Skin, Bones, Hearts & Private Parts, 2020

SEXUALITY AT MIDLIFE AND BEYOND

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Disclosures

- Vendor: Cord Blood Registry
- Speaker's Bureau / Advisory Board: AMAG, TherapeuticsMD, Hologic, El Camino Hospital

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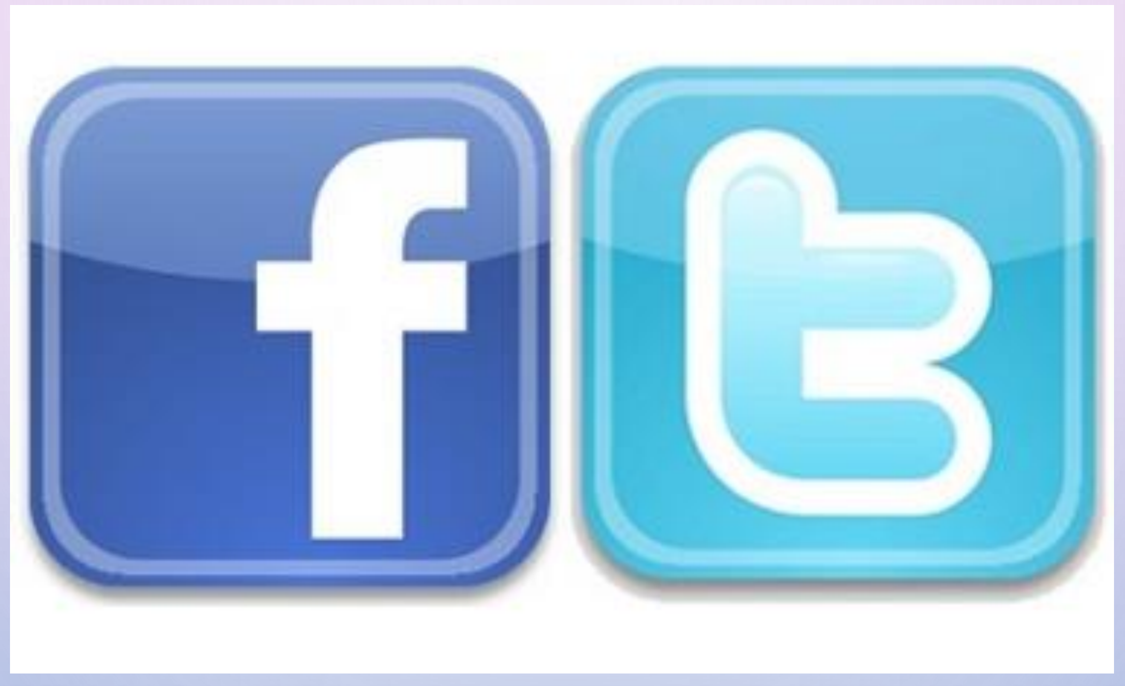

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SESSION OBJECTIVES

- Recognize the importance of sexual health for QOL
- Discuss factors which affect sexual functioning
- Assess patient sexual health
- Develop a plan that focuses on sexuality and health considerations
- Describe treatment options for menopausal women to improve sexual quality of life
- Thank you to Dr. Diane Todd Pace for permission to utilize the introductory slides

The Reality…

- In general, almost 3/4 of men and women reported that they were reluctant to seek help for sexual health issues...

- And over one half of men and women think that HCP should routinely ask about their sexual health

(Laumann et al., *International Journal of Impotence Research*, 2009

The Problem…

As HCPs we are generally not comfortable asking patients

AND, they are generally not comfortable asking us

AND, they want us to ask!

Kingsberg SA, et al. *Journal of Sexual Medicine*, 2013

WE CAN DO BETTER

- In a survey of postmenopausal women, results showed that
- **81% of healthcare providers don't proactively ask about sexual health.**

Kingsberg SA, et al. *Journal of Sexual Medicine*, 2013

Reasons To Ask:

- Prevalence of Sexual dysfunction, difficulties, and concerns are common.
- May be an indicator of organic disease (Diabetes) or psychiatric disease (Depression or Anxiety)
- Dysfunction may be an indicator of side effect of medication

