

Perimenopause & Menopause: Managing Vaginal Dryness, Thinning Tissue and Changing Sexual Desire With Age

An evidence-informed guide to vaginal health, painful intimacy, changing libido and healthy sexual ageing

Written in the voice of

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

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

Introduction

One of the most important messages I give women approaching midlife is this:

Menopause does not mean the end of sexual health, femininity, intimacy or pleasure.

Many women enter perimenopause and menopause expecting hot flushes and changes in their menstrual cycle, but they are surprised when the changes involve their intimate health as well. A woman may suddenly notice that vaginal lubrication is reduced, intercourse feels uncomfortable, the tissues around the vaginal opening seem more sensitive, arousal takes longer, or her sexual desire is no longer as spontaneous as it was earlier in life.

For some women these changes are mild. For others they can significantly affect confidence, relationships and quality of life.

Perimenopause and menopause themselves are **normal stages of biological ageing rather than diseases**. However, declining estrogen and other hormonal changes can produce a genuine medical condition known as **Genitourinary Syndrome of Menopause (GSM)**. GSM may involve vaginal dryness, thinning and reduced elasticity of vaginal tissues, burning, irritation, painful intercourse and urinary symptoms. Current international sexual-medicine recommendations describe GSM as a common, chronic



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

and potentially progressive condition that deserves recognition and treatment rather than being dismissed as an unavoidable consequence of ageing.

At **Saira Health Care**, my approach is therefore not to tell a woman that she simply has to “adjust to getting older.” We first try to understand what is changing, why it is happening, whether another medical condition is contributing and which treatments can safely restore comfort and sexual well-being.

Understanding Perimenopause

Perimenopause is the transition leading towards menopause. It commonly begins during the forties, although timing varies considerably between women.

During these years, the ovaries do not simply stop producing hormones overnight. Estrogen and progesterone levels fluctuate, sometimes considerably. This is why symptoms may appear, disappear and return.

Periods may become irregular. Some cycles become shorter, others longer. Bleeding may become lighter or heavier. Hot flushes, night sweats, sleep disturbance, mood changes, joint discomfort, headaches and changes in sexual desire may occur.

Vaginal symptoms can also begin **before menstrual periods have completely stopped**. A woman therefore does not have to be fully postmenopausal before experiencing vaginal dryness or discomfort during intercourse.

ACOG explains that during perimenopause declining estrogen can make vaginal tissue progressively thinner, drier and less elastic, while the amount of vaginal moisture can decrease.

What Is Menopause?

Menopause marks the end of natural menstrual cycling due to loss of ovarian follicular activity. In natural menopause, the diagnosis is generally made retrospectively after menstrual periods have stopped for 12 consecutive months when there is no other medical explanation.

But menopause is much more than the disappearance of menstruation.

Estrogen receptors exist throughout the reproductive and urinary tract. When estrogen levels decline, the tissues of the vagina, vulva, urethra and bladder may gradually change.

For this reason, some menopausal symptoms disappear with time while vaginal and urinary symptoms can persist or become more noticeable.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This distinction is very important.

A hot flush may eventually disappear.

Untreated vaginal dryness and tissue changes may not.

What Happens to Vaginal Tissue During Menopause?

Estrogen plays an important role in maintaining the thickness, elasticity, moisture and biological environment of vaginal tissue.

When estrogen decreases, several changes can occur.

The vaginal lining can become thinner. Natural lubrication can decrease. Vaginal tissues may become less elastic. The vaginal opening can become more sensitive, and the surrounding vulvar tissues can also become drier.

ACOG notes that declining estrogen during perimenopause and menopause may cause thinning, dryness and reduced elasticity of the vaginal lining, along with changes affecting the vulva and urinary tract.

These changes do not mean that the woman's body is “damaged.” They are consequences of changing hormonal physiology.

But they can and should be treated when they produce symptoms.

Genitourinary Syndrome of Menopause

The term **Genitourinary Syndrome of Menopause**, or GSM, is now preferred over older terms such as vaginal atrophy or atrophic vaginitis because menopause can affect more than the vagina.

GSM can involve the vulva, vagina, urethra and bladder.

