Sexual Function in Menopause

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Increasing age is a primary determinant of reduced sexual function in older women. Changes in the hormonal environment that accompany menopause are also believed to be significant contributors to female (and couples') sexual dysfunction. Loss of desire is increasingly reported by women with increasing age. In the age cohort between 50 and 70 years of age it is complained of by 48% of postmenopausal women. However, the distress associated with it is inversely associated with age, being more severe in the younger cohort, particularly after iatrogenic menopause (surgical, chemotherapic or radiotherapic). Estrogen deficiency initially accounts for irregular periods and diminished vaginal lubrication, leading to vaginal dryness, which is complained of by some 40-45% of women by the third year after the menopause. Continual estrogen loss is associated with changes in the vascular, muscular and urogenital systems, as well as alterations in mood, sleep, and cognitive functioning; these influence sexual function through both direct and indirect mechanisms. The age dependent decline in testosterone and androgen function, starting in the early twenties, may precipitate or exacerbate aspects of female sexual dysfunction; these effects are most pronounced following bilateral ovariectomy and consequent loss of greater than 50% of total testosterone. The contribution of progestogens to sexual health and variability in the effects of specific progestogens are being increasingly appreciated.

Orgasmic potential may be affected by different factors:
- age dependent, affecting the percentage of smooth muscle in the cavernosal bodies;
- hormone dependent, specifically linked to the gradual (with age) or acute (after bilateral oophorectomy) loss of testosterone, affecting the cavernosal body responsiveness to nitric oxide (NO), the most powerful vasodilating agent for the cavernosal bodies in both genders; loss of estrogens, permitting factors for the vasoactive intestinal peptide (VIP), contributing to the vasocongestion and the "orgasmic platform";
- pelvic floor related, when the muscular component of orgasm is affected by the reduced tonus, strength and/or muscular competence of the pelvic floor, particularly in multiparous women;
- dismetabolic, when diabetes affects both the nervous and vascular component of the sexual function and orgasmic response;
- iatrogenic, when antidepressants, such as the selective serotonin reuptake inhibitors (SSRI) are prescribed, or genital surgery disrupts the nervous component of the orgasmic reflex.

Introital dyspareunia is variably reported, in associations to:
- vaginal dryness or lichen sclerosus:
- hyperactivity of the pelvic floor;
- genital surgery, or radiotherapy.

Comorbidities, influenced by loss of sexual hormones, between mood and desire disorders and urogenital and sexual pain disorders are common and remain frequently overlooked in clinical practice. Physical and psychosexual changes may contribute to lower self-esteem, poorer self-image, and diminished sexual responsiveness and sexual desire.

Other important nonhormonal factors that affect sexuality are:
- health status and current medications;
- changes in or dissatisfaction with the partner relationship;
- the partner's general health and/or sexual problems;
- socioeconomic status;
- cultural attitudes towards sexuality and older women.

An interdisciplinary medical and psychosexual approach to postmenopausal sexual dysfunction must comprise an individualized hormone therapy and specific psychosexual and pelvic floor rehabilitative treatment. Key steps and tools for an appropriate diagnosis and treatment of women's sexual dysfunctions across the menopause will be presented with a clinical perspective, useful in the gynecologist' daily practice.