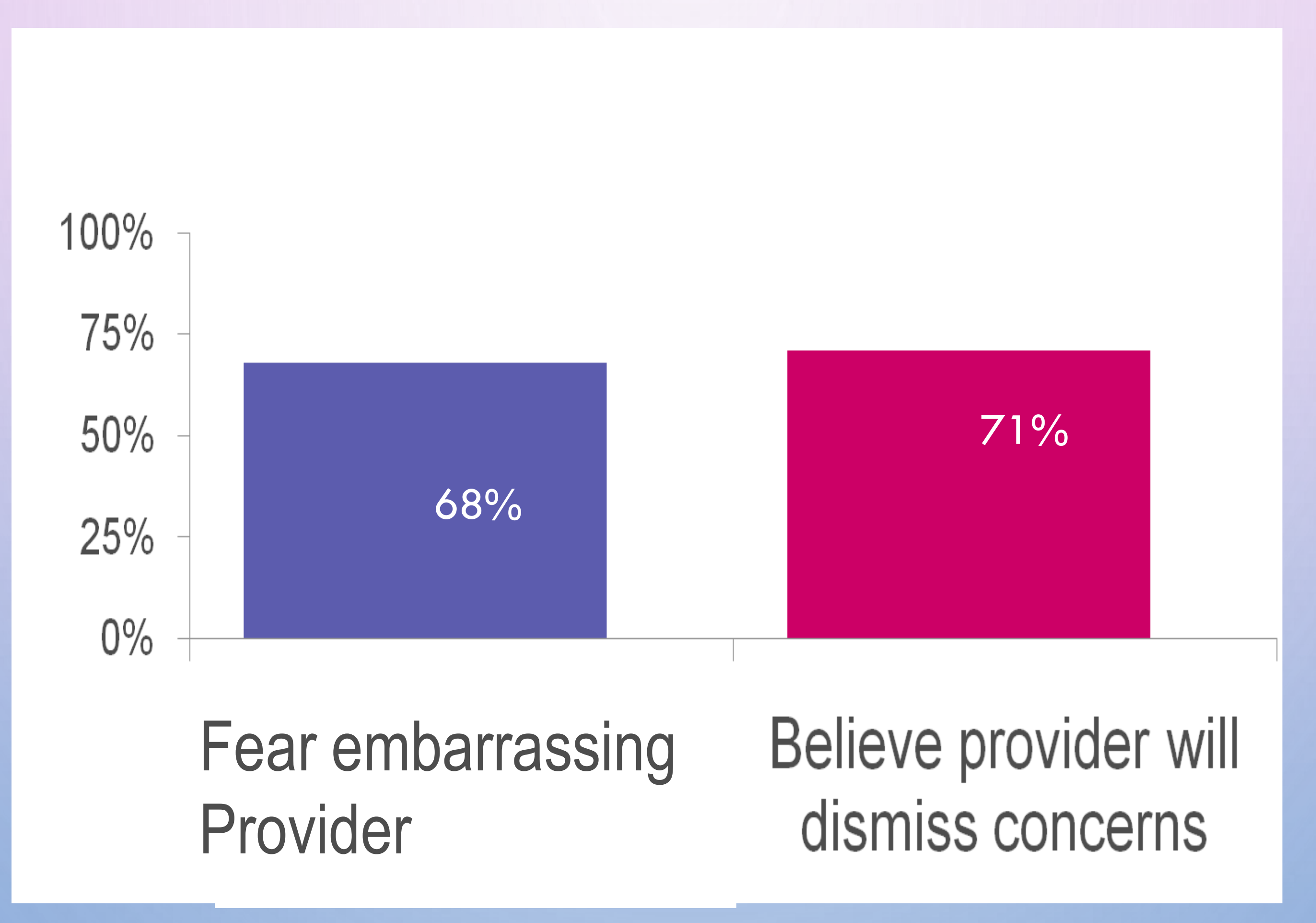
Nusbaum, M. & Hamilton, C. *American Family Physician*, 2002.

Reasons To Ask:

- Sexual function is lifelong: An elderly widow may be just as concerned about her sexuality as an adolescent
- Sexual health is associated with happiness, longevity, and well-being and an integral part of a person's general health
- Opportunity for primary prevention, discussion & education: STIs, myths & contraception

Nusbaum, M. & Hamilton, C. *American Family Physician*, 2002..

WHY DON'T PATIENTS BRING UP SEXUALITY ISSUES?



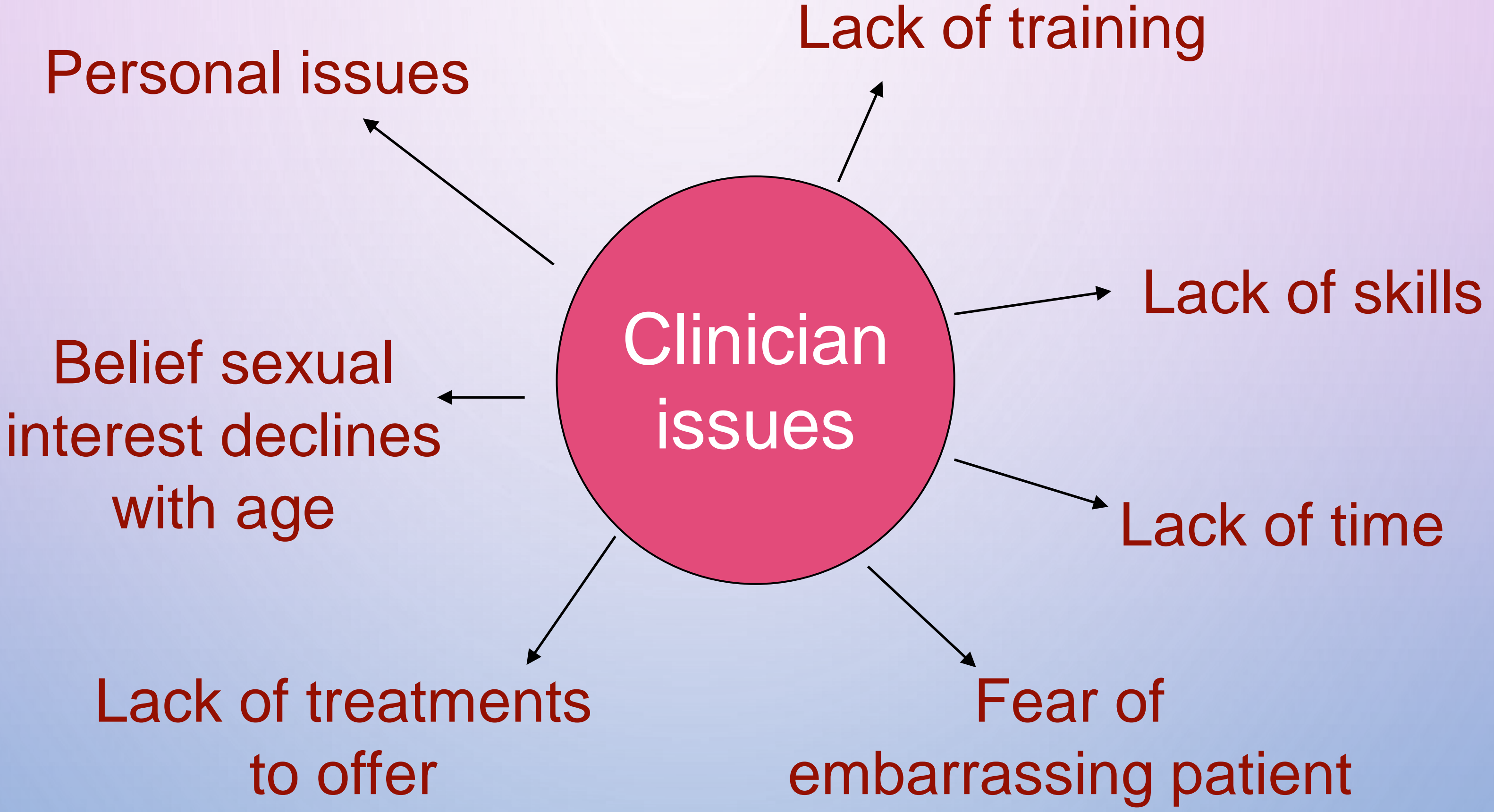
Marwick, C. *JAMA*, 1999.

