



Complete Summary

GUIDELINE TITLE

Urogenital health. In: Menopause and osteoporosis update 2009.

BIBLIOGRAPHIC SOURCE(S)

Urogenital health. In: Menopause and osteoporosis update 2009. J Obstet Gynaecol Can 2009 Jan;31(1 Suppl 1):S27-30. [32 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Johnston S. Urogenital concerns. In: Canadian consensus conference on menopause, 2006 update. J Obstet Gynaecol Can 2006 Feb;28(2 Suppl 1):S33-42. [79 references]

Basson R. Sexual concerns--menopause and sexual function. In: Canadian consensus conference on menopause, 2006 update. J Obstet Gynaecol Can 2006 Feb;28(2 Suppl 1):S43-52. [54 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

- Menopause
- Urogenital atrophy
- Urinary incontinence

GUIDELINE CATEGORY

Management
Risk Assessment
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To provide updated guidelines for health care providers on the management of menopause in asymptomatic healthy women as well as in women presenting with vasomotor symptoms or with urogenital, mood, or memory concerns, and on considerations related to cardiovascular disease, breast cancer, and bone health, including the diagnosis and clinical management of postmenopausal osteoporosis

TARGET POPULATION

- Menopause in asymptomatic healthy women
- Menopause in women presenting with vasomotor symptoms, urogenital, sexual, and mood and memory concerns and specific medical considerations, and cardiovascular and cancer issues

INTERVENTIONS AND PRACTICES CONSIDERED

1. Biopsychosexual assessment
2. Pharmaceutical options
 - Conjugated estrogen (CE) cream
 - Progestin co-therapy
 - Vaginal lubricants
 - Vaginal estrogen therapy
3. Non-surgical treatment options
 - Weight loss (in obese women)
 - Pelvic floor physiotherapy with or without biofeedback
 - Weighted vaginal cones
 - Functional electrical stimulation
 - Intravaginal pessaries
4. Lifestyle modification
 - Bladder drill
 - Antimuscarinic therapy

MAJOR OUTCOMES CONSIDERED

- Symptom relief
- Side effects of therapy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE was searched up to October 1, 2008, and the Cochrane databases up to issue 1 of 2008 with the use of a controlled vocabulary and appropriate key words. Research-design filters for systematic reviews, randomized and controlled clinical trials, and observational studies were applied to all PubMed searches. Results were limited to publication years 2002 to 2008; there were no language restrictions. Additional information was sought in BMJ Clinical Evidence, in guidelines collections, and from the Web sites of major obstetric and gynaecologic associations worldwide.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence from well-designed controlled trials without randomization.

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.

II-3: Evidence from comparisons between times or places with or without the intervention. Dramatic results from uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

* Adapted from the Evaluation of Evidence criteria described in: Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169(3):207-8.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The authors critically reviewed the evidence and developed the recommendations according to the methodology and consensus development process of the Journal of Obstetrics and Gynaecology Canada.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations*

- A.** There is good evidence to recommend the clinical preventive action
- B.** There is fair evidence to recommend the clinical preventive action
- C.** The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making
- D.** There is fair evidence to recommend against the clinical preventive action
- E.** There is good evidence to recommend against the clinical preventive action
- L.** There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*Adapted from the Classification of Recommendations criteria described in: Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169(3):207-8.

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

Not stated

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not applicable

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of recommendations (A-E and L) and levels of evidence (I, II-1, II-2, II-3, and III) are defined at the end of the "Major Recommendations" field.

