

Genitourinary Syndrome of Menopause (GSM)

Causes, Symptoms, Sexual and Urinary Effects, Diagnosis, Treatment, and an Integrative Unani Approach

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Introduction

Many women expect menopause to cause hot flushes, changes in periods, disturbed sleep or mood changes. What they often do not expect is that menopause can also affect the **vagina, vulva, urinary tract, bladder and sexual comfort**.

A woman may gradually begin noticing vaginal dryness. Intercourse that was previously comfortable may start burning or hurting. She may feel irritation around the vaginal opening, experience urinary urgency, need to pass urine more frequently, or develop repeated urinary infections.

Some women assume these changes are simply an unavoidable part of ageing and remain silent for years.

They do not have to.

These symptoms can form part of a recognized medical condition called **Genitourinary Syndrome of Menopause**, commonly shortened to **GSM**.

The term describes a group of genital, sexual and urinary symptoms related primarily to declining estrogen and androgen activity in the tissues of the vulva, vagina, urethra and bladder during and after the menopausal transition. The term replaced older expressions such as *vaginal atrophy*, *vulvovaginal atrophy*, *atrophic vaginitis* and *urogenital atrophy* because those older descriptions did not adequately represent the urinary and sexual components of the condition. Current 2025 AUA/SUFU/AUGS guidance and the 2026 Indian Menopause Society guideline use GSM as the broader clinical diagnosis.



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One of the most important messages I give my patients is:

Genitourinary Syndrome of Menopause is common, medically recognized and treatable. A woman should not feel that painful intimacy, persistent vaginal dryness or repeated urinary discomfort must simply be tolerated because she has reached menopause.

What Is Genitourinary Syndrome of Menopause?

Genitourinary Syndrome of Menopause is a collection of symptoms and physical changes caused predominantly by reduced estrogenic stimulation of the tissues of the genital and lower urinary tract.

It can affect the:

- Labia
- Clitoris
- Vulvar vestibule
- Vaginal opening
- Vaginal walls
- Urethra
- Bladder
- Pelvic-floor region

The 2026 Indian Menopause Society guideline describes GSM as involving genital symptoms such as dryness, burning and irritation; sexual problems including reduced lubrication, discomfort and pain; and urinary symptoms including urgency, frequency, painful urination and recurrent urinary tract infections.

GSM is therefore much more than “vaginal dryness.”

It is a **genital, urinary and sexual-health syndrome.**

How Common Is GSM?

GSM is very common, although prevalence estimates differ greatly because studies have used different definitions and populations.



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Recent international literature reports prevalence estimates ranging widely—from approximately 13% to more than 80% depending on age, population and diagnostic method.

For Indian women specifically, the **Indian Menopause Society 2026 guidelines report studies showing a GSM prevalence of approximately 31% to 79%**, with vaginal dryness and lower urinary-tract symptoms frequently reported.

Yet many women do not voluntarily discuss these symptoms. The Indian guideline therefore recommends that clinicians actively ask about genital, urinary and sexual concerns during menopausal consultations.

In my clinical approach, I consider this extremely important. A patient may comfortably tell me that she has hot flushes but may hesitate to say:

“Intercourse has become painful.”

or

“My vagina feels dry and burns all the time.”

or

“I keep feeling that I need to pass urine.”

Unless the clinician respectfully opens the conversation, an important medical problem may remain untreated.

Why Does Menopause Affect the Vagina and Urinary Tract?

Estrogen does much more than regulate the menstrual cycle.

Estrogen-sensitive tissues are present throughout the female genital and lower urinary system.

Before menopause, adequate estrogen helps maintain:

- Vaginal tissue thickness
- Elasticity
- Moisture
- Blood circulation
- Collagen and connective tissue
- Vaginal lubrication
- Tissue flexibility



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- Normal vaginal acidity
- Healthy local microbial conditions
- Urethral and bladder-supporting tissues

As ovarian estrogen production declines around menopause, these tissues gradually change.

The vaginal lining may become thinner and less elastic. Natural lubrication decreases. Blood supply and tissue resilience may decline. Vaginal pH becomes less acidic.

The Indian Menopause Society describes physical changes including loss of vaginal rugae, reduced vulval fat and blood flow, a paler appearance and a rise in vaginal pH from the normally acidic range toward approximately 6–8 in affected women.

These changes help explain why a woman can develop dryness, irritation, painful intercourse and urinary symptoms even though she previously had no genital or urinary problem.

GSM Is Different From Hot Flashes

This difference is very important.

Hot flashes and night sweats often become less troublesome over time.

GSM commonly does not behave that way.

Without treatment, symptoms can persist and may become progressively more troublesome as the duration of estrogen deficiency increases. The Indian Menopause Society's 2026 guideline describes GSM as a chronic, progressive condition that typically requires ongoing management.

That is why waiting indefinitely for vaginal dryness or painful intercourse to disappear by itself may not be the best strategy.