Clinician Based Barriers

- Embarrassment[1]
- Inadequate knowledge/skills[2]
- "Improving quality of life" may not be considered a high priority[3]
- Concern that management will be time-consuming and/or poorly reimbursed[4]

1. Korenman SG. *Am J Med.* 1998. 2. Broekman CPM, et al. *J Impot Res.* 1994. 3. Eid JF & Sadovsky R. *Cliniguide® to Erectile Dysfunction.* 2001. *4.* Baum N, et al. *Patient Care.*1998.

Midlife Sexuality and the Clinician



Berman, L et al. *Fertility Sterility,* 2003
Kingsberg, S. Sexuality, *Reproduction and Menopause,* 2004

How do we assess?

- First, we get comfortable with the terminology

Penetration
Intercourse
Sex
Vagina
Penis
Erection
Orgasm

Masturbation – Self Stim
Arousal
Dilator
Vibrator
Lubricant

Common Biases to Avoid

- Age
- Sexual Orientation
- Relationship Status
- Cultural Issues

ARHP Clinical Advisory Committee for *Nurture Your Nature: Women's Sexual Health in the Midlife and Beyond* in December 2007

SCRIPTS

- Your Sexual Health is an important part of your overall health and anything that we discuss is confidential
- These are questions that I ask all of my patients
- Do you have any concerns about your sexual health that you'd like to discuss

Kingsberg SA, et al. *Journal of Sexual Medicine*, 2013

General Sexual History Assessment

- *Are you currently involved in a sexual relationship?*
- *Do you have sex with men, women, or both?*
- *Are you or your partner having any sexual difficulties or concerns at this time?*
- *Do you have any questions or concerns about sex?*
- *Are you satisfied with your current sexual relationship?*

Kingsberg SA, et al. *Journal of Sexual Medicine*, 2013

More Extensive Assessment

- *Please tell me about your sexual history*
- *How often do you engage in sexual activity?*
- *What kinds of activities do you engage in?*
- *Do you have difficulty with desire, arousal, or orgasm?*
- *Are there underlying causes such as pain with penetration?*
- *Is there a relationship? If so, how is the relationship?*
- *Refer if needed:*

➢ *If available:* American Association of Sexuality Educators- *ASSECT certified counselor*

Kingsberg SA, et al. *Journal of Sexual Medicine*, 2013

Factors Affecting Sexual Functioning

DISEASE AND FEMALE SEXUAL RESPONSE

Neurologic

- Head/spinal cord injury
- MS
- Stroke

Endocrine

- Diabetes
- Hepatitis
- Kidney disease

Vascular Disorders

- Hypertension
- Leukemia
- Sickle-cell disease

Phillips, NA. *Am Fam Physician.* 2000.; Whipple, B. In: Sexual Function in People with Disability and Chronic Illness: A Health; Professional's Guide. 1997.

DISEASE AND FEMALE SEXUAL RESPONSE

Debilitating

- Cancer
- Degenerative disease
- Lung disease

Psychiatric

- Anxiety
- Depression

Voiding Disorders

- Overactive bladder
- Stress urinary incontinence

Phillips, NA. *Am Fam Physician.* 2000.; Whipple, B. In: Sexual Function in People with Disability and Chronic Illness: A Health; Professional's Guide. 1997.

