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Female sexual dysfunction and the menopause: new updates

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Background

Women are increasingly interested in having a longer and more satisfying sexual life. Female sexual dysfunction (FSD) is a multidimensional problem combining biological, psychological and interpersonal elements of multiple aetiology. The prevalence of this disorder is high: 29% of European women aged 18-70 complain of Hypoactive Sexual Desire Disorder (HSDD), 22% of arousal disorders, 19% of orgasmic disorders and 14% of sexual pain disorders. Up to 27% of women aged 40–80 years in Europe experience a lack of sexual interest; in the US, this number is considerably larger. Types of FSD include hypoactive sexual desire disorder, sexual arousal disorders, orgasmic disorders and sexual pain disorders.

Objective

The aim of the presentation is to review and update the etiology of FSD and the therapeutic options available for postmenopausal FSD, both pharmacological and non-pharmacological, with a special focus on giving practical recommendations to those physicians interested in the management of postmenopausal women with sexual complaints.

Method

Literature review and Author's clinical experience.

Results

1. Lifestyle intervention. Depression is the psychiatric disorder more frequently associated to HSDD. Obesity with metabolic syndrome, diabetes and CVD dramatically affect sexual function in women. Solid data indicate that diet, weight loss and regular exercise may significantly reduce CVD risk and improve FSD in women. Specifically, daily exercise can reduce inflammation, common denominator of depression and many diseases associated with aging, and specifically contribute to improve the sexual response in women.

2. Pharmacological therapy. For successful treatment of menopause-associated sexual dysfunction, interventional options include hormonal therapies such as oestrogens, topical or systemic, combined oestrogen and testosterone, testosterone alone (as in the Aphrodite study), tibolone and dehydroepiandrosterone. As solid data indicate that male sexual dysfunction (MSD) (erectile deficit the most) may induce FSD in the partner (HSDD, arousal disorders and orgasmic disorders) appropriate diagnosis and pharmacologic treatment of MSD is important as well.

3**. Physiotherapy.** This cost-effective intervention can contribute to improve the **hypotonic pelvic floor**, typical of women with multiple vaginal deliveries and/or operative vaginal deliveries, with the associated sexual symptoms of reduced vaginal sensitivity, incontinence during thrusting (when stress incontinence is comorbid), orgasmic difficulties; and the **hyperactive/hypertonic pelvic floor,** associated with **sexual pain disorders** (dyspareunia, vaginismus, post-coital cystitis, LUTS – lower urinary tract symptoms – and coital anorgasmia);

4. Psychosocial therapy. Psychosocial interventions include basic counseling, psychosexual intervention, either individual or couple, and is combined with biomedical interventions to provide an optimal outcome.

Conclusions

Dealing with sexual issues in clinical practice is becoming increasingly important, as FSDs can have an enormous impact on a patient's and couple's quality of life. Therapeutic interventions useful in the clinical practice will be presented.