Here, I have gathered only parts of the report issued by the American Urological Association. Please go to the following link to read the full report.
https://www.auanet.org/guidelines-and-quality/guidelines/genitourinary-syndrome-of-menopause#x21931

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Genitourinary Syndrome of Menopause: AUA/SUFU/AUGS Guideline (2025)

GUIDELINE STATEMENT 8 {EXCERPTS}

Clinicians should offer the option of local low-dose vaginal estrogen to patients with GSM to improve vulvovaginal discomfort/irritation, dryness, and/or dyspareunia. ***(Strong Recommendation; Evidence Level: Grade C)***

Local low-dose vaginal estrogen may be administered in the form of a cream, tablet, insert, or ring to improve symptoms of GSM. . . .

Despite the limitations of the literature, the Panel recommends local low-dose vaginal estrogen to treat GSM symptoms due to its effectiveness combined with a high margin of safety. The safety of low-dose vaginal estrogen is supported by Mitchell et al.[62] and Constantine et al.,[63, 64] both of whom found significant improvement in GSM symptoms with no increase in serum estradiol levels. Likewise, a 2019 systematic review[63] of 20 RCTs, 10 interventional trials, and 8 observational studies found no increased endometrial hyperplasia or cancer risk in patients on low-dose estrogen (without progestogen). There has been evidence of safety in breast cancer survivors using low-dose vaginal estrogen as well.[65-67] Finally, an 18-year follow-up of women enrolled in the Nurse's Health Study found no increased risk for chronic disease for low-dose vaginal estrogen when compared to systemic estrogen.[68] . . .

The evidence particularly supports the use of local low-dose vaginal estrogen to treat vaginal dryness. Seven studies[64, 69-74] (n=2072) showed mixed effects of vaginal estrogen on dryness when compared to placebo at 8-12 weeks. One study showed

a significant benefit when using 10 mcg of vaginal estrogen, but not 4 mcg.[64] Another study found daily utilization of vaginal estrogen cream was significantly better at improving vaginal dryness compared to twice weekly utilization when compared to placebo.[70] . . .

When comparing vaginal estrogen to no treatment, one RCT[75] (n=108) found patients with vaginal estrogen had significantly more symptom resolution than those without treatment after 36 weeks.

GUIDELINE STATEMENT 11

In patients with GSM who are on systemic estrogen therapy, clinicians should offer the option of local low-dose vaginal estrogen or vaginal dehydroepiandrosterone (DHEA). ***(Expert Opinion)***

{EXCERPTS} Some patients using systemic estrogen therapy for management of vasomotor symptoms or protection of osteoporosis, who also have GSM symptoms, may not achieve adequate relief of their GSM symptoms with systemic estrogen therapy alone. Although data are limited, in patients with GSM, the Panel recommends consideration of concurrent use of local low-dose vaginal estrogen or vaginal DHEA to manage GSM symptoms. Because these low-dose therapies are applied directly to the affected tissues, they are preferred over systemic therapy when only GSM symptoms are present.[32] Clinicians should be aware that there are no data investigating the potential risk associated with the addition of local low-dose vaginal estrogen or DHEA to systemic estrogen therapy. . . .

GUIDELINE STATEMENT 12

In patients with GSM and comorbid genitourinary conditions (e.g., overactive bladder), clinicians may offer local low-dose vaginal estrogen to improve genitourinary symptoms. ***(Expert Opinion)***

{EXCERPTS} The urinary symptoms associated with GSM are also linked with other common urinary conditions in older patients, such as OAB, making identification, evaluation, and treatment of these and other symptoms complex.[4] *The AUA/SUFU Guideline on the Diagnosis and Treatment of Idiopathic Overactive Bladder*[102] directs clinicians to assess a patient for signs of GSM on physical exam

during the workup for OAB and recommends local low-dose vaginal estrogen as a treatment option for OAB. . . .

GUIDELINE STATEMENT 13

In patients with GSM and recurrent urinary tract infections, clinicians should recommend local low-dose vaginal estrogen to reduce the risk for future urinary tract infections. ***(Moderate Recommendation; Evidence Level: Grade B)***

{EXCERPTS}. . . there is compelling evidence that low-dose vaginal estrogen therapy prevents rUTI in perimenopausal and postmenopausal patients, those who have ovarian dysfunction, and those who are post-oophorectomy. . . . In 2013, a systematic review of 44 papers that studied postmenopausal women with GSM showed that local low-dose vaginal estrogen lowered the incidence rate of UTI. . . . The *Recurrent Uncomplicated Urinary Tract Infections in Women: AUA/CUA/SUFU Guideline* (2022) also recommends the use of local low-dose vaginal estrogen to reduce the risk for rUTI in peri- and postmenopausal women.[105] The evidence used to support the rUTI guideline likewise found that local low-dose vaginal estrogen decreased the number of occurrences of rUTI. …Finally, a multicenter retrospective review of mostly (93.4%) postmenopausal women (n=5,600) in the Kaiser Permanente Southern California System showed that vaginal estrogen prescriptions reduced rUTI.