When Can GSM Begin?

Although GSM is strongly associated with postmenopause, symptoms can begin during the **perimenopausal transition**.

Some women first notice mild dryness or altered lubrication before their final menstrual period.

Symptoms may also develop earlier when estrogen levels fall because of:

- Surgical removal of both ovaries



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- Premature ovarian insufficiency
- Certain cancer treatments
- Pelvic radiation
- Some endocrine treatments for breast cancer
- Other hypoestrogenic states

Therefore, age alone should not determine whether GSM is considered.

The woman's hormonal and medical history matters.

Symptoms of Genitourinary Syndrome of Menopause

The symptoms can be divided into three major groups:

Genital symptoms

Sexual symptoms

Urinary symptoms

One woman may experience only one group, whereas another may have symptoms from all three.

Genital Symptoms

Common genital symptoms include:

- Vaginal dryness
- Vulvar dryness
- Burning
- Itching
- Irritation
- Tenderness
- A feeling of rawness
- Reduced vaginal elasticity
- Discomfort with clothing or activity
- Minor spotting associated with fragile tissue



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- Increased sensitivity around the vaginal entrance

The vagina may feel tighter even though there is no actual obstruction.

This can occur because both the vaginal tissues and pelvic-floor muscles may change.

Sexual Symptoms

GSM can significantly affect sexual health.

Women may experience:

- Reduced natural lubrication
- Pain during penetration
- Burning during intercourse
- Soreness after intercourse
- Reduced genital sensation
- Difficulty with penetration
- Fear of intercourse because pain is expected
- Reduced sexual enjoyment
- Reduced desire secondary to discomfort
- Avoidance of intimacy

The relationship between GSM and desire is particularly important.

A woman may initially have completely normal sexual desire.

However, if intercourse becomes painful every time, the brain can gradually begin associating sexual activity with pain rather than pleasure.

She may start avoiding intercourse.

Her partner may interpret this as loss of attraction.

Relationship tension then develops.

Therefore, what started as a biological tissue problem can eventually become a **sexual, psychological and relationship problem as well.**

Painful Intercourse and GSM



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Painful intercourse associated with menopause is known medically as **dyspareunia** when intercourse causes persistent or recurrent pain.

In GSM, pain is commonly caused by a combination of:

- Reduced lubrication
- Thinner vaginal epithelium
- Reduced tissue elasticity
- Vestibular sensitivity
- Narrowing or reduced flexibility at the vaginal opening
- Pelvic-floor muscle guarding

Some women describe pain only at initial penetration.

Others feel deeper discomfort.

Some experience burning for several hours afterward.

Painful intercourse should never simply be dismissed as “normal after menopause.”

Does GSM Reduce Sexual Desire?

It can, but often indirectly.

Hormonal changes during menopause may influence sexual desire in some women, but GSM may create an additional mechanism.

Consider this sequence:

Dryness → painful penetration → fear of pain → muscle tightening → avoidance → reduced sexual confidence → reduced desire.

If the original pain is treated successfully, sexual interest may sometimes improve because intimacy is no longer associated with discomfort.

Current Indian guidance emphasizes a multimodal approach to midlife sexual dysfunction, including treatment of GSM together with physical, psychological and relationship factors where relevant.

Urinary Symptoms of GSM

The urinary component of GSM is frequently overlooked.

Women may experience:



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- Urinary urgency
- Increased urinary frequency
- Burning while urinating
- Night-time urination
- Urinary discomfort
- Symptoms resembling recurrent cystitis
- Recurrent urinary tract infections
- Sometimes worsening urgency-related urinary leakage

A 2026 review of the urinary manifestations of GSM describes urgency, frequency, nocturia, dysuria, urgency incontinence and recurrent urinary infections among recognized lower urinary-tract manifestations.

Women sometimes receive repeated courses of antibiotics for urinary symptoms without anyone investigating whether menopause-related genitourinary changes are contributing.

GSM and Recurrent Urinary Tract Infection

This is one of the clinically important aspects of GSM.

Menopausal changes in vaginal and periurethral tissues can alter the local environment and contribute to susceptibility to recurrent UTIs.

For appropriately selected peri- and postmenopausal women with recurrent UTIs, **local low-dose vaginal estrogen has evidence for reducing future urinary infection risk.**

The 2025 AUA/SUFU/AUGS GSM guideline specifically recommends local low-dose vaginal estrogen for women with GSM and recurrent UTIs.

NICE guidance similarly recommends considering vaginal estrogen for recurrent UTI in menopausal women when behavioural and personal-hygiene approaches are insufficient or inappropriate.

This does not mean that every urinary infection in a menopausal woman is caused by GSM.

A true UTI still requires appropriate diagnosis, and repeated infections may need further investigation.



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Is GSM an Infection?

No.

GSM itself is **not an infection**.