A woman may experience dryness, burning, irritation, itching, discomfort with clothing, reduced lubrication during sexual activity, pain with penetration, urinary urgency, frequent urination or recurrent urinary infections.

The 2025 recommendations from the Fifth International Consultation on Sexual Medicine describe vaginal dryness and painful intercourse as two of the most frequently reported GSM symptoms.

It is important to recognize this as a medical condition because many women remain silent about it. They may assume:

“This is simply because I am getting old.”



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

That assumption can prevent them from seeking effective treatment.

Why Does Vaginal Dryness Occur?

Natural sexual lubrication results from a combination of healthy vaginal tissues, blood flow, hormonal environment and sexual arousal.

During and after menopause, lower estrogen can interfere with this process.

The tissue may therefore feel dry even when the woman feels emotionally attracted to her partner.

This is something couples need to understand.

Poor lubrication does not necessarily mean poor desire.

A woman can be interested in sexual activity while her body produces less lubrication than previously.

Similarly, a woman can have adequate lubrication but little sexual desire.

These are different components of sexual function and should not automatically be treated as the same problem.

Modern reviews describe female sexual function during menopause across several interconnected domains—**desire, arousal and lubrication, orgasm, satisfaction and pain**. Treatment should identify which domain is actually causing difficulty.

Dryness Can Affect More Than Intercourse

Some women initially notice dryness only during sexual activity.

Others experience symptoms throughout the day.

The vulva may feel irritated against underwear. There may be a burning sensation, tenderness or itching. Vaginal examinations may become uncomfortable. Inserting medication or other vaginal products may feel painful.

Because the urethra and bladder are also affected by estrogen changes, urinary symptoms may occur at the same time.

This combination is one reason the modern term **genitourinary syndrome** is more accurate than simply calling the condition “vaginal dryness.”

Why Does Sex Become Painful?

Pain during intercourse is known medically as **dyspareunia**.

When vaginal tissue becomes dry and less elastic, penetration creates more friction.

Small areas of tissue may become irritated, producing burning or soreness. If sexual activity repeatedly hurts, the woman may begin expecting pain before intimacy even starts.

This can create a cycle:

dryness → pain → anxiety about penetration → pelvic muscle tightening → reduced arousal → more pain.

At that stage, the problem is no longer only vaginal dryness.

The pelvic-floor muscles, emotional response and relationship may all become involved.

This is why I advise patients never to repeatedly force themselves through painful intercourse.

Pain is a signal to investigate the cause.

Not Every Painful Sexual Problem Is Menopause

This point is extremely important.

Although menopause frequently causes dryness and painful intercourse, not every genital symptom in a menopausal woman is caused by low estrogen.

Vulvar skin disorders, infection, pelvic-floor dysfunction, vulvodynia, prolapse, urinary disease, previous pelvic surgery, endometriosis, dermatological disorders and other gynecological conditions can produce similar symptoms.

ACOG specifically recognizes hormonal changes as only one of several potential causes of painful sex and recommends medical evaluation when pain is frequent or severe.

A proper diagnosis should therefore come before repeated treatment.

Vaginal Moisturizers and Lubricants: They Are Not the Same Thing

Patients frequently ask me whether a moisturizer and lubricant are simply two names for the same product.

They are not.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A **vaginal moisturizer** is generally used regularly to improve vaginal moisture and day-to-day comfort.

A **lubricant** is usually applied around sexual activity to reduce friction.

For mild vaginal dryness, these nonhormonal measures may be enough.

NICE currently recommends vaginal moisturizers or lubricants when vaginal estrogen is unsuitable or when a woman prefers not to use estrogen. They can also be used together with vaginal estrogen when additional lubrication is required.

ACOG similarly recommends moisturizers and lubricants as practical initial options for vaginal dryness.

The goal is simple: intimacy should not depend on tolerating unnecessary friction and pain.

Adequate Arousal Becomes Increasingly Important

A woman may also notice that she needs more time to become physically aroused after menopause.

This is not abnormal.

Sexual response changes throughout life.

Instead of expecting the same response that occurred at age 25, couples may need to allow more time for affection, emotional connection, stimulation and relaxation.

Rushing directly towards penetration can make dryness and discomfort worse.