MEDICATIONS CAUSING DESIRE DISORDERS

- **Psychoactive medications**
  - Antipsychotics
  - Barbiturates
  - Benzodiazepines
  - Lithium
  - Ssris
  - Tricyclic antidepressants
- **Hormonal agents**
  - Danazol
  - Propecia
  - GNRH agonists
  - Oral contraceptives
- **Cardiovascular medications**
  - Antilipidemics
  - Beta blockers
  - Clonidine
  - Digoxin
  - Spironolactone
- **Others**
  - Indomethacin
  - Ketoconazole
  - Phenytoin sodium

Medications Causing Orgasmic Disorder

- Amphetamines and related anorexic drugs
- Antipsychotics
- Methyldopa
- Narcotics
- SSRIs
- Trazodone
- Tricyclic antidepressants

ARHP Clinical Advisory Committee for *Nurture Your Nature: Women's Sexual Health in the Midlife and Beyond* in December 2007.

Female sexual response

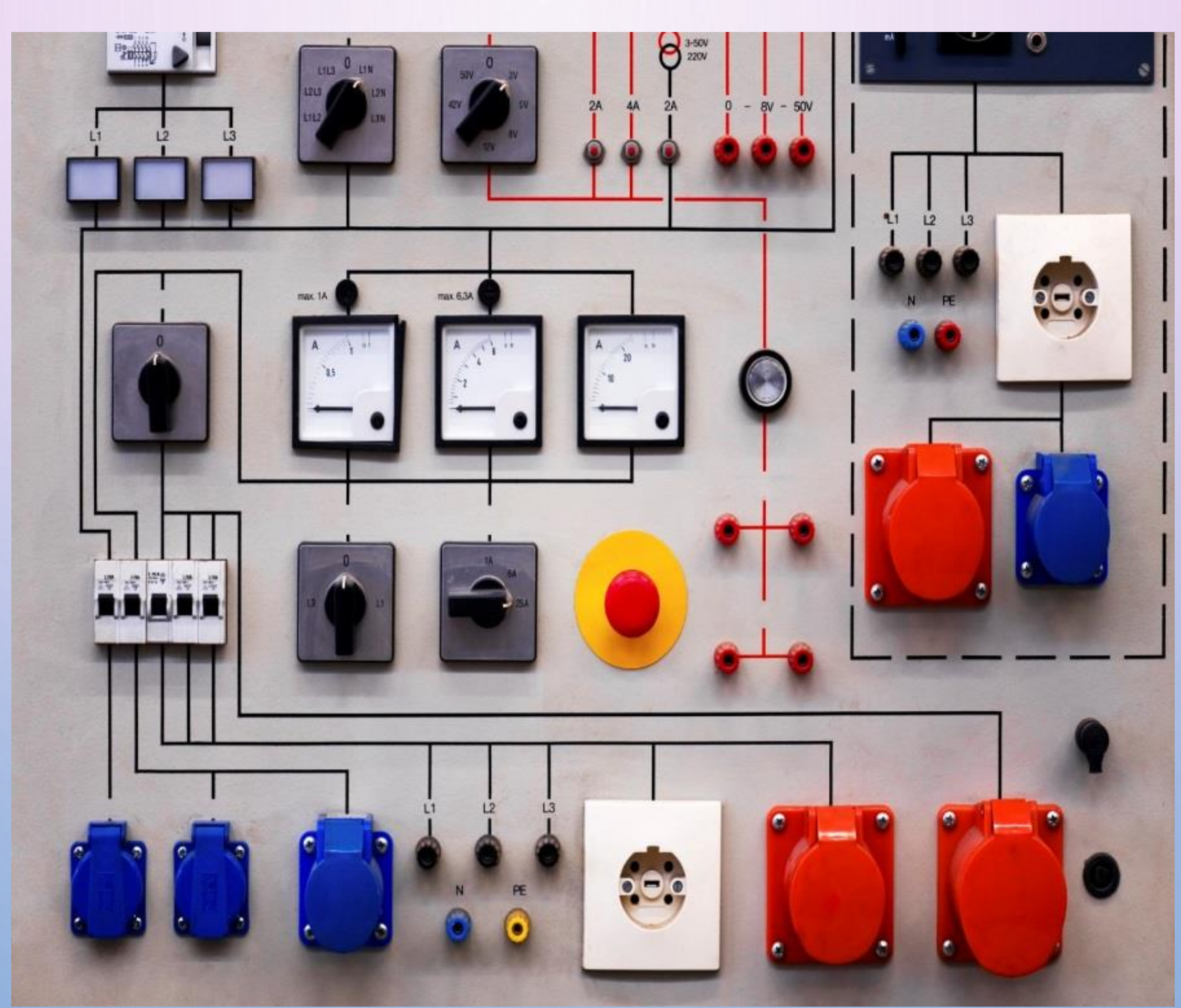


Photo purchased by Barb Dehn NP, iStockphoto

Problems with the Linear Models

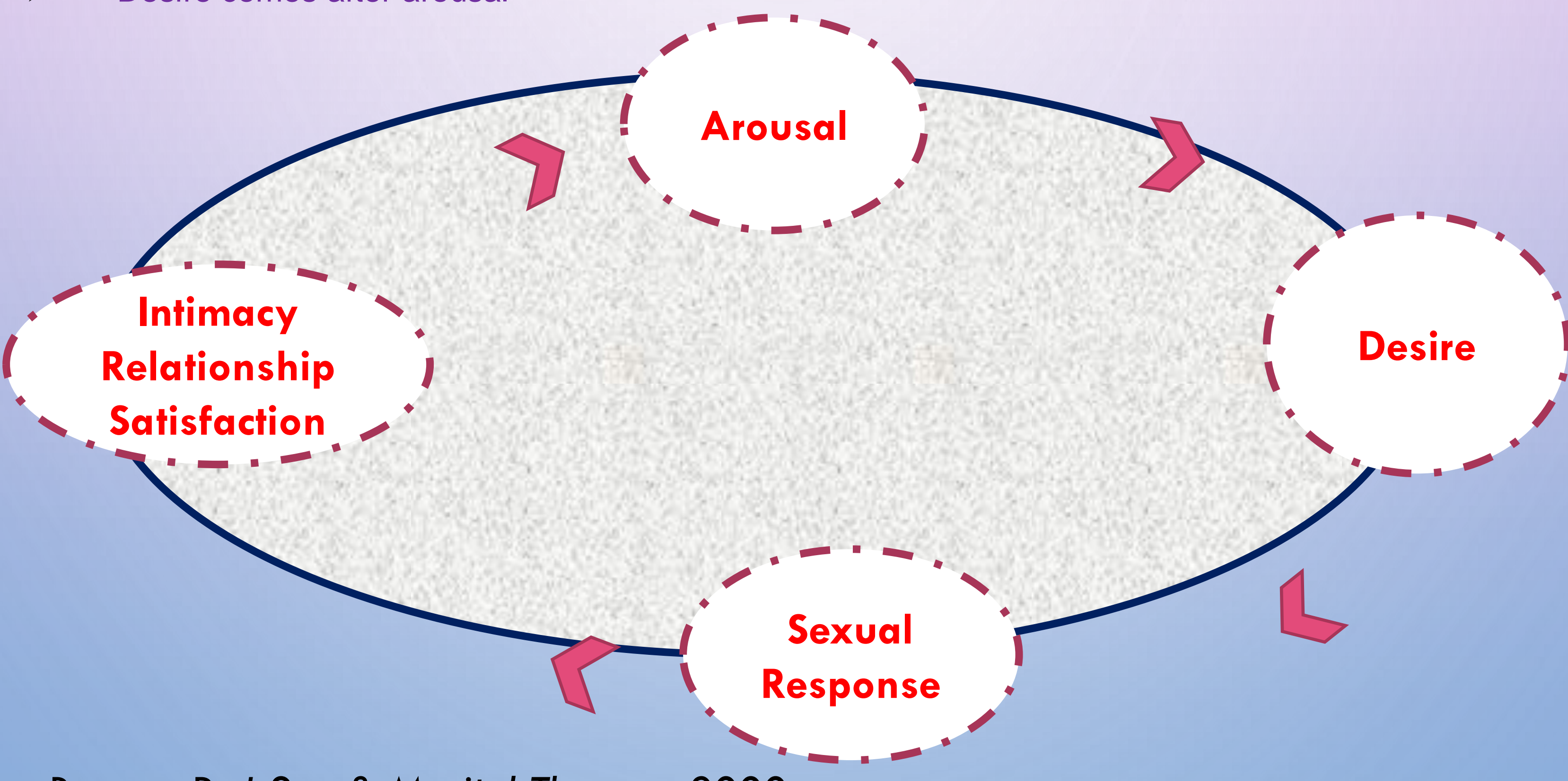
1. Masters & Johnson and Kaplan Models of Sexual Response were linear models.
2. Models based assumptions that women and men have similar sexual responses.
3. Further assumption was women move progressively and sequentially through phases as described by each model.
4. Biologic models *DIDN'T* take into account psychosocial effects on sexual response.

- Masters WH, Johnson VE. *Human Sexual Response*. Boston, MA: Little Brown, 1966.
- Kaplan HS. *Disorders of Sexual Desire and Other New Concepts and Techniques in Sex Therapy*. New York, NY: Brunner/Hazel Publications, 1979.
- ARHP Clinical Advisory Committee for *Nurture Your Nature: Women's Sexual Health in the Midlife and Beyond* in December 2007.

Basson's Female Sexual Response Model

Rosemary Basson more accurately described the sexual response model for women:

- Sexual response cycle different for women than men
- Cycle is not linear
- Many women begin from a point of ***sexual neutrality***
- Desire comes after arousal



Basson, R. *J Sex & Marital Therapy*, 2000.

Office based counseling for sexual problems: follow **PLISSIT** model

Permission to talk about sexual issues, reassurance and empathy:

May I ask you about your pain with intercourse?

Limited **I**nformation

That's a common concern at menopause as estrogen levels change

Specific **S**uggestions

Have you tried lubricants, moisturizers, altering position?

