee of Novo Nordisk Inc.

Source of funding The focus groups were organized and conducted by Synovate, an independent market research firm, and commissioned by Novo Nordisk Fem Care AG.

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