The objective should not be:

“How quickly can intercourse begin?”

It should be:

“Is the woman relaxed, comfortable and adequately aroused?”

This small change in perspective can substantially improve intimacy.

Vaginal Estrogen: An Important Evidence-Based Treatment

When vaginal dryness, painful intercourse or other GSM symptoms persist, **low-dose vaginal estrogen** is one of the most established treatments.

Current NICE guidance recommends offering vaginal estrogen to people with menopausal genitourinary symptoms, including women who are already using systemic



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

hormone replacement therapy. NICE also notes that systemic absorption is minimal compared with systemic HRT and that serious adverse effects are very rare in appropriately selected patients.

Vaginal estrogen may be available in several forms, depending on country and medical circumstances, including creams, tablets, pessaries, gels or vaginal rings.

ACOG reports that topical estrogen can improve vaginal or vulvar dryness and pain during intercourse, often with improvement becoming noticeable within several weeks.

This therapy should nevertheless be prescribed after appropriate assessment rather than purchased or used indiscriminately.

Vaginal Estrogen Is Different From Systemic HRT

Many patients become concerned when they hear the word “estrogen.”

It is important to distinguish **local vaginal estrogen** from **systemic menopausal hormone therapy**.

Local treatment delivers a relatively small amount of estrogen primarily to vaginal tissues.

Systemic HRT delivers hormones into the circulation through preparations such as tablets, patches, gels or sprays and can address broader menopausal symptoms such as hot flushes and night sweats.

ACOG notes that women who still have a uterus and receive systemic estrogen generally also require progestogen to reduce the risk of endometrial cancer from unopposed systemic estrogen.

The appropriate treatment depends on the woman's symptoms, medical history and individual risk profile.

Other Treatments for GSM

Modern management has expanded beyond moisturizers and estrogen.

The updated NICE guideline states that **vaginal prasterone** may be considered when vaginal estrogen or nonhormonal moisturizers and lubricants are ineffective or not tolerated. It also allows consideration of **ospemifene**, an oral selective estrogen receptor modulator, when locally applied treatments are impractical in suitable patients.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A large systematic review of randomized trials found evidence that vaginal estrogen, vaginal DHEA, vaginal moisturizers and oral ospemifene may improve at least some GSM symptoms, although effectiveness differs according to the symptom and intervention.

These are medical treatments and require individualized consideration of contraindications, availability and patient preference.

What About Vaginal Lasers and “Rejuvenation” Procedures?

Women are increasingly exposed to advertising for vaginal lasers, radiofrequency procedures and “vaginal rejuvenation.”

Marketing claims should not be confused with established medical evidence.

Studies continue to investigate energy-based devices, but evidence remains less established than for conventional therapies. A major systematic review found that available evidence did not establish efficacy of energy-based treatments for GSM with the same confidence as vaginal estrogen and other established therapies.

Newer trials are continuing to emerge, including comparisons of laser or radiofrequency with estrogen, but researchers continue to call for stronger evidence and longer-term safety data.

Patients should therefore be cautious about expensive procedures promising permanent restoration of vaginal youth.

Sexual Desire During Perimenopause and Menopause

Changing libido is another major concern.

Some women report that their spontaneous sexual thoughts become less frequent. Others retain strong sexual desire throughout menopause. Some women actually feel more sexually confident later in life.

There is no single menopausal pattern.

A 2025 review of sexual function through menopause emphasizes that sexual difficulties during this period are **multifactorial**, involving biological, psychological, social and relationship factors rather than hormones alone.

Another recent review examining sexual desire specifically found associations with vaginal dryness and pain, sleep disruption, general health, anxiety, depression, body image and relationship satisfaction.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Therefore:

Low desire is not automatically “low estrogen.”

Why Libido May Change

A woman's sexual desire can be affected by many simultaneous changes during midlife.

Imagine a woman experiencing night sweats, poor sleep, vaginal dryness and painful intercourse while also caring for ageing parents, managing a demanding job and feeling uncomfortable about changes in her body.

If she develops less interest in sexual activity, prescribing an aphrodisiac without addressing these factors is unlikely to solve the real problem.