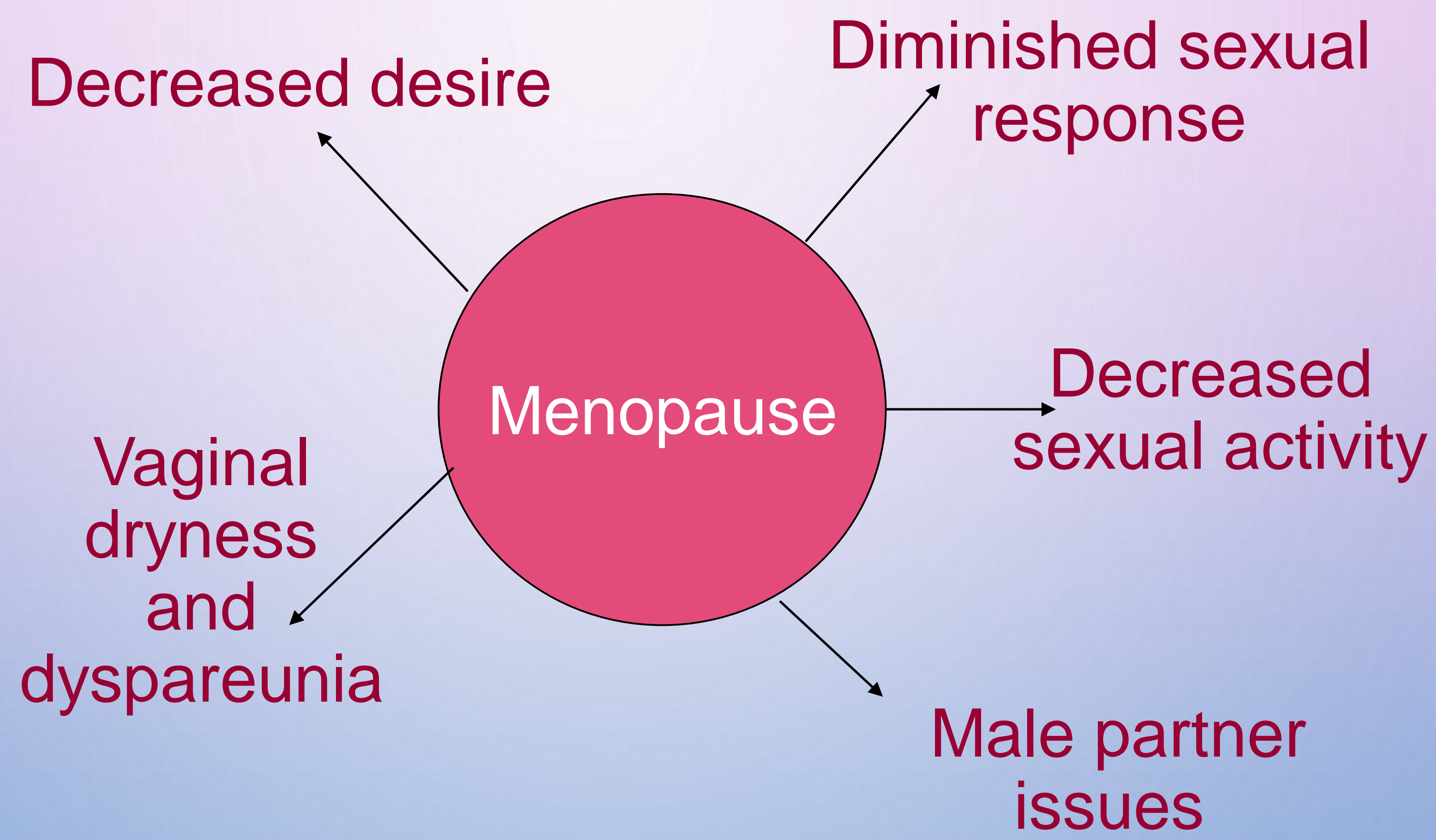
Intensive **T**herapy

Would you feel comfortable talking with someone about this?

(Referral for psychotherapy/sex therapy)

Annon, J *Journal of Sex Education and Therapy,* 1976

EFFECTS OF MENOPAUSE



Kingsberg, SA. *Arch Sex Behav.* 2002.
Basson, R. *Menopause.* 2004.

GSM: GenitoUrinary Syndrome of Menopause

- Vaginal dryness, thinning of skin
- Vulvovaginal irritation, itching
- Increased pH : fewer or absent lactobaccilli
- Dyspareunia ~ 10% - 40%
- Unlike Hot Flashes & Night Sweats, which improve in time — Vaginal atrophy is progressive.

Does not resolve on its own!

Stika CS *Dermatol Ther* 2010.

Less Estrogen = Puberty in Reverse

- Vagina loses elasticity, shortens, narrows, easily traumatized and irritated
- Loss of ruggae, fornices become obliterated, cervix flush with vaginal vault
- Loss of fat pads with Labia, clitoral hood shrinks
- Worse for women on chemo (Tamoxifen, Aromatase Inhibitors)

