Distressing Sexual Function at Midlife
Unmet Needs, Practical Diagnoses, and Available Treatments

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Question 1:
Is there a role for physicians who do not specialize in female sexual dysfunction (FSD) in prescribing medications, such as flibanserin, for hypoactive sexual desire disorder (HSDD) prior to initiation of other nonpharmaceutical modalities such as counseling?

Response from Dr. Simon and Ms. Lukas:
Yes, there is a role for providers of many designations (MD, NP, PA, etc.) who do not specialize in FSD for diagnosing HSDD and prescribing the appropriate medications for treatment. The HSDD diagnosis and intervention may not result from a single office visit or consultation. Getting to know your patients’ complaints regarding sexual desire, and the psychosocial context, will greatly affect the treatment course. For example, is a history of sexual abuse or assault relevant? How has the relationship with a partner been affected by the low desire, or was it related? An understanding of whether an arousal or an orgasmic component is present may each shift the focus of and approach to treatment. Depending upon the circumstances, individual or couples counseling may be required. If the dysfunction is arousal- or orgasm-based, options to provide greater stimulation may be helpful, such as a phosphodiesterase type 5 inhibitor for improved arousal or devices like Fiera or KegelSmart for improved physiologic arousal and pelvic floor tone, respectively. While counseling may be effective for some patients and couples, it results in high attrition and recurrence rates. HSDD is biological, not psychological, and therapy cannot completely address the neurologic effects.

Initiating flibanserin (Addyi) prior to or in conjunction with counseling is advisable. Flibanserin has a relatively safe adverse events profile and can be managed easily by a trained physician, nurse practitioner, or physician’s assistant even if not specialized in FSD. An 8-week treatment course to assess efficacy is all that’s required. Unfortunately, the U.S. Food and Drug Administration (FDA) has created a barrier for physicians who do not regularly see HSDD patients by requiring mandatory Risk Evaluation and Mitigation Strategies (REMS)
In the event that flibanserin does not resolve HSDD symptoms in 8 weeks, off-label prescriptions may be explored as outlined in our Clinical Expert Series article.

**Question 2:**

How do you incorporate topics on FSD into an already full 4-year residency curriculum? How can the physician educators of residents incorporate the topics of FSD more effectively?

**Response from Dr. Simon and Ms. Lukas:**

Time is always a constraint in medical education as electives are limited. I have had many residents elect to rotate through my clinic in their third and fourth year to gain exposure to evaluating and treating menopause and FSD. My suggestion for practitioners and trainees who do not have formal training is to begin by adding sexual dysfunction screening to their regular clinic evaluation, even as part of the routine annual examination. By simply asking the right questions regarding sexual satisfaction, residents may discover that more of their patients are silently experiencing dysfunction. Becoming comfortable discussing sexual concerns with patients is the first step to initiating an informal FSD curriculum within resident education.

**Question 3:**

In your practice, do you routinely order blood work for new patients presenting with FSD?

**Response from Dr. Simon and Ms. Lukas:**

In my practice and in general, initial bloodwork plays a minimal role in the actual diagnosis of FSD in patients that are not presenting with other symptoms or known concomitant disease. For new patients, it may be important to collect serum chemistries and hormone levels (ie, estradiol, follicle-stimulating hormone, prolactin) when menstrual irregularity or possible menopause may be contributing to FSD. Testing testosterone can often be confusing as testosterone levels poorly correlate with sexual desire. That said, serum testosterone can serve as a baseline measure for monitoring testosterone treatment absorption and assessing overdosing or abuse. If the local lab does not offer testosterone testing with adequate sensitivity for the postmenopausal range, albumin, sex hormone-binding globulin, and total testosterone levels can be collected to estimate free testosterone using web-based free and bioavailable testosterone calculators (eg, http://www.issam.ch/freetesto.htm).

**Question 4:**

When treating vulvovaginal atrophy (VVA), are there specific vaginal estrogen preparations that patients respond to better to than others?