The burning, irritation and urinary discomfort can sometimes resemble:

- Candidiasis
- Bacterial vaginosis
- Urinary infection
- Sexually transmitted infection

This can lead to unnecessary repeated antifungal or antibiotic treatment.

A woman who repeatedly treats herself for “infection” despite negative investigations should be properly examined.

Is GSM a Sexually Transmitted Infection?

No.

GSM is not sexually transmitted.

However, sexually transmitted infections can produce similar symptoms such as genital burning, discharge, urinary discomfort, pelvic pain or pain during intercourse.

Therefore, STI testing may be appropriate when the clinical history indicates a risk.

GSM and Vaginal pH

Before menopause, estrogen supports a relatively acidic vaginal environment.

After estrogen declines, vaginal pH commonly increases.

The 2026 Indian Menopause Society guideline notes that vaginal pH may shift from approximately **3.5–5.0 toward 6.0–8.0** as menopausal tissue changes develop.

A higher pH is not by itself sufficient to diagnose GSM, because several other conditions can alter vaginal pH.

It is one part of the clinical picture.

Physical Changes a Doctor May See



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Possible examination findings include:

- Pale vaginal mucosa
- Thinner tissues
- Reduced moisture
- Reduced elasticity
- Loss of vaginal folds or rugae
- Greater tissue fragility
- Narrowing of the vaginal opening
- Reduced vulvar fullness
- Mild petechiae or contact bleeding
- Reduced secretions

But an important point is that **symptom severity and visible tissue changes do not always match.**

One woman may have obvious changes but few symptoms.

Another may have substantial burning and painful intercourse despite relatively mild examination findings.

Current Indian guidance emphasizes patient symptoms and individualized assessment rather than judging severity only from the appearance of the tissues.

How Is GSM Diagnosed?

There is no single blood test that diagnoses GSM.

Diagnosis usually combines:

- Menstrual and menopausal history
- Symptoms
- Sexual history
- Urinary history
- Medication history
- Relevant medical conditions
- Physical examination



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- Exclusion of other diseases

The 2026 Indian Menopause Society guideline notes that universally accepted diagnostic criteria still do not exist. It proposes a practical clinical approach based on bothersome genital or urinary symptoms, exclusion of alternative causes and, where useful, measures such as vaginal pH or a Vaginal Health Index.

For most patients, diagnosis is primarily clinical.

Questions I Consider Important

When assessing a patient, I want to know:

When did the dryness begin?

Is there burning or itching?

Does pain occur only during intercourse or also at other times?

Is penetration possible?

Is there bleeding after intercourse?

Has sexual desire changed because intercourse hurts?

Is urinary urgency present?

Are urinary infections confirmed by testing or assumed from symptoms?

Has menopause occurred naturally or after surgery?

Has the patient received cancer treatment?

Is she taking tamoxifen or an aromatase inhibitor?

Are there recurrent vaginal infections?

Does she use fragranced washes or irritating products?

Is there pelvic-floor tightness?

Are there symptoms suggesting another vulvar disease?

This information often reveals more than a long list of laboratory investigations.

Conditions That May Resemble GSM

A diagnosis of GSM should not become an excuse to attribute every genital symptom in an older woman to menopause.



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Other causes may include:

- Vulvovaginal candidiasis
- Bacterial vaginosis
- Sexually transmitted infections
- Contact dermatitis
- Vulvar eczema
- Lichen sclerosus
- Lichen planus
- Vulvodynia
- Vestibulodynia
- Pelvic-floor dysfunction
- Urinary tract infection
- Interstitial cystitis/bladder pain syndrome
- Vulvar precancer or cancer
- Vaginal or cervical disease

The 2026 Indian guideline specifically recommends excluding infections, vulvar dermatitis, lichen planus, lichen sclerosus, malignancy and alternative causes of recurrent UTI.

Postmenopausal Bleeding Must Not Simply Be Blamed on GSM

Fragile menopausal tissues can sometimes bleed after intercourse or examination.

But **any unexplained postmenopausal bleeding requires medical evaluation** because other important causes—including endometrial disease and cancer—must be excluded.

The 2025 AUA GSM guideline emphasizes that postmenopausal bleeding should be investigated even in women who are using local low-dose vaginal estrogen.

A woman should never assume that bleeding is “only dryness” without being assessed.

Treatment of Genitourinary Syndrome of Menopause



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Treatment depends upon:

- Severity
- Dominant symptoms
- Sexual activity
- Urinary symptoms
- Previous treatments
- Medical history
- Personal preferences
- Breast-cancer history
- Other hormone-sensitive diseases

There is no need to treat an asymptomatic woman merely because examination shows age-related vaginal changes.

We treat **the patient and her symptoms**, not only the appearance of tissue.

Non-Hormonal Vaginal Moisturizers

For mild symptoms, vaginal moisturizers can be useful.

A moisturizer is not the same as a lubricant.