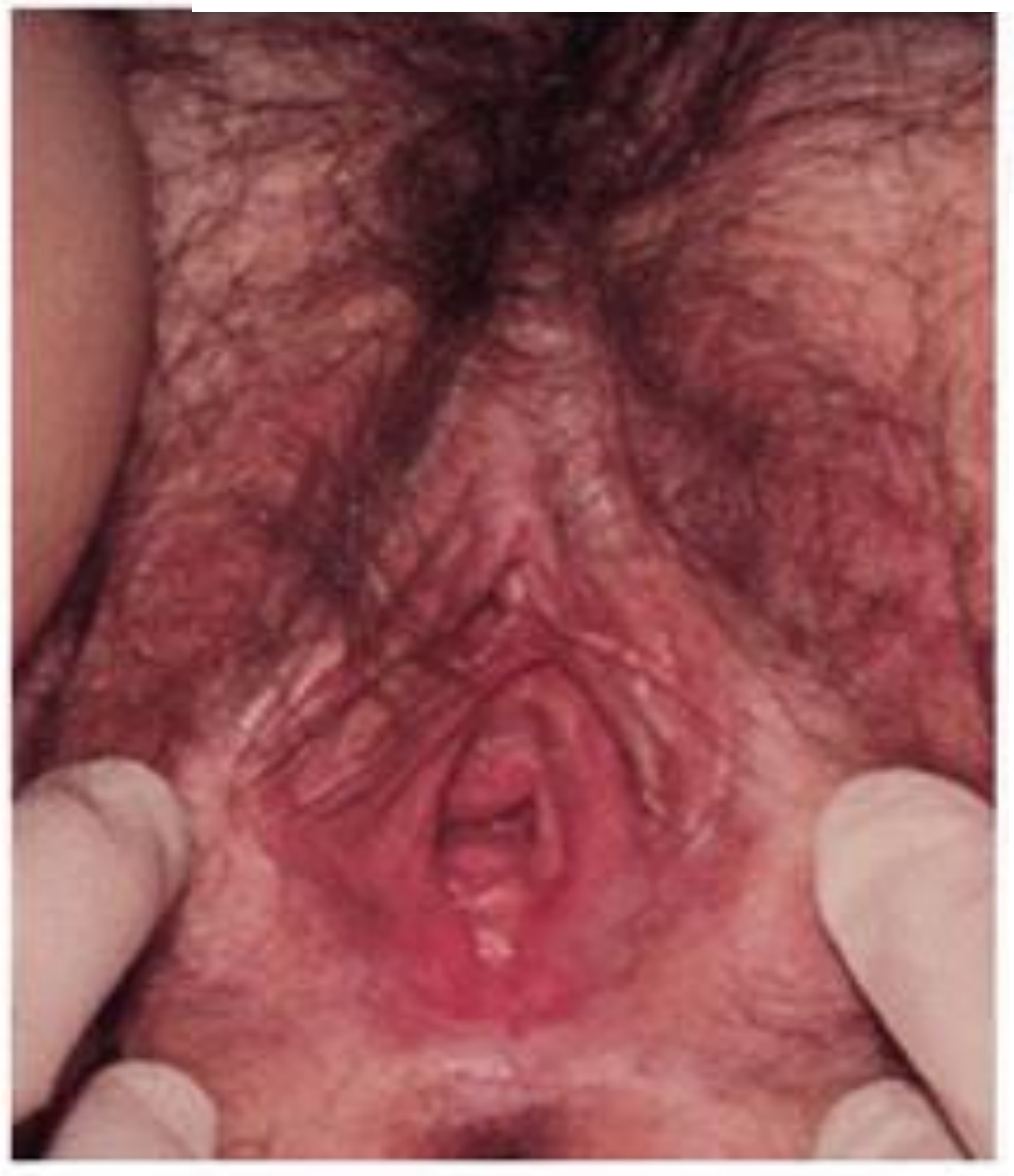


Image courtesy of Barb Dehn NP

Puberty in Reverse

Well-estrogenized Premenopausal State

Low-estrogen Postmenopausal State

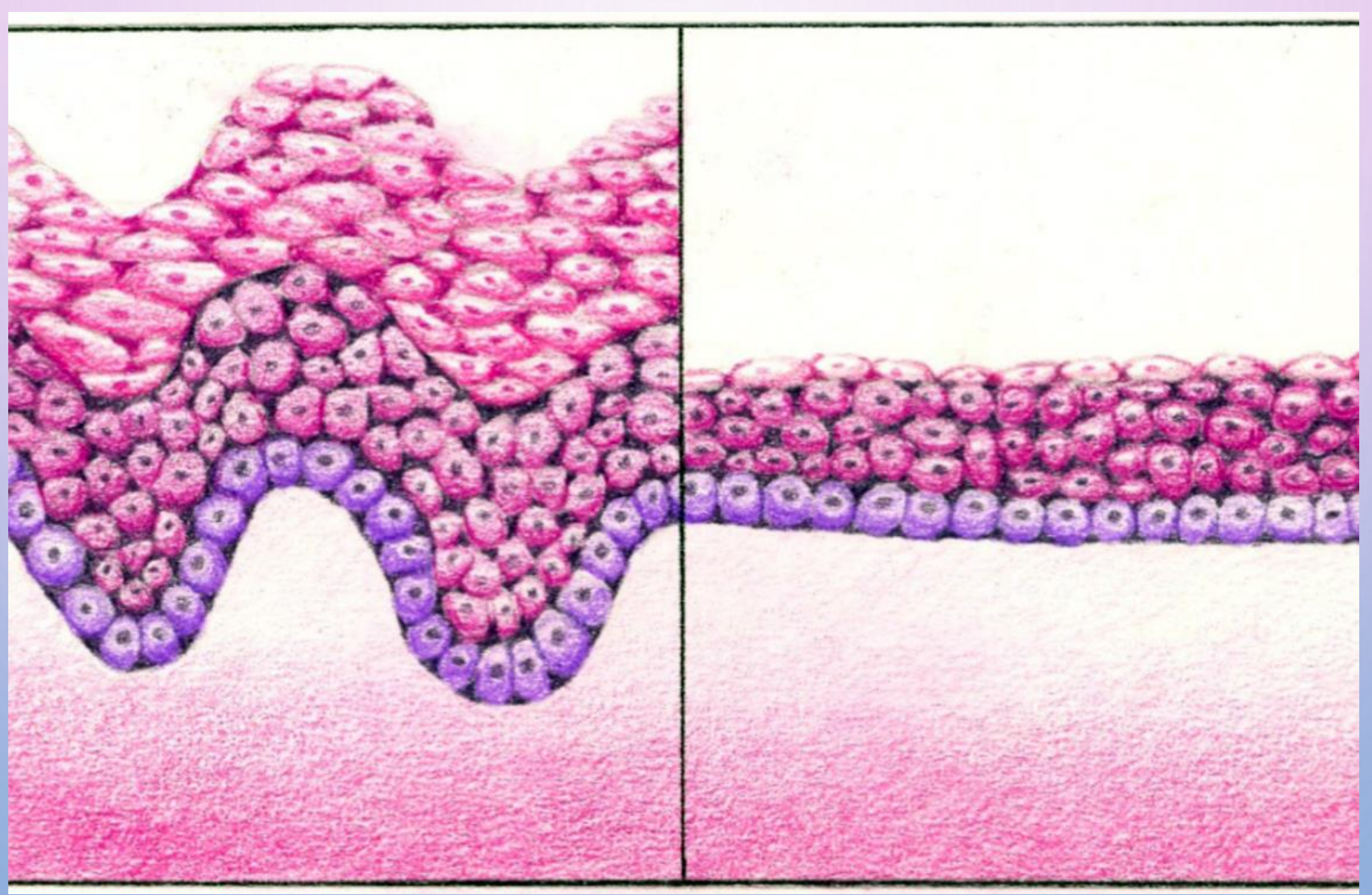
