NAMS Practice Pearl

Clinical Management of Hypoactive Sexual Desire Disorder in Postmenopausal Women

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***Approximately 10% to 12% of women meet the criteria for hypoactive sexual desire disorder, with the highest prevalence in midlife women, ranging from 14.5% to 33%. Despite the negative effect on health and quality of life, most women are reluctant to discuss sexual concerns with healthcare professionals (HCPs). Although HCPs have the best opportunities to address these problems, most of them have limited awareness, education, and comfort about addressing sexual concerns, resulting in a conspiracy of silence. The purpose of this* Practice Pearl *is to improve the understanding of hypoactive sexual desire disorder, including symptoms, etiology, diagnosis, and treatment*.**

Hypoactive sexual desire disorder (HSDD) can be described as the persistent deficiency or absence of sexual interest or desire that causes a woman personal distress.[1] It is best understood using a biopsychosocial model to capture the interaction of physiologic, psychologic, sociocultural, and interpersonal influences.[2]

Prevalence and etiology. Prevalence can only be estimated, but large surveys indicate that approximately 10% to 12% of women meet the criteria for HSDD,[3,4] with women in midlife (45-64 y) having the highest prevalence, ranging from 14.5%[3] to 33%.[4]

Assessment and diagnosis. The International Society for the Study of Women's Sexual Health (ISSWSH) Process of Care for HSDD provides a useful algorithm to help HCPs identify, diagnose, and treat HSDD.[5]

Healthcare professionals can and should open the door to discussing sexual health and assessing concerns by explaining that sexual health is important to overall health and that assessment of sexual function is a routine part of good medical care. An initial assessment can be accomplished quickly during any office visit, beginning with a statement validating or legitimizing the woman's right to have healthy sexual function and to have concerns addressed and treated, followed by a few open-ended questions. A ubiquity statement such as, "Most women have sexual concerns at midlife; what concerns do you have?" or, "How do you feel about your current level of sexual

desire, arousal, orgasm, and satisfaction with sexual activity?" helps to validate a woman's concerns.

Consider the validated Decreased Sexual Desire Screener (DSDS)[6] or a focused sexual history to determine whether a woman meets criteria for HSDD. The DSDS, available online, consists of five "yes/no" questions. If a woman answers "yes" to the first four, she may have acquired HSDD. The fifth question includes seven groups of factors that might be contributing to her decreased sexual desire. For the women whose DSDS indicates HSDD, the HCP may elicit more sexual history in accordance with the ISSWSH Process of Care algorithm.

A sexual history should include details of past and present sexual desire, arousal, orgasm, and pain because of the common overlap of problems, as well as a review of partnered and unpartnered sexual experiences. Medical, psychological, and social histories and a list of prescription and over-the-counter medications and misuse of substances can be helpful in identifying factors that may explain loss of desire and identify contributing factors that may be potentially reversible.[5]

Although neither a physical examination nor laboratory testing are required to make the diagnosis of HSDD, it may be helpful in postmenopausal women to rule out other factors that might better explain their loss of sexual interest. For example, women with dyspareunia because of genitourinary syndrome of menopause may report less sexual desire because of painful sex. This reflects the biopsychosocial nature of HSDD and the importance of considering the association of these factors and their contributions with complaints of loss of desire.

Treatment. Treatment for HSDD may include education, modification of contributing factors, psychotherapy, pharmacotherapy, or a combination of treatments.

***Education*.** Education consists of providing information on normal sexual function. In addition, HCPs should educate women about factors identified by the sexual history, screening questions, and potential examination or laboratory test findings that may be disrupting sexual function.[5]

***Psychotherapy*.** The goal of psychotherapy is to alter the psychological and interpersonal factors contributing to low desire. Interventions include sensate focus (nondemand sensual touching exercises), cognitive-behavior therapy (learning to alter thoughts and behaviors that cause or maintain HSDD), mindfulness cognitive-behavior therapy (exercises designed to promote nonjudgmental observation of experiences), and couples therapy to improve communication skills around intimacy and to reestablish a sexual relationship that has been compromised.[5]

***Medications*.** There are several pharmacologic options to consider for postmenopausal women suffering from HSDD. Informed consent should include an explanation that these options may be off-label therapies for postmenopausal women depending on the preparation and the woman's age. Although these therapies were developed specifically for HSDD, responders have experienced downstream benefits for arousal and orgasm as well.