A **vaginal moisturizer** is generally used regularly to improve ongoing comfort and hydration.

A **lubricant** is typically used around sexual activity to reduce friction.

Current evidence supports vaginal moisturizers as an option for vaginal dryness and some associated discomfort. The 2025 AUA evidence review found that vaginal moisturizers may improve at least some GSM symptoms, while the 2026 Indian guideline recommends them particularly for dryness and dyspareunia.

Lubricants During Sexual Activity

A suitable lubricant can significantly reduce friction during intercourse.

This can be particularly helpful when the major complaint is penetration-related discomfort.

Water- or silicone-based products are commonly used.



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Patients prone to irritation should generally select products without unnecessary fragrance, warming agents or irritants.

The Indian Menopause Society recommends physiologic-pH, low-osmolality products and cautions that high-osmolality preparations may irritate the vaginal epithelium.

Lubricant provides symptomatic relief but does not necessarily reverse the underlying menopausal tissue changes.

Hyaluronic Acid

Vaginal hyaluronic-acid preparations have attracted increasing attention as nonhormonal moisturizers.

They may be useful for women who prefer a nonhormonal approach or cannot use estrogen.

ACOG includes hyaluronic-acid products among nonhormonal options used for menopausal urogenital symptoms, although comparative evidence remains less extensive than that for vaginal estrogen.

Local Vaginal Estrogen

For many women with clinically significant GSM, **local low-dose vaginal estrogen is one of the most effective and best-established treatments.**

The 2025 AUA/SUFU/AUGS guideline recommends offering low-dose local vaginal estrogen to improve vulvovaginal dryness, irritation and dyspareunia.

NICE's updated menopause guidance similarly recommends vaginal estrogen for menopausal genitourinary symptoms, including in women already using systemic HRT when local symptoms remain troublesome.

The 2026 Indian Menopause Society describes local estrogen therapy as the **cornerstone of GSM management.**

How Does Local Estrogen Help?

Local estrogen acts primarily on estrogen-sensitive tissues of the vagina and surrounding genital region.

Treatment can improve:

- Tissue thickness



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- Moisture
- Elasticity
- Lubrication
- Vaginal maturation
- Vaginal pH
- Pain during intercourse
- Dryness
- Irritation

It can also reduce recurrent UTIs in appropriate menopausal patients.

Forms of Vaginal Estrogen

Depending upon country and product availability, local estrogen may be available as:

- Vaginal cream
- Vaginal tablet
- Vaginal insert/pessary
- Vaginal ring
- Vaginal gel

There is no universally best preparation for every woman.

NICE recommends shared decision-making when choosing among local preparations, taking patient preference and practicality into account.

Is Vaginal Estrogen the Same as Systemic HRT?

No.

Systemic menopausal hormone therapy—such as oral or transdermal estrogen—is intended to produce effects throughout the body and is commonly used when women also have significant hot flashes or other systemic menopausal indications.

Local low-dose vaginal estrogen is primarily designed to treat genitourinary tissues.

NICE explains that systemic absorption from vaginal estrogen is **minimal compared with systemic HRT**.



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Some women taking systemic HRT still require additional local treatment because genital or urinary symptoms persist.

Does Vaginal Estrogen Require Progesterone?

For conventional **low-dose local vaginal estrogen**, routine systemic progestogen is generally not required solely for endometrial protection because systemic estrogen exposure is minimal.

Both NICE's rationale and the 2026 Indian Menopause Society guidance state that additional progesterone is not routinely required with standard low-dose local vaginal estrogen treatment.

However, unexplained vaginal bleeding still requires investigation.

The distinction between **local low-dose vaginal estrogen and systemic estrogen therapy** is crucial because systemic estrogen has different endometrial considerations.

How Long Is Treatment Needed?

GSM frequently returns when therapy is stopped because the underlying menopausal hormonal environment remains.

NICE specifically advises patients that symptoms commonly return after discontinuing vaginal estrogen and that treatment can be restarted when appropriate.

For many women, GSM therefore requires **long-term symptom management rather than a brief one-time course**.

The dose and duration should be individualized.

Vaginal DHEA / Prasterone

Prasterone, or vaginal dehydroepiandrosterone (DHEA), is another treatment option for selected women with moderate-to-severe menopausal vulvovaginal symptoms.

Within vaginal tissues, DHEA is converted locally into estrogenic and androgenic metabolites.

The 2026 Indian Menopause Society guideline recognizes vaginal DHEA as an effective treatment option, and NICE recommends considering vaginal prasterone if vaginal estrogen or nonhormonal products are ineffective or not tolerated.

Availability and regulatory approval differ between countries.

Ospemifene

Ospemifene is an oral selective estrogen receptor modulator.

It is another option for selected patients, particularly when locally applied treatment is impractical or unsuitable.

Evidence reviewed by AUA found that oral ospemifene may improve some GSM symptoms, particularly dryness and dyspareunia.