I often explain this to patients using a simple principle:

Desire tends to decrease when the brain begins associating intimacy with fatigue, pressure or pain.

Treat the pain.

Improve sleep.

Reduce pressure.

Restore communication.

Then reassess desire.

Spontaneous Desire and Responsive Desire

Many couples expect sexual desire always to appear first:

desire → intimacy → arousal.

But human sexuality does not always work that way.

For some women—particularly in long-term relationships or later life—desire may become more **responsive**.

That means affectionate touch, emotional connection and physical arousal may begin first, with desire developing afterwards.

A woman who does not suddenly think about sex during the day may still enjoy sexual intimacy once affectionate interaction begins.

This distinction can relieve unnecessary anxiety.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Not every reduction in spontaneous desire represents sexual dysfunction.

When Does Low Desire Become a Medical Problem?

Variation in sexual desire is normal.

Clinically, a reduced desire becomes more concerning when it is persistent, represents an unwanted change and causes significant personal distress.

If the woman herself is not distressed by a lower frequency of sexual interest, it should not automatically be labelled a disorder merely because a partner expects more sexual activity.

The woman's experience matters.

Treatment should support her well-being rather than impose someone else's expectations.

Pain Can Quietly Destroy Desire

When sexual activity hurts repeatedly, avoiding sex is a logical protective response.

This is why I do not treat a woman presenting with “low libido” until I ask:

“Does intercourse hurt?”

If the answer is yes, the pain may be the real problem.

A 2025 study published in *Menopause* found that GSM was associated with reduced female sexual function and could affect couples' sexual desire and satisfaction.

Restoring comfort may therefore allow desire to improve naturally.

Pelvic-Floor Dysfunction During Menopause

The pelvic floor also deserves attention.

Some women have weak pelvic-floor muscles and experience urinary leakage or prolapse symptoms.

Others have muscles that are excessively tight or painful.

A woman with painful penetration should therefore not automatically be told to perform more Kegel exercises.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

If muscles are already tight, further repetitive contraction may not address the underlying problem.

Specialist pelvic-floor physiotherapy can assess whether strengthening, relaxation, coordination work or other approaches are appropriate.

This is particularly important when vaginal dryness has been treated but pain persists.

Urinary Symptoms and Recurrent UTIs

Because the urethra and bladder are also influenced by estrogen, GSM may produce urinary symptoms.

Women may notice urgency, increased frequency of urination, burning or recurrent urinary tract infections.

ACOG includes frequent urination and recurrent vaginal or urinary infections among recognized manifestations of menopausal genitourinary changes.

However, burning during urination should not automatically be assumed to be GSM.

Actual urinary infection, diabetes, bladder disorders and other conditions may need to be excluded.

Menopause and Emotional Well-Being

Sexuality is not located only in the reproductive organs.

The brain plays an essential role in desire and arousal.

Anxiety, depression, chronic stress, relationship conflict, sleep deprivation, body-image concerns and previous negative sexual experiences can influence sexual response.

This is why modern sexual medicine increasingly uses a **biopsychosocial approach**.

The word sounds complicated, but the principle is simple:

Biological factors + psychological factors + relationship and social factors all matter.

This is also one area in which an appropriately applied holistic Unani approach can complement contemporary clinical care.

Body Image During Ageing



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Menopause often occurs during a period when women notice broader physical changes.

Weight distribution may change. Skin and hair can change. Breasts may look different. Muscle mass may decrease without sufficient resistance exercise. Previous surgeries may leave scars.

A woman may begin comparing herself with how she looked decades earlier.

This can reduce sexual confidence even when sexual physiology remains healthy.

Partners can either worsen or improve this situation.

Criticism, comparison and pressure damage intimacy.

Affection, reassurance and respectful communication can support confidence.

Healthy sexuality at 50 or 60 should not be judged by the body standards of age 20.

Sleep Matters More Than Most People Realize

Night sweats and hot flushes may repeatedly interrupt sleep.

Poor sleep reduces energy, affects mood and may reduce sexual interest.

The NHS currently lists both sleep disturbance and reduced sex drive among common symptoms associated with menopause and perimenopause.

Sometimes improving broader menopausal symptoms improves sexual well-being even without directly prescribing a treatment for libido.