GUIDELINE STATEMENT 17

Clinicians should counsel patients that the evidence does not support the use of CO_2 laser, ER:YAG laser, or radiofrequency in the treatment of GSM-related vulvovaginal dryness, vulvovaginal discomfort/irritation, dysuria, quality of life,

change in bothersome symptoms, satisfaction with treatment, or dyspareunia. ***(Moderate Recommendation, Evidence Level: Grade C)***

GUIDELINE STATEMENT 18

In the context of shared decision-making, and with the disclosure that these therapies are considered experimental outside of clinical trials, clinicians may consider CO_2 laser treatment in patients who are not candidates for, or prefer alternatives to, FDA-approved treatments for GSM-related vulvovaginal dryness, vulvovaginal discomfort/irritation, dysuria, and/or dyspareunia. ***(Expert Opinion)***

Breast and Endometrial Cancer

GUIDELINE STATEMENT 19

Clinicians should inform patients of the absence of evidence linking local low-dose vaginal estrogen to the development of breast cancer. ***(Expert Opinion)***

{EXCERPTS} In 2003, the FDA required a warning placed on all estrogen products regarding an increased risk for endometrial cancer, cardiovascular disorders, breast cancer, and dementia.[160] Since that time, there has been a growing body of evidence that local low-dose vaginal estrogen does not increase the risk for primary breast cancer[161] or recurrence of breast cancer in women with a personal history of breast cancer.[65, 66, 162, 163]

While breast cancer was not an endpoint in the evidence report used to develop this guideline, existing data supports conclusions that local low-dose vaginal estrogen does not increase breast cancer risk in individuals without a history of breast cancer and at average risk (less than 15%) for developing breast cancer. Per the National Cancer Institute, a woman's lifetime risk for developing breast cancer is 12.9%.[164] There are various risk models assessing individual risk for breast cancer that can modify this risk. Individuals with less than a 15% lifetime risk are considered average risk and those with >20% lifetime risk are considered high risk and include individuals with BRCA mutations and strong family histories.

In a secondary review of the Women's Health Initiative Observational Study that included 45,633 women without prior history of breast or endometrial cancer and not on systemic estrogen therapy, those with self-reported use of local low-dose

vaginal estrogen during the follow up period did not have higher risk for breast cancer, stroke, endometrial cancer, colorectal cancer, or venous thromboembolism. The risk for coronary artery disease and all-cause mortality were likewise lower in the local low-dose vaginal estrogen users.[161]

While there are no data stratifying the risk for breast cancer in users of local low-dose vaginal estrogen who have an above average or high risk for breast cancer, data suggest that local low-dose vaginal estrogen does not increase the risk for recurrence or of breast cancer mortality in women with a personal history of breast cancer.[65, 66, 162, 163, 165]

There is a dearth of data on patients who are at moderate to high risk for breast cancer (i.e., those with BRCA gene mutations or a strong family history) and their risk for developing breast cancer as a result of using local low-dose vaginal estrogen. There are data to suggest that systemic estrogen in this group does not further increase the risk for breast cancer in individuals with BRCA mutations.[30] Although systemic levels of estradiol may increase briefly and to a small degree after starting local low-dose vaginal estrogen (theoretically via the atrophic vaginal epithelium), the levels return to menopausal levels after 12 weeks.[166] Serum levels with 10mcg tablet and vaginal ring remain in the menopausal range.[167, 168] Estradiol cream or conjugated equine estrogen cream could result in elevated serum levels, particularly if used incorrectly. In general, however, local low-dose vaginal estrogen for GSM, unlike systemic estrogen used to treat vasomotor and other systemic symptoms, results in negligible serum levels of estradiol, and thus does not increase risk for breast cancer.

GUIDELINE STATEMENT 20

For patients with GSM who have a personal history of breast cancer, clinicians may recommend local low-dose vaginal estrogen in the context of multi-disciplinary shared decision-making. ***(Expert Opinion)***

GUIDELINE STATEMENT 22

Clinicians should counsel patients with GSM that local low-dose vaginal estrogen does not increase the risk for endometrial hyperplasia with atypia or endometrial cancer. ***(Moderate Recommendation; Evidence Strength:***

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