NICE recommends considering ospemifene in situations where local treatment is impractical.

Like any prescription medicine, it requires individual assessment of risks, contraindications and interactions.

Pelvic-Floor Physiotherapy

Pelvic-floor dysfunction may coexist with GSM.

After months or years of painful penetration, some women develop protective tightening of the muscles around the vagina.

In such patients, treating dryness alone may not completely resolve painful intercourse.

Specialized pelvic-floor physiotherapy may address:

- Muscle overactivity
- Difficulty relaxing during penetration
- Pelvic pain
- Urinary leakage
- Sexual discomfort

The Indian Menopause Society includes pelvic-floor interventions among useful components of menopausal sexual and urinary care.

However, the exact type of pelvic-floor exercise matters. A woman with excessively tight muscles may need relaxation and coordination rather than simply more strengthening exercises.

Sexual Counselling



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Sexual counselling can be extremely helpful when GSM has affected:

- Sexual confidence
- Desire
- Fear of penetration
- Partner communication
- Relationship intimacy
- Body image

Suppose intercourse has been painful for two years.

Even after the vaginal tissues begin improving, the patient may still expect pain.

She becomes tense before penetration.

The pelvic floor contracts.

Pain returns.

In such circumstances, treatment must address both the tissues and the **learned pain-fear response**.

Current Indian guidelines recommend a multimodal approach to female sexual dysfunction, including appropriate lubricants or moisturizers, physical approaches, stress management and psychological or sex therapy when indicated.

Regular Sexual Activity: Is It Helpful?

Comfortable sexual activity can help maintain genital blood flow, flexibility and tissue function in some women.

But this should never be interpreted as:

“You must have intercourse even if it hurts.”

Forcing painful penetration can worsen fear and pelvic-floor guarding.

Sexual activity should remain consensual and comfortable.

Nonpenetrative intimacy, gradual rehabilitation, lubricants, moisturizers, local therapy and pelvic-floor treatment can be used while comfort is being restored.

Vaginal Laser and Energy-Based Treatments



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Vaginal laser treatments are widely marketed for menopausal vaginal symptoms.

The advertising is often stronger than the current scientific evidence.

The 2025 AUA evidence review concluded that current evidence **does not demonstrate established efficacy of CO₂ or Er:YAG laser treatments for GSM symptoms.**

NICE is even more explicit: vaginal laser should not be offered for menopausal genitourinary symptoms outside a randomized controlled trial.

The 2026 Indian Menopause Society also states that better-quality randomized evidence is still needed before definitive conclusions about vaginal laser efficacy and safety can be made.

Therefore, patients should be cautious about expensive claims promising vaginal “rejuvenation” or permanent cure.

GSM in Women With a History of Breast Cancer

This is one of the most sensitive areas of menopause care.

Breast-cancer treatments can themselves produce or worsen GSM, particularly therapies that markedly suppress estrogen.

For women with a history of estrogen-dependent breast cancer, nonhormonal treatments are generally used first.

ACOG recommends moisturizers and lubricants as first-line options in this population. If symptoms remain significant, **low-dose vaginal estrogen may be considered after discussion of risks and benefits**, including in women taking tamoxifen; for women using aromatase inhibitors, shared decision-making involving the patient, gynecologist and oncologist is advised.

NICE similarly recommends nonhormonal options first and advises specialist involvement when symptoms persist in women taking aromatase inhibitors.

This is not an area for self-prescribing hormones.

Is GSM Related to Infertility?

In women who have undergone **natural menopause**, GSM itself is not the cause of infertility. Menopause reflects the end of natural ovarian reproductive function.

However, GSM can occur in younger women with:

- Premature ovarian insufficiency



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- Surgical menopause
- Medical ovarian suppression
- Certain cancer treatments

In such situations, the underlying cause of estrogen deficiency may also have important fertility consequences.

At Saira Health Care, when younger women present with symptoms suggesting early hypoestrogenism, I believe it is important to consider not only genital comfort but also menstrual history, ovarian function, fertility plans, bone health and general endocrine health.

GSM should therefore be considered within the woman's complete reproductive context.

Genitourinary Syndrome of Menopause and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I value one particular feature of Unani clinical practice: it encourages us to look at the patient as a whole rather than reducing her health to one isolated symptom.

Traditional Unani therapeutic principles include:

- **Ilaj-bil-Ghiza — Dietotherapy**
- **Ilaj-bil-Tadbir — Regimental therapy**
- **Ilaj-bil-Dawa — Pharmacotherapy**
- **Ilaj-bil-Yad — Surgical/interventional therapy where applicable**

CCRUM also describes the principle of **Izala-i-Sabab**, meaning attention to the causative or maintaining factor, along with individualized dietary, drug and regimental treatment.

These principles can be meaningfully incorporated into comprehensive menopausal care—but they must be applied with scientific responsibility.