**Response from Dr. Simon and Ms. Lukas:**

Patient preference is the paramount determinant for vaginal estrogen preparations. Tablets, rings, and creams work equally well for the resolution of VVA symptoms and reestablishment of a healthy vaginal flora. For patients presenting with severe atrophy, creams may be preferred as they will liberally coat the vagina, introitus, and vulva. As VVA is progressive, the best treatment regimen will be the one that the patient will use consistently. There are multiple pressures that will influence which vaginal estrogen preparation results in the best compliance for patients. These include dose form, dose frequency, and for many, insurance coverage and price. Rings have the highest compliance due to their infrequent dosing regimen (aka, “set it and forget it”). Patients for whom the concept of a “permanent” ring is distasteful often prefer vaginal tablets. Some patients appreciate the extra lubrication and variable dosing options that cream-based products afford. Offering all options and letting the patient choose the best option for her lifestyle is the best approach. Ultimately, insurance coverage
and price considerations are most influential to patients. Using the Medicare formulary as an example, all vaginal estrogen products are tier 3 including Yuvafem, the generic for Vagifem. Cost can be prohibitive to some patients.

Lastly, in addition to vaginal estrogen preparations, daily oral ospemifene (Osphena) and daily vaginal dehydroepiandrosterone (prasterone; Intrarosa) are also approved by the FDA for dyspareunia.

Question 5:

The American College of Obstetricians and Gynecologists’ Practice Bulletin No. 119 (see Obstet Gynecol 2011;117:996–1007) includes a Level A conclusion that transdermal testosterone has shown to be effective for the short-term treatment of HSDD; however, there is not an FDA-approved transdermal patch specifically for HSDD. Is there a role in prescribing testosterone in the treatment of women with HSDD?

Response from Dr. Simon and Ms. Lukas:

Regardless of the lack of an FDA-approved testosterone product for women, there is a role for testosterone in the treatment of HSDD. Testosterone has documented benefit for women with HSDD in increasing the number of sexually satisfying events, increasing desire, and decreasing sexually related distress. Prescribing testosterone off-label for use in postmenopausal women has even been recommended by the Endocrine Society (see J Clin Endocrinol Metab 2014;99:3489–510).

The most important consideration for practitioners who are not accustomed to prescribing testosterone off-label is to reiterate to the patient that they are to use one-tenth of the male dose. Confusion can occur when premeasured dosage packets of the male dose are dispensed instead of resealable tubes. Additionally, the small amount of gel prescribed can confuse patients resulting in overdosing. If the physician has a trusted compounding pharmacy, compounded formulations can be prescribed. Patients should be advised of the signs of overdosing, including acne and hirsutism. Additionally, regular 6-month interval serum testosterone testing should be considered to monitor testosterone absorption and confirm proper use without excess.

Question 6:

How should the general practitioner approach a patient with FSD during an already full, busy clinic with limited time for the described detailed interactions?

Response from Dr. Simon and Ms. Lukas:

General practitioners have a few options as how to screen for FSD within the clinic. Practitioners can add a brief survey regarding sexual function to their intake documents or take the time to ask an informal line of questioning regarding sexual satisfaction during their regular well-woman consultation. When FSD is identified in the clinic, a separate consultation will be necessary to fully address the patient’s complaint. It is important to validate the patient’s concern and address it as a medically valid concern. Providing a brief education of the patient’s specific complaint using medical terminology in addition to lay language will provide the patient with the framework to address this problem. Such an approach validates the patient’s concerns and emphasizes that she is not the only one with such problems. For example, most patients will not come to the clinic complaining specifically of HSDD, but they may use terminology such as “there is no more spark anymore” or “I don’t have urges like I used to.” After establishing that this loss of desire is new and distressing to the patient, a practitioner can introduce the term HSDD and tell her that you would like to set up a separate appointment to discuss these concerns further and go over all the options for treatment. Evaluation of FSD should not be rushed nor ignored due to time constraints. Patients are typically motivated to explore the problem through multiple consultations to find a satisfactory solution.
Question 7:
What percentage of FSD patients with other comorbidities such as diabetes, thyroid disorders, or prolactin excess are successfully treated after the comorbidity is addressed?

Response from Dr. Simon and Ms. Lukas:
This is a very difficult question to answer because the percentage cannot be known. For patients with diabetes, FSD can be caused by underlying cardiovascular and neurological dysfunction. As a chronic disease, diabetes can only be managed, not cured, and even well-managed diabetes can result in vascular and neurological impairment over time. For these patients, phosphodiesterase type 5 inhibitors may help improve blood flow to the genital tissues and help with arousal and orgasmic dysfunction. After thyroid disorders and hyperprolactinemia are addressed, FSD can successfully be addressed in full. In premenopausal women, normal menstrual cyclicity is frequently a prerequisite for a normal hormonal milieu. Ultimately, the percentage to which FSD is able to be addressed is dependent on the patient’s commitment to the available therapy(s) and maintenance of control over their underlying comorbidity.