

When Libido Is Low- Where Do You Go?

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Objectives

- Review of sexual response
- Components of libido
- Assessment
- Treatment
- Summary

Mrs. O

- 51 y.o., menopausal for 2 years
- 6 year history of no libido
- Participates in sex when approached
- Some enjoyment once in the mood
- Dyspareunia
- Wants testosterone patch

Definition of Sex

“Personally experienced, emotional and physical sexual arousal in an interpersonal context of mutual trust and vulnerability, (i.e. intimacy).”

Sanders

What is Normal?

- No definition
- Majority of complaints of lack of libido are actually discrepancies in desire between partners or lack of spontaneous initiation

What is Abnormal?

DSM-IV

- Hypoactive sexual desire disorder
- Sexual aversion disorder
- Lifelong or acquired
- Situational or generalized

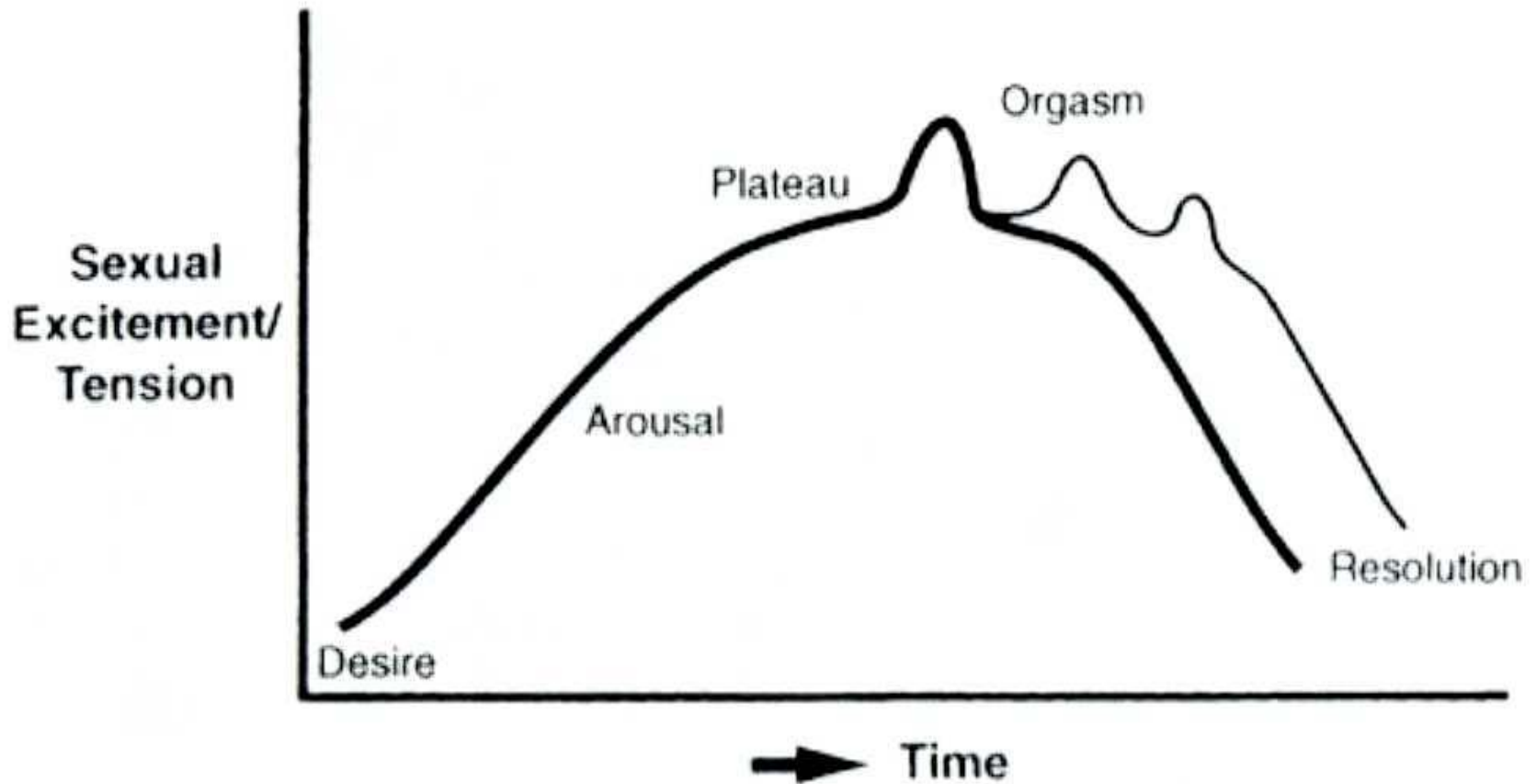
What Is Libido?