How I View GSM From an Integrative Unani Perspective

A woman presenting with vaginal dryness may also have:

- Poor sleep
- Psychological stress



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- Reduced physical activity
- Diabetes
- Obesity
- Hypertension
- Constipation
- Urinary symptoms
- Relationship stress
- Reduced sexual confidence

Treating only one symptom may therefore provide incomplete care.

An integrative Unani approach can focus on improving general health through individualized lifestyle regulation, diet, activity, sleep, stress management and, when appropriate, carefully selected Unani pharmacotherapy.

However, this holistic approach should **complement—not replace—evidence-based treatment of estrogen-deficient genitourinary tissues.**

Ilaj-bil-Ghiza — Dietary Management

Diet cannot replace estrogen in vaginal tissue, but nutritional health remains important during and after menopause.

I generally regard diet as part of the broader health plan rather than as a specific cure for GSM.

Useful principles include maintaining:

- Adequate protein intake
- Vegetables and fruits
- Whole grains
- Appropriate healthy fats
- Adequate hydration
- Healthy body weight
- Good metabolic control
- Appropriate calcium and vitamin D intake according to individual need



Women with diabetes or metabolic disease particularly benefit from good systemic health because urinary and genital symptoms may be more difficult when glucose control is poor.

Traditional Unani literature places considerable importance on dietotherapy as part of overall treatment and health maintenance.

But there is **no scientifically established special food that cures GSM**.

Ilaj-bil-Tadbir — Lifestyle and Regimental Care

The regimental component of Unani medicine can be integrated with modern menopause care through attention to:

- Regular appropriate physical activity
- Sleep
- Stress control
- Weight management
- Sexual well-being
- Pelvic-floor health
- General hygiene without over-cleansing
- Management of associated health conditions

Regular exercise and pelvic-floor rehabilitation can also improve mobility, body confidence and urinary health.

I consider these measures valuable because successful menopausal care should improve the woman's overall health, not only one genital symptom.

Ilaj-bil-Dawa — Unani Pharmacotherapy

Unani medicine has traditionally used herbal and compound preparations for women's health and age-related complaints.

But a very important distinction must be made.

Traditional use is not the same as modern clinical proof of efficacy for Genitourinary Syndrome of Menopause.

At present, high-quality evidence specifically demonstrating that a particular Unani medicine reverses GSM is insufficient.



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The 2024 AHRQ systematic review that formed part of the evidence base for modern GSM guidance found support for treatments such as vaginal estrogen, vaginal DHEA, moisturizers and ospemifene, while evidence for many alternative interventions remained limited or inadequately studied.

For this reason, I do not believe women should be told that an untested herbal preparation is a proven substitute for established treatment.

Avoid Irritating Home Remedies

This is especially important for genital symptoms.

The menopausal vulva and vaginal entrance may already be thin, dry and sensitive.

I discourage unsupervised use of:

- Strong herbal oils
- Essential oils
- Antiseptic solutions
- Perfumed products
- Harsh soaps
- Chemical vaginal washes
- Vaginal douching
- Unknown “tightening” creams
- Irritating home remedies

These products can produce contact dermatitis or worsen burning.

“Natural” does not automatically mean safe for sensitive vulvovaginal tissue.

The Saira Health Care Approach to GSM

At **Saira Health Care**, I believe the appropriate approach to GSM should begin by asking a very basic question:

What is actually troubling this particular woman?

For one woman, the main problem may be dryness.

For another, it may be painful intercourse.

For another, repeated urinary infections.

Another may have lost sexual confidence because penetration has become painful.

And another may have symptoms following premature ovarian insufficiency or cancer treatment.

They should not all receive exactly the same treatment.

My Individualized Clinical Approach

When evaluating GSM, my approach is to consider several areas together.

Menopausal and hormonal history

I assess whether menopause was natural, surgical, premature or treatment-induced.

Genital symptoms

Dryness, burning, itching, tenderness and tissue irritation are reviewed.

Sexual health

I ask sensitively about lubrication, penetration, sexual pain, desire, orgasm, fear and avoidance.

Urinary health

Urgency, frequency, burning, incontinence and recurrent infection are considered.

Medical health

Diabetes, hypertension, endocrine disease, cancer history and medications may influence management.

Pelvic-floor function

Persistent pain can produce pelvic-floor guarding that requires additional treatment.

Psychological and relationship health

Chronic sexual discomfort may affect confidence and partner communication.

Patient preference

Some women are comfortable using vaginal estrogen. Others prefer nonhormonal approaches. Some have medical conditions requiring additional specialist discussion.

Treatment therefore needs to be individualized rather than imposed.