Medicines Can Affect Sexual Desire and Arousal

Not every change that begins around menopause is caused by menopause.

Some antidepressants, particularly SSRIs, can reduce sexual desire or make orgasm more difficult. Other medicines may contribute to vaginal dryness or changes in sexual response in some individuals.

ACOG specifically notes that certain antidepressants and other medications may contribute to vaginal dryness.

A medication should **never be abruptly stopped** because of sexual side effects.

The prescribing physician can review whether the medicine is contributing and whether dose modification, substitution or another strategy is appropriate.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Testosterone and Low Sexual Desire

Women naturally produce androgens as well as estrogen.

For selected postmenopausal women with persistent, distressing low sexual desire after other relevant factors have been addressed, testosterone may sometimes be considered under specialist guidance.

The NHS notes that testosterone preparations can help improve low libido in some menopausal women, while emphasizing that many other factors—including physical discomfort, self-image and relationships—may contribute.

This is not a treatment to purchase casually online.

Appropriate assessment, dosing and follow-up are required.

Breast Cancer and Vaginal Dryness

Menopausal symptoms after breast cancer require particular care.

Some breast cancer treatments reduce estrogen activity and can produce significant vaginal dryness and discomfort.

Nonhormonal lubricants and moisturizers are commonly considered first.

ACOG states that low-dose vaginal estrogen may sometimes be considered in breast cancer survivors whose symptoms do not improve sufficiently with nonhormonal approaches, with the risks and benefits discussed with the gynecologist and oncologist.

Treatment must therefore be individualized rather than based on general internet advice.

Postmenopausal Bleeding Is Not “Just Menopause”

This deserves special emphasis.

Although dryness and delicate vaginal tissue can occasionally contribute to spotting after intercourse, **bleeding after menopause must be medically evaluated.**

Do not repeatedly apply creams or herbal treatments without first establishing the cause.

Abnormal uterine, cervical, vaginal and other gynecological conditions need to be excluded.

The same principle applies to persistent unexplained discharge, sores, lumps or severe pelvic pain.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Intimacy Does Not Have to Mean Penetration

Some couples unconsciously define successful sex only as penetrative intercourse.

This can create tremendous pressure when dryness or pain develops.

Healthy intimacy can include affection, touch, kissing, massage, emotional connection and other mutually comfortable forms of sexual expression.

Taking penetration temporarily out of the equation can sometimes reduce anxiety enough for recovery to begin.

Once pain is controlled and the woman feels ready, penetration can be gradually reintroduced if desired.

The objective is **mutual comfort and satisfaction**, not performance.

The Role of the Partner

Partners should understand that menopause-related vaginal changes are biological.

A woman experiencing reduced lubrication is not necessarily rejecting her partner.

Likewise, a woman who needs more time for arousal is not “less interested” simply because her response has changed.

A supportive partner can help by slowing down, avoiding pressure, using appropriate lubrication, discussing comfortable forms of intimacy and respecting when something hurts.

Sexual health becomes much easier to restore when the woman feels safe rather than evaluated.

The Unani Perspective on Menopause

As a physician trained in the **Unani system of medicine**, I consider menopause from a whole-person perspective.

The Unani system traditionally emphasizes the interaction of constitution, nutrition, physical activity, rest, sleep, psychological state and other lifestyle factors.

CCRUM, under India's Ministry of Ayush, describes a holistic approach as an established principle of Unani medicine, taking physical, emotional, lifestyle and constitutional factors into account rather than considering only the affected organ.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

This perspective can be particularly useful during menopause because menopausal sexual complaints rarely occur in isolation.

A woman may simultaneously have disturbed sleep, constipation, anxiety, reduced exercise, chronic pain, metabolic problems and vaginal discomfort.

Addressing the whole patient therefore makes clinical sense.

Unani Medicine Specifically Recognizes Menopausal Women's Health

This is not simply a theoretical connection.

CCRUM's **Training Module for Geriatric Health Care** includes a dedicated section on women's healthcare covering hormonal changes related to the premenopausal and menopausal period, postmenopausal syndrome, vaginal conditions, osteoporosis and psychological problems.