- Want or need to be sexual
- May or may not involve sexual activity
- Involves fluctuating energy
- Source is often personally baffling
- Spontaneous **or** *in response to stimuli*

Primary Influences

- Innate biological function
- Culture
- Spirituality
- Family of origin
- Learned- abuse, pain
- Psychological distress
- Sexual identity

Masters, Johnson and Kaplan



Intimacy Based Desire and Arousal

- Wanting emotional closeness
- Show love and affection
- Share pleasure
- Increase attractiveness and attraction
- Increase sense of commitment
- Satisfy a sexual need

Basson Model of Female Sexual Response

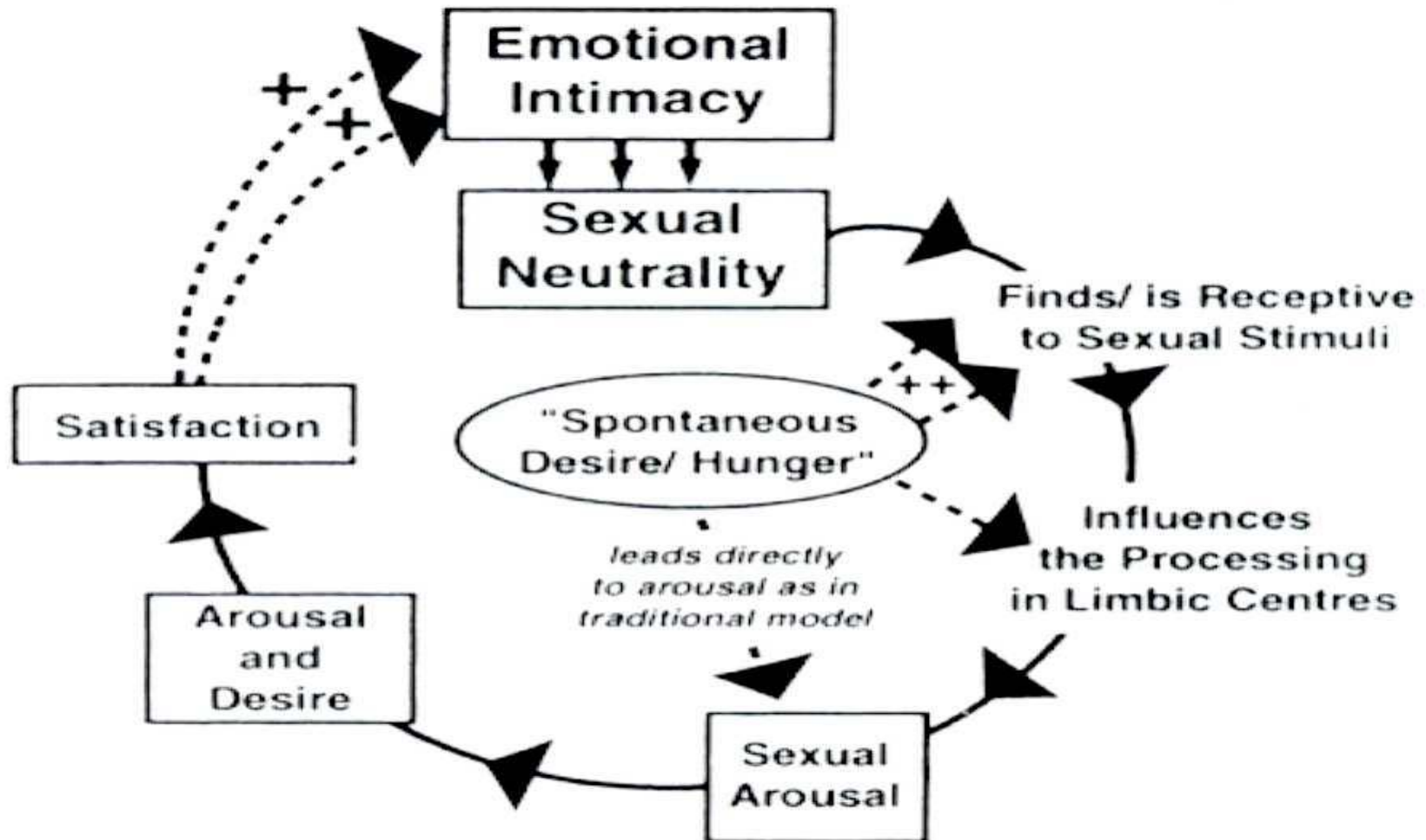


Fig. 3. Blended sexual response cycles.

Individual