Urogenital Concerns

1. Conjugated estrogen cream, an intravaginal sustained-release estradiol ring, or estradiol vaginal tablets are recommended as effective treatment for vaginal atrophy. **(IA)**
2. Routine progestin cotherapy is not required for endometrial protection in women receiving vaginal estrogen therapy in appropriate dose. **(IIIC)**
3. Vaginal lubricants may be recommended for subjective symptom improvement of dyspareunia. **(IIIC)**
4. Health care providers can offer polycarbophil gel (a vaginal moisturizer) as an effective treatment for symptoms of vaginal atrophy, including dryness and dyspareunia. **(IA)**
5. As part of the management of stress incontinence, women should be encouraged to try nonsurgical options such as weight loss (in obese women), pelvic floor physiotherapy, with or without biofeedback, weighted vaginal cones, functional electrical stimulation, and/or intravaginal pessaries. **(II-1B)**
6. Lifestyle modification, bladder drill **(II-1B)**, and anti-muscarinic therapy **(IA)** are recommended for the treatment of urge urinary incontinence.
7. Estrogen therapy should not be recommended for the treatment of postmenopausal urge or stress urinary incontinence but may be recommended before corrective surgery. **(IA)**
8. Vaginal estrogen therapy can be recommended for the prevention of recurrent urinary tract infections in postmenopausal women. **(IA)**
9. Following treatment of adenocarcinoma of the endometrium (stage 1) estrogen therapy may be offered to women distressed by moderate to severe menopausal symptoms. **(IB)**

Sexual Concerns

10. A biopsychosexual assessment of preferably both partners (when appropriate), identifying intrapersonal, contextual, interpersonal, and biological factors, is recommended prior to treatment of women's sexual problems. **(IIIA)**
11. Routine evaluation of sex hormone levels in post-menopausal women with sexual problems is not recommended. Available androgen assays neither reflect total androgen activity, nor correlate with sexual function. **(IIIA)**

12. Testosterone therapy when included in the management of selected women with acquired sexual desire disorder should only be initiated by clinicians experienced in women's sexual dysfunction and with informed consent from the woman. The lack of long-term safety data and the need for concomitant estrogen therapy mandate careful follow-up. **(IC)**

Definitions:

Quality of Evidence Assessment*

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Classification of Recommendations**

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*The quality of evidence reported in these guidelines has been adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.***

Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.*

***Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169(3):207-8.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of urinary incontinence in post menopausal women

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

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This guideline reflects emerging clinical and scientific advances as of the date issued and are subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2006 Feb (revised 2009 Jan)

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The following conflicts of interest have been disclosed by the authors.

Dr Reid: Speaker or consultant to Wyeth, Bayer, Organon, Proctor and Gamble, Novo Nordisk; advisory boards: Paladin, Wyeth; research support: Organon, Bayer.

Dr Blake: Speaker or consultant to Wyeth, Merck, Glaxo Smith Kline, Bayer; advisory boards: Bayer, Wyeth and Lilly, Novo Nordisk.

Dr Abramson: Speaker or consultant to Abbott, Astra Zeneca, Boehringer Ingelheim, Bristol Myer Squibb, Dupont, Eli Lilly, Lifespeak, Novartis, Fournier,

Merck Frosst, Pfizer, Servier, Schering, Sanofi-Aventis; advisory boards: Astra Zeneca, Boehringer-Ingelheim, Novartis, Pfizer, Sanofi-Aventis; research support: Astra Zeneca, Boehringer Ingelheim, Merck.

Dr Khan: Speaker or consultant to Amgen, Merck, Lilly, Novartis, Servier, Proctor and Gamble; research support: Merck, Lilly, Novartis, Alliance for Better Bone Health.

Dr Senikas: None declared.

Dr Fortier: Speaker or consultant to Proctor and Gamble, Merck; advisory boards: Amgen, Bayer, Novo Nordisk, Novartis, GlaxoSmith Kline, Lilly, Paladin; research support: Wyeth, Sanofi.

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Basson R. Sexual concerns--menopause and sexual function. In: Canadian consensus conference on menopause, 2006 update. J Obstet Gynaecol Can 2006 Feb;28(2 Suppl 1):S43-52. [54 references]

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [Society of Obstetricians and Gynaecologists of Canada Web site](#).

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on May 4, 2009. The information was verified by the guideline developer on May 21, 2009.

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Date Modified: 6/15/2009