The module identifies Unani therapeutic approaches including **Ilāj bil-Tadbīr (regimenal therapy)**, **Ilāj bil-Ghīdhā (dietotherapy)**, **Ilāj bil-Dawā (pharmacotherapy)** and **Ilāj Nafsānī (psychological approaches)** as components of care for older women.

This provides a legitimate traditional framework for supportive menopausal care.

But it must be interpreted responsibly in light of modern evidence.

Ilāj bil-Ghīdhā – Dietotherapy

Nutrition is important during menopause not merely for sexual function but for overall health.

The traditional Unani concept of **Ilāj bil-Ghīdhā**, or dietotherapy, emphasizes adapting food to the patient's health status and constitution.

In modern clinical practice, I combine this principle with contemporary nutritional considerations.

Women entering menopause should pay attention to adequate protein, appropriate caloric intake, vegetables, fruits and micronutrients, particularly in the context of bone, cardiovascular and metabolic health.

Nutrition should also be individualized for conditions such as diabetes, obesity, hypertension, kidney disease or gastrointestinal disorders.

A healthy body provides a stronger foundation for healthy sexual function.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Ilāj bil-Tadbīr – Regimenal and Lifestyle Therapy

Unani medicine gives significant importance to lifestyle and regimen.

CCRUM describes regimenal therapy as a traditional method for maintaining general health through systematic modification of lifestyle and physical routines.

For a menopausal patient, appropriate lifestyle care may include regular physical activity, maintaining muscle strength, managing stress, improving sleep and addressing constipation or general physical deconditioning.

These measures do not directly replace vaginal estrogen when GSM is significant.

Rather, they improve the broader health environment in which sexual function occurs.

This distinction is important.

Ilāj Nafsānī – Psychological and Emotional Care

Traditional Unani medicine also recognizes psychological care.

CCRUM describes **Ilāj Nafsānī** as an established component of the Unani approach and notes the importance of sleep, psychological processes and the traditional Six Essential Factors in health.

Modern sexual medicine arrives at a similar conclusion through the biopsychosocial model.

A woman experiencing anxiety, depression, fear of painful intercourse or relationship conflict may need counselling alongside physical treatment.

Medicine alone does not repair every sexual problem.

Unani Pharmacotherapy: Where Does It Fit?

Selected Unani medicines may be used by a qualified practitioner according to the woman's constitution, symptoms and overall medical condition.

However, I believe it is essential to be transparent about evidence.

High-quality modern evidence supporting specific Unani formulations as direct treatments for GSM, vaginal tissue atrophy or menopause-related sexual dysfunction remains limited.

Therefore, Unani treatment should be used as part of an individualized and integrative approach rather than making unsupported claims that an herbal medicine can “restore estrogen,” “reverse menopause” or permanently rejuvenate vaginal tissues.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

The evidence supporting low-dose vaginal estrogen for GSM is currently much stronger than the evidence supporting specific Unani herbal formulations for this particular indication.

Responsible traditional medicine should acknowledge this.

“Natural” Does Not Always Mean Risk-Free

This is especially important with menopausal products.

Women may encounter herbal supplements advertised for hormone balance, vaginal rejuvenation or libido enhancement.

ACOG cautions that many plant and herbal supplements marketed for menopause have limited safety and effectiveness data and may not be regulated to the same standard as prescription medicines.

Some herbs can interact with antidepressants, blood thinners, blood-pressure medicines, diabetes treatment or cancer therapies.

At Saira Health Care, medicines should therefore be selected after understanding the patient's medical history rather than simply because a product is labelled “natural.”

My Clinical Approach at Saira Health Care

When a woman comes to me saying:

“Doctor, I have lost interest in intimacy since menopause,”

I do not immediately prescribe a sexual tonic.

I first try to understand her experience.

Does she still have emotional desire but intercourse hurts?

Is vaginal dryness the main problem?

Has lubrication changed?

Has orgasm become difficult?

Is she afraid because she experienced bleeding after intercourse?

Is she exhausted because of poor sleep?

Is she experiencing anxiety or depression?

Has she started an antidepressant?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Does she have diabetes, thyroid disease or chronic pain?

Is there relationship pressure?

Has she undergone hysterectomy or cancer treatment?

Are urinary symptoms present?