Psychology

Biology

Couple Issues

Prevalence

- 1992 cohort of US adults
- Self-reported sexual dysfunction
- 43% of women and 31% of men reported dysfunction
 - 51% desire problems
 - 32% arousal problems
 - 16% pain problems

Laumann et al. JAMA 1999;281:537

Assessment

- Sexual History
- Individual but preferably couple
- 30 minutes of uninterrupted time

- Current problem
- Relationship history
- Sexual development
- Medical history
- Psychiatric illness
- Medications, EtOH, street drugs
- Social history
- Motivation for change

Mrs. O

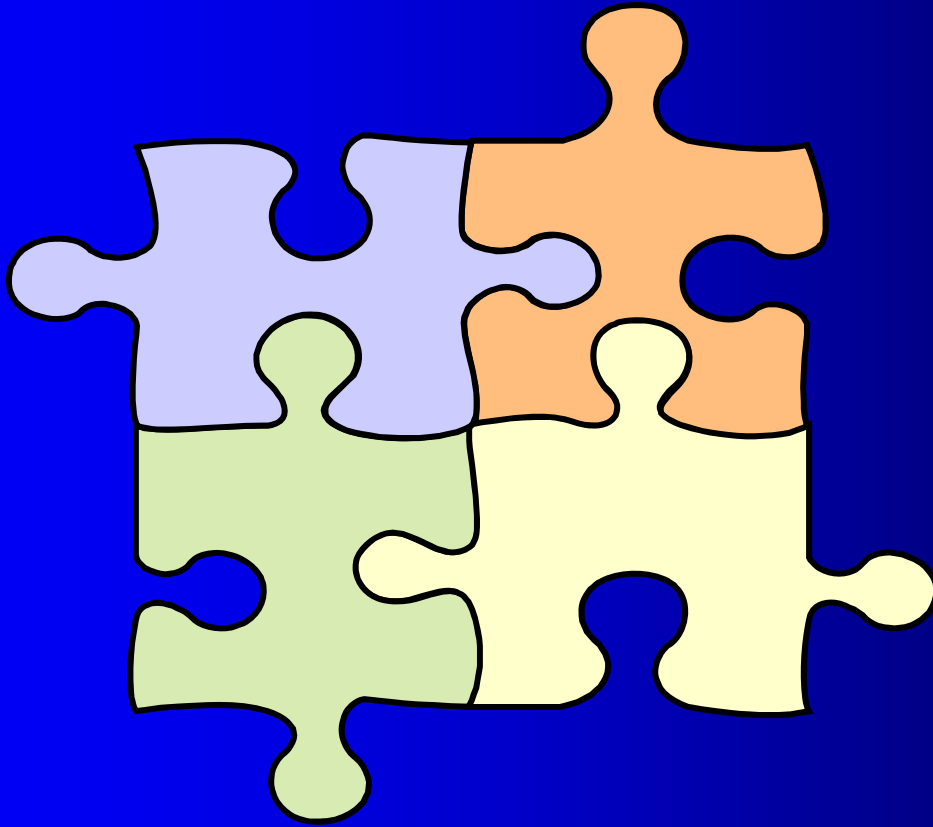
- Requests you check her hormone levels, ‘there must be hormonal reason, I read in Chatelaine that you should check my hormone levels’