Flibanserin, a 5-HT1a receptor agonist and 5-HT2a receptor antagonist, is a nonhormone centrally acting daily oral therapy FDA approved for acquired, generalized HSDD in premenopausal women. It is approved by Health Canada for menopausal women aged up to 60 years. It is given

as a once-daily, 100-mg dose at bedtime. Its efficacy and safety have been shown in postmenopausal women.[7] Approximately 50% of women with HSDD respond to flibanserin within 8 weeks.

The most common adverse events (AEs) in postmenopausal women have been dizziness (9.9%), somnolence (8.8%), nausea (7.5%), and headache (6.0%). Most AEs are mild to moderate in severity and mitigated with bedtime dosing. A prior alcohol contraindication has been removed, and instead a boxed warning instructs women to wait at least 2 hours after consuming one to two standard alcoholic drinks before taking flibanserin to reduce the risk of hypotension and syncope. Also, a prior risk evaluation and mitigation strategy program in the United States has been modified, removing certification requirements for prescribing HCPs. Flibanserin has "off-target" benefits to some postmenopausal women. These include weight loss and improved sleep (as judged by next day driving).

Bremelanotide, also FDA approved for premenopausal women with acquired, generalized HSDD, is a melanocortin receptor agonist. It is self-administered "as needed," using a subcutaneous auto injection device prefilled with 1.75 mg/0.3 mL delivered with a 29-gage nonvisible needle approximately 45 minutes before the earliest anticipated sexual activity. Dosing should not occur more than once in 24 hours, with a maximum of eight uses per month. Contraindications are uncontrolled hypertension and known cardiovascular disease. The most common AEs are nausea (40.0%), flushing (20.3%), and headache (11.3%).[8] Efficacy is similar to that of flibanserin.

ISSWSH has published a clinical practice guideline, informed by a Global Consensus Position Statement[9] developed by 11 international medical societies, including The North American Menopause Society, on the use of testosterone therapy in women that supports the use of systemic transdermal testosterone therapy for postmenopausal and late-reproductive-aged women with HSDD.[10] Recommended formulations are approved transdermal products for men using approximately one-tenth of the dose for men, with the targeted goal of the physiologic premenopause range.

Compounded transdermal products are suboptimal because of potential variability in testosterone concentration. Average efficacy emerges 6 to 8 weeks after initiation but may take as long as 12 weeks. Although there is a lack of long-term safety data, ongoing testosterone therapy may be needed to maintain improvements in HSDD. Total testosterone should be measured before treatment to exclude women with high baseline testosterone concentrations. Measuring sex hormone-binding globulin is also recommended because women with greater-than-normal levels are less likely to benefit from treatment. Safety data show no serious AEs with physiologic testosterone use.

Pearl. Midlife women's HCPs are uniquely positioned to identify and counsel women with sexual concerns. Using a biopsychosocial lens, HCPs can easily and accurately screen, diagnose, and treat HSDD. Treatment options include education, psychotherapy, or pharmacotherapy used alone or optimally in combination. Healthcare professionals should use shared decision-making when choosing among these treatment options.

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Disclosures

Dr. Kingsberg reports Consultant, Stock Options for Field Trip and Materna Medical; Physician Advisory Board for Ms.Medicine; Scientific Advisory Board for Astellas, Bayer, Dare, Lupin, Madorra, Materna Medical, Ovoca, Palatin Tech, Pfizer, Sprout, Strategic Science Technologies, and TherapeuticsMD; Scientific Content Advisor for Alloy; Stock Options for Viveve.
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