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A Practical Treatment Framework at Saira Health Care

Depending on the patient's assessment, an integrative plan may include:

- Education and reassurance
- Gentle vulvar care
- Appropriate vaginal moisturizer
- Lubricant for sexual activity
- Pelvic-floor assessment
- Sexual counselling
- Couple counselling where useful
- Lifestyle and metabolic optimization
- Individualized Unani supportive measures
- Referral for gynecological assessment
- Evidence-based hormonal or nonhormonal treatment through an appropriately qualified clinician
- Evaluation of recurrent urinary infection
- Referral to oncology or other specialists where relevant

The important principle is that **Unani supportive treatment and modern evidence-based GSM management should not be placed in competition with each other.**

When appropriately integrated, each component should serve the patient's needs.

Why Saira Health Care Gives Special Attention to Sexual Health

Women sometimes receive treatment for vaginal dryness but no one asks whether the problem has affected their marriage or sexual confidence.

Sexual health is not separate from health.

At Saira Health Care, our focused work in **sexual disorders and infertility** makes it particularly important to consider the consequences of GSM on:

- Pain during intercourse
- Sexual desire
- Intimacy



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- Partner communication
- Fear of penetration
- Sexual avoidance
- Self-esteem

A treatment plan that improves vaginal tissue but leaves the patient afraid of intimacy may remain incomplete.

GSM and Relationship Problems

A common misunderstanding occurs when a woman begins avoiding intercourse because it hurts.

Her partner may believe:

“She has lost interest in me.”

The woman may think:

“I do not want to disappoint my partner, but I know it will hurt.”

Both gradually become anxious.

Open communication can prevent the biological effects of menopause from becoming a major relationship conflict.

Where appropriate, couples counselling or sex therapy can therefore complement physical treatment.

Can GSM Be Permanently Cured?

It is more accurate to talk about **effective long-term management** than guaranteed permanent cure.

GSM results from the ongoing hormonal environment of menopause.

Treatments can produce major improvement in symptoms and quality of life, but symptoms frequently recur if effective therapy is discontinued. NICE specifically advises women of this possibility.

Many women therefore require maintenance treatment.

This does not mean treatment has failed.

It reflects the chronic nature of the condition.



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When Should a Woman Seek Medical Advice?

Professional assessment is particularly important when there is:

- Persistent vaginal dryness
- Recurrent burning or irritation
- Pain during intercourse
- Difficulty with penetration
- Bleeding after intercourse
- Any bleeding after menopause
- Persistent urinary burning
- Recurrent confirmed UTIs
- New urinary urgency or frequency
- Vulvar sores or skin changes
- Persistent discharge
- Pelvic pain
- Symptoms after breast-cancer treatment
- Severe symptoms affecting intimacy or quality of life

Do not assume every symptom after menopause is GSM.

Some symptoms require investigation for other diseases.

Common Mistakes I Encourage Patients to Avoid

Repeatedly treating presumed vaginal infection without testing

Dryness and burning are not always infection.

Assuming painful sex is inevitable after menopause

Effective treatments are available.

Using harsh intimate washes

These can worsen irritation.

Forcing intercourse despite pain



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This may strengthen pelvic-floor guarding and fear.

Self-prescribing hormones

Hormone treatment should consider medical history.

Assuming systemic HRT automatically treats all vaginal symptoms

Some women still require local therapy.

Spending large amounts on unproven vaginal laser treatment

Current high-quality guidelines consider the evidence inadequate for routine use.

Ignoring urinary symptoms

GSM involves the lower urinary tract as well as the vagina.

Frequently Asked Questions About GSM

Is Genitourinary Syndrome of Menopause the same as vaginal atrophy?

Vaginal atrophy is part of GSM, but GSM is a broader and more accurate term because it also includes vulvar, sexual and urinary symptoms.

Does every menopausal woman develop GSM?

No, but it is common. Indian studies reviewed in the 2026 Indian Menopause Society guideline report prevalence ranging roughly from 31% to 79%.

Can GSM begin before menopause is complete?

Yes. Symptoms can develop during the menopausal transition as estrogen levels decline.

Can GSM cause painful intercourse?

Yes. Reduced lubrication, thinner tissues, decreased elasticity and associated pelvic-floor guarding can make penetration painful.

Can GSM reduce sexual desire?

It can contribute to reduced desire, particularly when repeated pain or dryness makes sexual activity uncomfortable.

Can GSM cause urinary problems?

Yes. Urgency, frequency, dysuria and recurrent urinary infections are recognized components of the syndrome.

Is GSM an infection?

No. However, infections can produce similar symptoms and should be excluded when appropriate.

Can GSM cause recurrent UTIs?

Menopausal genitourinary changes can contribute to recurrent UTIs. Local low-dose vaginal estrogen is recommended by the 2025 AUA GSM guideline for appropriate patients with GSM and recurrent UTIs.

Is vaginal estrogen effective?

Yes. Local low-dose vaginal estrogen is one of the principal evidence-based treatments for GSM and is recommended by major contemporary guidelines.

Is vaginal estrogen absorbed throughout the body?