Laboratory Workup

- Thyroid screen
- Prolactin

- There is currently no evidence that any currently available hormonal levels are at all predictive of sexual dysfunction
- This includes, testosterone, free testosterone, bioavailable testosterone, DHEAS
- Only true measure may be intracellular testosterone or it's metabolites and this is not available outside of research

Libido



Treatment

- Vaginal estrogen (Vagifem®, Estring®, Premarin®)
- Viagra®
- Testosterone cream/patches
- Conservative treatment
- SSRI induced dysfunction

Phosphodiesterase Inhibitors

- Viagra®, Levitra®, Cialis®
- In general no use
- Possibly helpful in specific subgroups

Mrs. O

What about the testosterone
patch?

Testosterone Patch (Intrinsa)

- P&G product
- 300 mcg patch with ERT
- Surgically menopausal women
- 24 week trial
- Both placebo and patch showed improvement over baseline but patch more than placebo
- Mean 1.56 more satisfying episodes/4 weeks

FDA

- Rejected application for approval
- Primarily felt to be because of lack of long-term safety data, came at same time as WHI controversy
- Question is now whether there will ever be enough data

- Total testosterone levels were above upper limit of normal for young women
- Free testosterone were within normal
- Mild androgenic side effects

Non-Oophorectomized women

- NO appropriate data
- If women with no ovaries show only small improvement with above normal levels- biologically- why would women with ovaries show much of a response?

- If using androgens with informed consent, best route would be to try transdermal
- May try Androgel™ (testosterone 1% gel), smallest dose packet (2.5 g) or 2 pumps of meterdose pump, and divide over 7 days
- Testosterone levels to avoid supraphysiologic levels

PLISSIT

- Provide limited information/education
- Specific suggestions
- Intensive therapy

Sensate Focus Exercises

- Learning to give and receive pleasure
- Removes sexual intercourse expectations

Long-term Relationship Issues

- Sexual frequency declines once limerance is over
- Sexual energy is excess energy
- Less sexual cues
- Less organization around sexual interaction
- Less attention to “needs”

Sexual “Needs” Attention

Work with woman to establish her needs required to be receptive to sexual activity

- Time
- Safety
- Cues
- Negotiation

- Provision/referral for individual psychotherapy
- Provision/referral for relationship/marital therapy

Mrs. O

- Not dysfunctional
- Explain responsive sexual desire
- Strategies for dyspareunia- ? Vaginal E2
- Relationship issues

SSRI Induced Dysfunction

- Decrease the dose
- Switch to another SSRI- no definitive comparisons
- Switch to a non-SSRI
- Use a second drug to offset adverse effects
- Drug holidays- no data to support- not practical

Non-SSRI

- Mirtazapine (Remeron®)
- Bupropion (Wellbutrin®)

Second Drugs

- Sildenafil- extrapolation from males
- Bupropion- uncontrolled trials
- Buspirone- conflicting results
- Amantadine, cyproheptadine and yohimbine- only anecdotal evidence

Summary

- Libido is a result of a complex interplay of the body and brain
- Patient history is everything
- Crucial role of relationship issues
- Supportive forum for discussion is mainstay of treatment in women
- Little/no role of drugs at this point