The silent burden of genitourinary syndrome of menopause in general practice

Sara Whitburn

With menopause gaining long-overdue attention in general practice, an important gap remains. Despite genitourinary syndrome of menopause (GSM) being highly prevalent, affecting more than half of postmenopausal individuals,[1] GSM remains consistently underdiagnosed and undertreated.[2] GSM is not benign. It is progressive with substantial impact on quality of life: sexual, relational and physical.

Questions about vaginal dryness, dyspareunia, urinary urgency, recurrent urinary tract infections and vulval discomfort are important but often do not enter our routine questioning. The evidence reflects this gap: most individuals do not volunteer genitourinary symptoms, and many clinicians do not routinely ask.[3]

This creates a perfect storm. Patients downplay symptoms, assuming they are a normal and inevitable part of ageing.[4] Patients often present with recurrent urinary tract infections or dyspareunia symptoms that have never been linked to GSM. Clinicians, commonly constrained by time and uncertainty regarding the type, availability and safety of moisturisers, lubricants and hormonal treatments to offer for management, may be less inclined to explore these symptoms further. The result often goes unrecognised: quiet, prolonged and often-avoidable suffering.

One of the most transformative experiences in my career was undertaking 6 months of training in vulval health. Almost daily, I found myself asking when managing vulval conditions, 'Why didn't I know this before?' It changed how I take histories, examine patients and give advice about genital skin care across life stages. Just as importantly, it raised an important question: 'Now that I do know, how do I embed this into everyday general practice?'

I now routinely ask about vulval, vaginal and urinary symptoms in menopause consultations. And when I do, patients tell me, often with relief. I have come to see GSM care as one of the most rewarding aspects of general practice. The reason is simple: treatment works.

Normalising these conversations and offering guidance on safe, appropriate genital care products can make a significant early difference. Local vaginal oestrogen is safe, effective and underused. In a large cohort study, only approximately 9% of women with GSM were prescribed vaginal oestrogen, despite strong evidence of benefit.[5] Safety concerns persist, but they are often misplaced. Low-dose vaginal oestrogen has minimal systemic absorption and has not been associated with increased risks of cardiovascular disease, cancer or thromboembolism in current evidence.[2,6] Vaginal dehydroepiandrosterone (DHEA) now provides another option to add to the treatment toolkit.

This disconnect between evidence and practice is something we need to actively address. In the article 'The assessment and management of genitourinary syndrome of menopause in primary care' in this issue of *Australian Journal of General Practice*,[7] I discuss approaches to history, examination and management of GSM in general practice. I also emphasise the importance of a trauma-informed approach. For some patients, genitourinary symptoms, and particularly examination, may be shaped by past experiences of trauma, pain or dismissal. Taking time, offering control and ensuring consent are not optional extras; they are central to effective care.

GSM management intersects with broader menopause care, including use of systemic and topical menopausal hormone therapy (MHT). In this second issue on menopause, Dr Ruth Spencer builds on the previous menopause issue's articles on menopause management with tips for troubleshooting MHT.[8]

Burns et al discuss menopause, cardiovascular health and the role of hormone therapy.[9] Caution around MHT and cardiovascular disease remains. However, contemporary guidance supports a more nuanced, individualised approach: assessing baseline cardiovascular risk, considering timing relative to menopause, and selecting appropriate formulations such as transdermal oestrogen where indicated.[10]

Goeltom and Sztal-Mazer examine the relationship between menopause and bone health,[11,12] highlighting that MHT, when initiated around the time of menopause, can reduce bone loss and fracture risk. This makes it a key area where menopause management aligns directly with preventive healthcare. Although guidelines recommend screening, access to dual-energy X-ray absorptiometry remains restricted by Medicare criteria.[13] This can delay risk assessment and complicate shared decision making. Despite improved Pharmaceutical Benefit Scheme access to MHT and new Medicare rebates for menopause consultations, financial and regulatory factors continue to influence menopause care.

And importantly, not all vulval symptoms are GSM.

This issue also contains an article on the management of stable vulval lichen sclerosus.[14] Improved understanding of

this chronic condition will support growing confidence in managing vulval disease in general practice.[15] Lichen sclerosus, when underdiagnosed or undertreated, can lead to discomfort, pain and sexual dysfunction. This underscores the importance of maintaining diagnostic vigilance when assessing genital skin conditions.

So where does this leave us?

For me, the answer is simple: we must start by asking. A single, routine question – 'Have you noticed any changes in your vaginal, vulval or bladder health?' – can open the door to conversations patients have been waiting years to have.

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Competing interests: None.

AI declaration: The author advises that there was use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript, and accepts full responsibility for all content. Details on how AI was used have been declared to the Editors.

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Erratum

Sleaby R, Furler J, Sanci L. Digital health inequity in Australian primary care. Aust J Gen Pract 2026;55(5):259–63. Available at www1.racgp.org.au/ajgp/2026/may/digital-health-inequity-in-australian-primary-care

In this article under the subheadings 'Challenges for bridging the digital health divide' and 'Practitioners', in the second sentence of this section it stated that a 'lack of practice resources' favours innovation. This should be: 'practice resources'.

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