Does examination suggest GSM, infection, vulvar disease or pelvic-floor dysfunction?

Only after these questions are addressed can treatment become rational.

That is how I believe sexual-medicine practice should be approached.

Integrating Unani and Contemporary Treatment

At **Saira Health Care**, an integrative strategy may include appropriate dietary and lifestyle guidance based on Unani principles together with evidence-based evaluation of menopausal sexual symptoms.

For example, a woman may simultaneously benefit from improved sleep and physical activity, individualized nutritional counselling, appropriate Unani supportive treatment and an evidence-based vaginal therapy prescribed after gynecological assessment.

Another woman may primarily need pelvic-floor physiotherapy.

Another may require treatment of depression.

Another may benefit from local vaginal estrogen.

Another may need evaluation of postmenopausal bleeding before any treatment can safely begin.

Another may simply require counselling, lubrication and reassurance.

Personalization is more important than prescribing the same formula to every woman.

The Contribution of Saira Health Care

Through its focused clinical work in **sexual disorders and infertility**, Saira Health Care aims to encourage patients to discuss intimate health concerns without embarrassment.

Female sexual-health complaints are often underreported because many women hesitate to discuss dryness, pain, low desire or changes in orgasm.

Part of our role is therefore educational.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

A woman should understand that vaginal dryness is treatable.

Painful intercourse deserves evaluation.

Low desire has multiple possible causes.

Menopause does not mean sexual life has ended.

And traditional medicine should be integrated responsibly with appropriate modern investigation rather than used as a reason to avoid necessary medical care.

This patient-centred and integrative philosophy forms an important part of the approach promoted at Saira Health Care.

When Should a Woman Seek Medical Assessment?

Professional evaluation is particularly important when any of the following occurs:

- Bleeding after menopause or repeated bleeding after intercourse
- Persistent or severe vaginal or pelvic pain
- Unexplained vaginal discharge, sores, ulcers or a new lump
- Recurrent urinary tract infections or persistent urinary burning
- Vaginal dryness or painful intercourse that does not improve with basic measures
- Significant difficulty with penetration despite adequate lubrication
- Persistent low sexual desire that causes personal distress
- Sudden major changes in sexual function
- Symptoms occurring after cancer treatment or pelvic surgery
- Severe anxiety, depression or other significant mental-health symptoms
- A desire to stop antidepressants or other prescribed medicines because of sexual side effects

These problems deserve diagnosis rather than assumptions.

Frequently Asked Questions

Is vaginal dryness normal during menopause?

It is **common**, but that does not mean it should simply be tolerated.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Lower estrogen can reduce vaginal moisture and change tissue thickness and elasticity. Effective nonhormonal and hormonal treatments are available.

Does vaginal tissue permanently become thin after menopause?

Low estrogen can produce ongoing tissue changes, and GSM may persist without treatment. Appropriate vaginal therapy can substantially improve dryness, irritation and painful intercourse in many women.

The goal is not to reverse ageing but to restore tissue comfort and function.

Can lubricants cure vaginal atrophy?

Lubricants reduce friction during sexual activity and can make intercourse more comfortable, but they do not reproduce all of estrogen's biological effects on vaginal tissue.

Moisturizers can improve ongoing moisture, while local estrogen directly treats estrogen-responsive vaginal tissue in suitable patients.

Can a woman have sexual desire after menopause?

Absolutely.

Menopause does not eliminate sexuality.

Desire varies widely between individuals and is influenced by physical comfort, health, sleep, mood, relationship quality, medications and psychological factors in addition to hormones.

Why do I want intimacy but my body does not lubricate?

Desire and lubrication are related but are not identical processes.

Menopausal estrogen changes can reduce vaginal lubrication even when emotional interest remains present.

Lubricants, moisturizers and appropriate medical treatment can help.

Why has my libido suddenly decreased?



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Possible contributors include vaginal pain, menopausal symptoms, poor sleep, anxiety, depression, relationship difficulties, chronic illness and medications.

The correct treatment depends on identifying the cause rather than automatically prescribing a sexual stimulant.

Is vaginal estrogen safe?