A small amount can be absorbed, but systemic exposure from low-dose local treatment is much lower than with systemic HRT.

Can a woman with breast cancer use vaginal estrogen?

This requires individualized assessment. Nonhormonal therapy is generally tried first. ACOG states that low-dose vaginal estrogen may be considered after appropriate discussion in some women with previous estrogen-dependent breast cancer; women using aromatase inhibitors require particularly careful shared decision-making with their oncology team.

Is vaginal laser better than estrogen?

Current evidence does not establish vaginal laser as superior or sufficiently proven for routine GSM treatment. NICE recommends its use only within randomized clinical trials.

Can pelvic-floor therapy help?

Yes, especially if urinary symptoms, muscle dysfunction or painful penetration coexist. Treatment should be individualized to whether the muscles require strengthening, relaxation or both.

Can Unani medicine help?

Unani medicine can contribute an **individualized supportive framework** involving diet, lifestyle, sleep, stress management, general health and carefully selected treatment. However, high-quality evidence proving a specific Unani medicine as a standalone cure for GSM is currently lacking. Evidence-based gynecological and menopause treatment should therefore remain part of appropriate care.

A Message to Women From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, I thought dryness and painful intercourse were simply part of ageing,”

I explain that menopause is natural, but suffering in silence is not required.

When another patient says:

“I have stopped intimacy because every attempt causes burning,”

I do not regard this simply as a relationship problem. We first need to understand the physical changes occurring in the vulva, vagina and pelvic floor.

And when a woman says:

“I keep having urinary discomfort, but antibiotics do not always help,”

I consider whether the lower urinary tract manifestations of menopause may be contributing.

The purpose of treatment is not to make a woman “young again.”

The purpose is to restore **comfort, tissue health, urinary well-being, sexual confidence and quality of life** as far as reasonably possible.

Menopause should be treated with dignity and scientific understanding.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Professional Qualifications and Training

BUMS — Hamdard University, Delhi

MD

CGO

Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health — ISRH, UNFPA

At **Saira Health Care**, Dr. Nizamuddin Qasmi's focused clinical work includes sexual disorders, male and female sexual-health concerns, infertility, reproductive counselling and individualized Unani-based supportive care.



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For women with GSM and related sexual concerns, the clinical objective is to recognize the physical problem, identify overlapping sexual or pelvic-floor difficulties and develop an individualized plan while referring for gynecological, urological, pelvic-floor, oncological or other specialist care where necessary.

Conclusion

Genitourinary Syndrome of Menopause is a common, chronic and frequently under-recognized consequence of declining estrogen and androgen activity during and after the menopausal transition.

It can affect the vulva, vaginal entrance, vaginal tissues, urethra and bladder and may produce:

- Vaginal dryness
- Burning and irritation
- Reduced lubrication
- Painful intercourse
- Sexual avoidance
- Urinary urgency and frequency
- Dysuria
- Recurrent urinary infections

Modern evidence shows that GSM is generally **persistent or progressive without effective management**, unlike many hot flushes that may diminish over time.

Current evidence-based management includes **vaginal moisturizers and lubricants, local low-dose vaginal estrogen, vaginal DHEA/prasterone and oral ospemifene in appropriately selected patients**. Local vaginal estrogen has particularly strong clinical importance and is also recommended for reducing recurrent UTIs in appropriate menopausal women.

At the same time, modern guidelines caution against presenting vaginal laser or other energy-based treatments as established solutions because evidence remains insufficient for routine use.

From the **Unani perspective**, individualized diet, lifestyle regulation, regimental care and attention to the whole patient's physical and emotional health can make a meaningful supportive contribution. However, responsible integrative practice requires



acknowledging that direct high-quality evidence for Unani medicines specifically treating GSM remains limited.

At **Saira Health Care**, my preferred approach is therefore not to choose between modern medicine and Unani medicine as competing systems. It is to understand the patient's symptoms correctly, rule out other diseases, use evidence-based treatments where indicated and integrate appropriate Unani principles for overall health and well-being.

A woman experiencing dryness, painful intimacy or urinary discomfort after menopause deserves more than the statement:

“This happens with age.”

She deserves a proper explanation, respectful assessment and an individualized treatment plan.

For more information:

<https://www.sairahealthcare.com/>

Book an appointment:

<https://www.sairahealthcare.com/Appointment.aspx>

Saira Health Care Pharmacy:

<https://pharmacy.sairahealthcare.com/>

Medical Disclaimer: This article is intended for general patient education and professional health awareness. It does not replace individual examination, diagnosis or treatment. Any postmenopausal bleeding should be medically evaluated. Women with a history of breast cancer, endometrial cancer, unexplained vaginal bleeding or other hormone-sensitive conditions should discuss hormonal treatment with an appropriately qualified clinician. Unani medicines, herbal products, vaginal preparations and hormones should be used only after appropriate professional assessment.



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