

Never too late to talk about sex



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Postmenopausal women are at high risk of sexual dysfunction, but most don't actively seek their GP's advice

FOLLOWING menopause, many women suffer from a drop in their libido. This can be accompanied by orgasmic dysfunction, with or without pain, due to vulvovaginal atrophy.

These changes in sexual wellbeing are often associated with significant personal and relationship distress. However, healthy sexual wellbeing at midlife can enhance overall health and improve longevity.

Low libido that causes distress is a hallmark of female sexual dysfunction (FSD). FSD is prevalent in Australian postmenopausal women, with one in three women aged between 40 and 64 years, and one in six women aged 65-79 years, experiencing low libido that causes distress.^{1,2}

Research has shown that women place a high value on sexual intimacy in their relationships.^{3,4} Despite this, only 12% of postmenopausal women raise the topic of sexual dysfunction with their GP.⁵

Furthermore, some doctors may not inquire about sexual function because of time constraints, discomfort in broaching the topic or lack of awareness of how many women are affected. Consequently, many women remain untreated, despite the availability of safe and effective treatments.

This issue is summarised in the International Menopause Society's October white paper; Sexual wellbeing after menopause, published in the journal *Climacteric*.



CONSULTATION

Consider biological, psychological, interpersonal and sociocultural factors when assessing sexual function in women, as well as all phases of the sexual response cycle and sexual pain.

HISTORY

Talking about sex isn't always easy. If a woman doesn't raise sexual concerns herself, gentle inquiry is recommended.

An example of a conversation starter could be: "Many postmenopausal women experience problems with their sexual functioning or pain with sex."

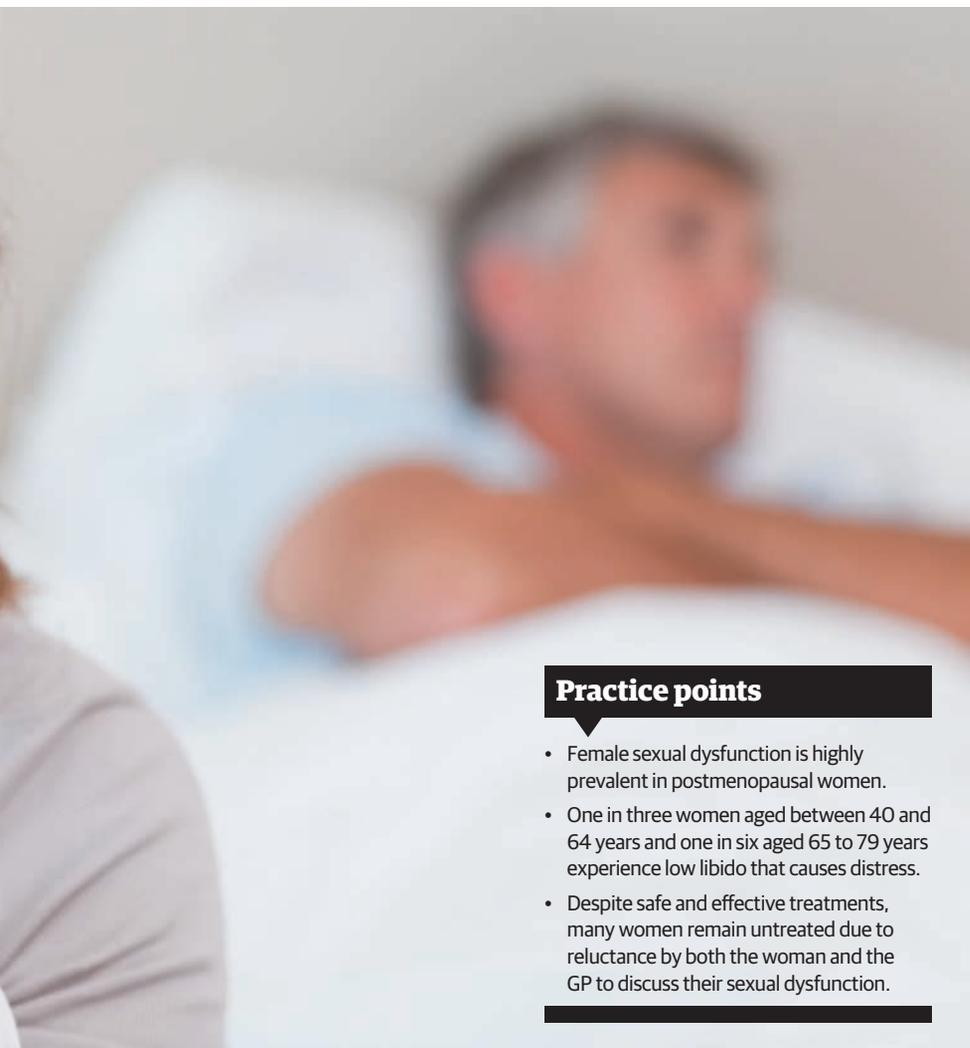
Ask about sexual activity/history, concerns and associated distress. The Decreased Sexual Desire Screener, available in the International Menopause Society white paper, is a useful tool (see online resources).