For many women, low-dose vaginal estrogen is considered an effective treatment with minimal systemic absorption. NICE states that serious adverse effects are very rare in appropriately selected patients.

Women with certain medical histories, particularly hormone-sensitive cancers, require individualized consultation with appropriate specialists.

Can Unani medicine help?

Unani medicine can contribute an important **supportive and holistic framework** through dietotherapy, regimenal care, psychological support, lifestyle modification and carefully selected pharmacotherapy.

CCRUM specifically includes menopausal and postmenopausal women's health within its Unani geriatric-care framework.

However, significant vaginal atrophy, persistent sexual pain, unexplained bleeding, recurrent urinary symptoms and suspected gynecological disease require evidence-based assessment. Unani care should complement rather than delay appropriate diagnosis.

A Message to Women

I want every woman going through this stage of life to understand:

Your body is changing, but your sexual health still matters.

You do not have to accept painful intercourse simply because you are older.

You do not have to feel embarrassed about needing lubricant.

You do not have to interpret reduced spontaneous libido as a failure of femininity.

You do not have to remain silent about urinary symptoms or vaginal discomfort.

And you should never feel pressured into painful intimacy merely to satisfy someone else's expectations.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Menopause is a transition.

It requires adaptation—not resignation.

A Message to Partners

If your partner is experiencing menopausal vaginal dryness or changing libido, patience can be therapeutic.

Do not interpret reduced lubrication as a measure of attraction.

Do not rush penetration.

Do not pressure her because sexual frequency has changed.

Do not tell her that pain is “all in the mind.”

Instead, communicate.

Allow more time for arousal.

Use appropriate lubrication.

Encourage medical consultation when pain persists.

Remember that intimacy is a shared experience, not a performance test.

Healthy Sexual Ageing

One of the most positive developments in modern sexual medicine is the recognition that sexual health remains relevant throughout life.

A woman does not stop being a sexual person at menopause.

Healthy sexual ageing means allowing sexuality to evolve.

The body may need more time.

Lubrication may need assistance.

Chronic health conditions may require adjustments.

Some forms of intimacy may become more important than others.

What matters is that sexual activity remains **comfortable, consensual, meaningful and safe.**

Conclusion



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Perimenopause and menopause can change vaginal health and sexual response through declining and fluctuating hormones, especially estrogen.

Vaginal tissues may become thinner, drier and less elastic. Lubrication may decrease. Urinary symptoms may develop. Penetration may become uncomfortable. Sexual desire may increase, decrease or simply change in character.

These symptoms are common, but they should not be dismissed.

Modern evidence supports several treatment options, ranging from lubricants and vaginal moisturizers to local vaginal estrogen and other prescription treatments for appropriate patients. Psychological care, relationship counselling and pelvic-floor physiotherapy can be equally important when those factors contribute.

Unani medicine contributes a valuable whole-person perspective through **Ilāj bil-Ghidhā, Ilāj bil-Tadbīr, Ilāj bil-Dawā and Ilāj Nafsānī**, with attention to diet, lifestyle, sleep, emotional health and individualized care. CCRUM formally recognizes menopausal and postmenopausal health within its women's-health framework.

The best approach is therefore not to choose between traditional and contemporary medicine as though they must oppose one another.

The safer approach is to use **evidence, careful diagnosis and individualized integrative care.**

At Saira Health Care, this is the principle I emphasize in the management of intimate and reproductive health concerns:

Understand the cause first. Treat the woman as a whole. Protect her health. Restore comfort. And never dismiss sexual well-being as unimportant simply because she has reached menopause.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

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



+91-9452580944



+91-5248-359480



www.sairahealthcare.com

Medical Disclaimer

This article is intended for general education and health awareness and is not a substitute for individualized medical examination, diagnosis or treatment. Menopausal hormone therapy, vaginal estrogen, testosterone and other prescription treatments should be used only after appropriate professional assessment. Herbal and Unani medicines can also have contraindications and drug interactions and should not be self-prescribed.

Any bleeding after menopause, persistent pelvic or vaginal pain, unexplained genital lesions, significant urinary symptoms or other concerning changes should be medically evaluated rather than assumed to be a normal part of menopause.



+91-9452580944



+91-5248-359480



www.sairahealthcare.com