Treating the Intimate Area for Menopausal Patients

Three practitioners share their strategies for identifying and improving the intimate area for menopausal patients

The external genitalia are among the most oestrogen dependent tissues in the body.[1] With the onset of menopause, declining ovarian hormones drive a spectrum of structural and functional changes collectively described as genitourinary syndrome of menopause (GSM); vulvovaginal atrophy, altered pH and microbiome, dyspareunia, lower urinary tract symptoms and recurrent infections.[1,2] Although these manifestations have a clear pathophysiological basis, they remain under reported by patients and are often managed suboptimally in routine practice.[1,3]

Parallel to this, there is growing demand for interventions that address not only function but also aesthetic changes in the vulval region – including labial volume loss, skin laxity, pigmentation changes and perceived alterations in genital appearance.[4]

Aesthetics spoke to menopause specialist Dr Sarah Jenkins; consultant gynaecologist and vulval specialist Miss Smita Sinha; and dermatologist and gynaecologist Dr Farzana Khan on how to assess and treat indications within a medically governed framework.

Emerging evidence for vaginal aesthetic treatments

A prospective, open-label, uncontrolled multicentre study published in the *International Urogynecology Journal* has evaluated the efficacy and safety of hyaluronic acid (HA) filler for restoring volume in women with labia majora hypotrophy or atrophy.[5]

The ESOLANE study enrolled 73 women, with 72 receiving treatment, and followed participants for 52 weeks. At 12 weeks after injection, 97% of patients reported an aesthetic improvement on the Global Aesthetic Improvement Scale. Patient-reported improvement remained above 92% over the full follow-up period, while investigator-assessed improvement remained above 86%.[5]

Participants also reported improvements in sexual function and physical symptoms, alongside high satisfaction. The treatment was well tolerated.

Smaller case-based research published in the *Journal of Applied Cosmetology* has explored combination treatment in women with vulvovaginal symptoms following cancer therapy. In a three-patient series involving women aged 48-60, polyethylene glycol diglycidyl ether (PEGDE)-crosslinked HA filler was combined with bipolar radiofrequency (RF). Presenting concerns included vaginal dryness, dyspareunia, reduced sexual sensation, urge incontinence and labia majora volume loss.[6]

The protocol included one session of labia majora filler and RF, followed by three RF-only sessions at three- to four-day intervals. Between 1-2ml of HA filler was placed in each labium majus using an 18G cannula, in the subcutaneous plane. RF was applied to the vulva and vaginal canal, with settings adjusted to patient comfort. Sexual function was assessed using the validated Female Sexual Function Index (FSFI).[6]

Following the four-session protocol, FSFI scores improved in all three cases, rising from 27 to 31.5, 13.7 to 30.1 and 19.2 to 30, respectively. The mean score increased from 19.9 to 30.5, and one patient also reported an improvement in urge incontinence. No side effects were reported; however, these outcomes are drawn from a small uncontrolled case series and should be interpreted cautiously.[6]

Further evidence, published in *Obstetrics and Gynecology Reports*, suggests that biorevitalisation approaches may have a role in managing vulvovaginal symptoms associated with the GSM. In a prospective cohort study of 19 post-menopausal women experiencing vulvovaginal symptoms for at least one year, participants underwent three priming sessions with polynucleotides (PNs), followed by two consolidation sessions with sodium hyaluronate.[7]

All participants reported rapid symptom improvement after the first two PN treatments, with overall symptom scores decreasing by 42.2% to 52.6% compared with baseline. Improvements were particularly notable for itching, soreness, tenderness and tingling. By the end of the 90-day follow-up period, dyspareunia and vaginal dryness scores had decreased by 59.4% and 59.1%, respectively.[7] While these findings are encouraging, the small, uncontrolled nature of the study means that well-designed controlled trials are required to confirm efficacy and establish the role of this approach in clinical practice.



Figure 1: 49-year-old patient before and three months after one session of Neauvia Intense Rose in combination with four sessions of Sectum Radiofrequency, with ongoing use of Intense Rose Topical Gel. Images courtesy of Dr Farzana Khan.

Menopausal intimate concerns

For many menopausal patients, intimate concerns are primarily functional rather than aesthetic, explains Dr Jenkins. “Most menopausal women do not come to me because they dislike how the vulva looks. They come because of functional problems – dryness, pain, urinary leakage – and the cosmetic concerns sit on top of that,” she says.[8]

Miss Sinha notes there are natural changes in the appearance of both the external and internal genitalia – the vulva and vagina, respectively. “The labia majora and minora can become smaller in volume, while the vagina itself may become shorter and narrower. The skin within the vagina can also become less elastic,” she adds.[9]

Dr Khan explains that these changes are largely caused by declining oestrogen levels. “This can lead to dryness of the mucous membranes, similar to changes seen in facial skin. There is also a reduction in collagen, which contributes to ageing of the vulval skin and vaginal canal,” she says.[9]

Aesthetically, Dr Khan says this can result in a loss of volume which is not a purely cosmetic concern. “When there is greater gaping, the thinner, more fragile lining associated with menopause can make patients more susceptible to infections during sexual intercourse,” she adds.[9]