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EDITORIAL

Dyspareunia: including this diagnosis in chronic pain reporting

The data from the hormone therapy (HT) arm of the Women's Health Initiative published in 2002 by Rossouw et al[1] changed the course of systemic HT prescribing immediately, and many postmenopausal women were left with few options for managing their debilitating symptoms from estrogen loss. In the almost decade and a half since this report, research is now providing clinicians with a more complete risk/benefit ratio regarding the specifics of individualized hormonal prescribing and the reassurance that HT can be safely used in women who are fully counseled, have indications for its use, and request this intervention. Estrogen's dose and route of delivery, the individual woman's family history with breast cancer gene testing and genetic counseling as needed, age at and years since menopause, and personal medical history help establish each woman's risks as compared to the benefits she will derive from HT use. In this issue of *Menopause*, the research that is presented in the study by Setty et al[2] greatly adds to the menopausal world literature. Most importantly, the findings in this study further assist clinicians in taking care of not only existing postmenopausal women with the specific complaint of dyspareunia but also provides the template to provide optimal and early intervention for the many women who are currently becoming menopausal (which amounts to about 6,000 US women/day or over 2 million women annually) and have sexual pain. Specifically, local estrogen has an important role in the sexual health and well being of the aging population of women and should be offered to appropriately screened women who want intervention for this sexual dysfunction and are not getting adequate relief of their pain from other options. Additionally, as the data in this study suggest, even for postmenopausal women already on systemic therapy, local vaginal application of estrogen should be offered if they continue to report sexual pain.

This latter issue of vaginal estrogen and its role in amelioration or elimination of sexual pain demands the attention of both clinicians and researchers from both the menopausal/hormonal perspective, and is important from the chronic pain perspective. The issue of chronic, noncancer-related pain is already considered a major public health, and financial issue in the aging population. As noted by a recent Institute of Medicine Report "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," the costs to society of chronic pain hovers from $560 to $635 billion annually, a number that includes direct healthcare costs and lost productivity.[3] However, pain during penetrative sex in aging women is usually not included in the chronic pain statistics, since most of these data from the 100 million Americans who suffer from pain report on back pain, severe headache or migraine, neck pain, and facial ache or pain. Chronic sexual pain also should be included in any questionnaires or surveys that inquire about chronic pain, as there are ample data that dyspareunia impacts quality of life (QOL) like other chronic pain conditions. Moreover, as noted in this review, women who are not on systemic HT and were given vaginal estrogens as a management strategy for sexual pain reported a higher score on the sexual QOL scale than those women who did not have this pain issue addressed.

Relief from dyspareunia and the subsequent improvement in QOL have widespread implications in the aging population, as sexual pain has a high prevalence in postmenopausal women. Up to 50% of postmenopausal women will report symptoms of vaginal atrophy, particularly sexual pain, which results from loss of adequate lubrication during sexual exchange. And, although widely known, it bears repeating that women may not be asked about these symptoms during clinical encounters, as noted by Kingsberg et al. In their data from the Real Women's Views of Treatment Options for Menopausal Vaginal Changes (REVIVE) survey, most women do not offer symptoms related to their vulvovaginal health to their healthcare practitioner.[4] Of the 3,036 postmenopausal women with vulvovaginal atrophy who responded to this survey, 44% reported dyspareunia as one of their vaginal symptoms, with 15% reporting this as their only complaint. What is even more striking from this study is that over 80% of the women surveyed reported dyspareunia within the past year. In addition to sexual issues, the REVIVE study also noted several QOL issues which were negatively impacted by the presence of dyspareunia, including relationship with partner (48%), temperament (19%), enjoyment of life (19%), sleep (14%), travel (8%), seeking a new partner(8%), everyday activity (3%), athletic activity (3%), ability to work (3%), and social activity (1%). These far-reaching effects certainly qualify dyspareunia as chronic pain disorder.

Clearly, this current study reinforces the findings of the REVIVE survey—that dyspareunia, especially for women not using HT, can detract from QOL, and that an effective intervention should be offered to affected women by clinicians. What makes this topic more compelling is the fact that additional options that include ospemifene, fractional microablative CO_2 laser, and dehydroepiandrosterone are currently

available or are being studied in clinical trials as additional options for dyspareunia management. Over the counter products also should be included in the management strategy when appropriate. Dyspareunia is chronic pain and should be globally addressed as an important aspect of the clinical care of aging women.

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REFERENCES

1. Rossouw JE, Anderson GL, Prentice RL, et al; Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results From the Women's Health Initiative randomized controlled trial. *JAMA* 2002; 288:321-333.
2. Setty P, Redekal L, Warren MP. Vaginal estrogen use and effects on quality of life and urogenital morbidity in postmenopausal women after publication of the Women's Health Initiative in New York City. *Menopause* 2016;23:7-10.
3. Institute of Medicine Committee on Advancing Pain Research, Care, and Education. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*. Washington, DC: The National Academies Press; 2011.
4. Kingsberg SA, Wysocki S, Magnus L, Krychman ML. Vulvar and vaginal atrophy in postmenopausal women: findings from the REVIVE (REal Women's VIews of Treatment Options for Menopausal Vaginal ChangEs) survey. *J Sexual Med* 2013;10:1790-1799.