Attentive listening and picking up on body language and other cues are helpful. Trust – always ensure confidentiality – and rapport will help women feel more able to disclose and discuss.

Distress may appear as frustration, grief, guilt, incompetence, loss, sadness, sorrow or worry. Use diagrams to locate where the pain/problem is and take the opportunity to discuss anatomy and physiology of female sexual response in a positive and kindly manner.

Sexual function includes both partnered and unpartnered sexual activity. It should not be assumed that unpartnered women do not suffer from FSD.

It is vital to identify reversible factors such as physical and psychiatric conditions, including endocrine disorders, menopausal changes, genitourinary



Practice points

- Female sexual dysfunction is highly prevalent in postmenopausal women.
- One in three women aged between 40 and 64 years and one in six aged 65 to 79 years experience low libido that causes distress.
- Despite safe and effective treatments, many women remain untreated due to reluctance by both the woman and the GP to discuss their sexual dysfunction.

conditions, neurologic disease, cancer and depressed mood.

Medications and substance use, relationship difficulties, partner sexual dysfunction and any history of sexual, physical or emotional trauma all need to be considered.

EXAMINATION

Physical examination is a critical part of assessment. For example, confirmation of normal genitourinary anatomy will reassure the patient that there is nothing wrong anatomically that is causing their sexual dysfunction.

Conversely, the finding of vulvovaginal atrophy (VVA) can direct effective treatment and alleviate dyspareunia, which is a common cause of sexual avoidance.

The examination can be an emotionally and physically sensitive time for the patient.

Make sure to obtain the patient's permission, as well as feedback about specific areas of discomfort, to enable an individualised examination that minimises pain.

For anxious patients, the initial part of the examination – the inspection of the vulva – can be performed without a speculum. Laboratory tests for sexual health are minimal unless a specific clinical concern emerges.

TREATMENT

PSYCHOLOGICAL/SEXUAL COUNSELLING

Female sexual function is best addressed using a model that reflects a woman's fluctuations in health status, hormones, psychological issues, interpersonal concerns and sociocultural beliefs and values.

Psychotherapy may be used alone or in conjunction with medical treatments

(multimodal therapy), which may include psychotherapy together with hormonal and non-hormonal pharmacologic therapies and/or pelvic floor physical therapy or medical devices.

Even when the problem is primarily biological, CBT can help to improve symptoms. Some psychotherapeutic techniques can be used within office-based counselling, while other techniques will be used by sexual medicine experts if the patient is referred for sex therapy.

MEDICATIONS

1. Local vaginal therapy

Appropriate for the treatment of VVA in women (including post-breast cancer). Options include vaginal oestrogen therapy, vaginal moisturisers and lubricants for sexual intercourse. Vaginal oestrogen therapy alleviates VVA symptoms and is inexpensive and safe, yet it remains underprescribed. Less than 10% of postmenopausal women are treated with it.

2. Hormonal therapy

Systemic oestrogen therapy offers relief of VVA and may improve libido. Some women also require vaginal oestrogen in addition to systemic oestrogen to effectively alleviate VVA symptoms.

Transdermal testosterone cream greatly improves sexual function in naturally or surgically postmenopausal women presenting with low libido, with or without concurrent oestrogen therapy. Testosterone therapy should not be considered until a full clinical assessment has been performed. It can be started while other potentially modifiable factors are being addressed.

3. Systemic non-hormonal therapy

None is approved for use in postmenopausal women. ■

ONLINE RESOURCES

- International Menopause Society White Paper: Sexual wellbeing after menopause. See: bit.ly/2FYc3MK
- Jean Hailes webinar series: Let's Talk about Sex. See: bit.ly/2zbZyFw

References on request

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