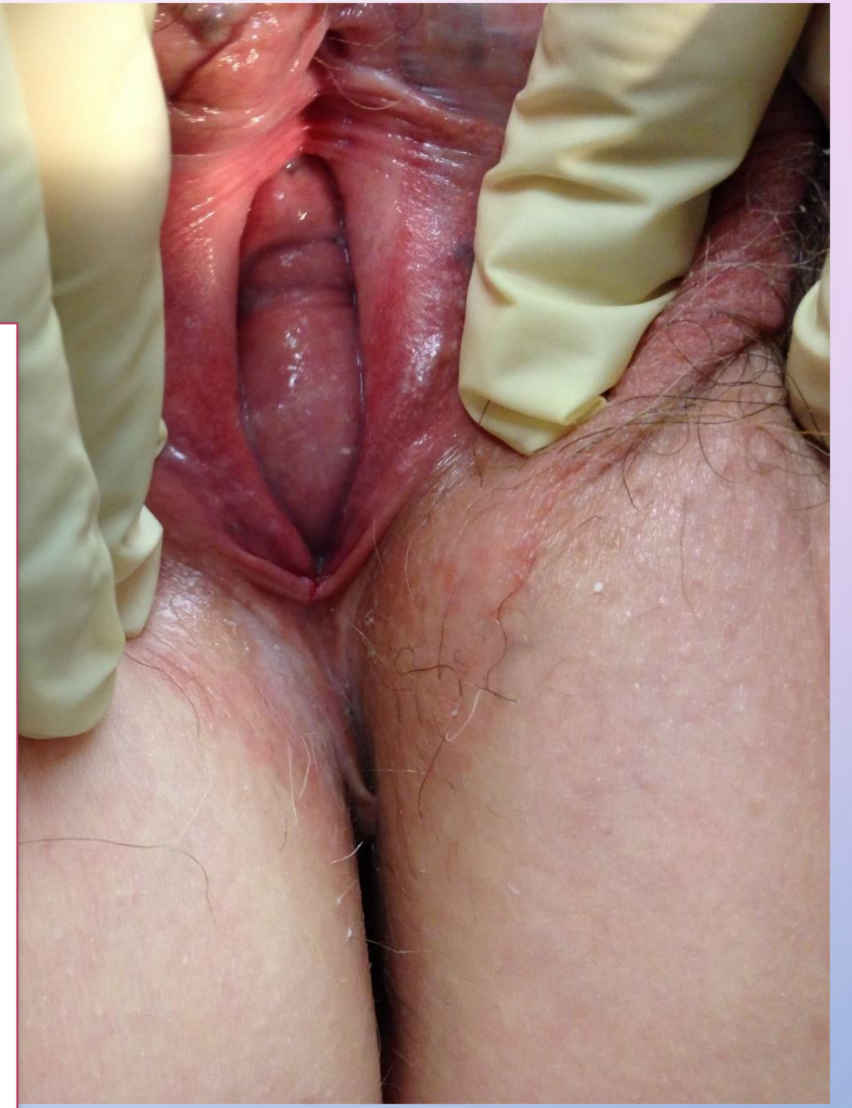


Image courtesy of Dr. Diane Todd-Pace



- Vaginal Pressure
- Discomfort
- Protrusion?
- Urinary Retention
- Mechanical obstruction with sex
- Dyspareunia

Image courtesy of Barb Dehn NP

CYSTOCELE

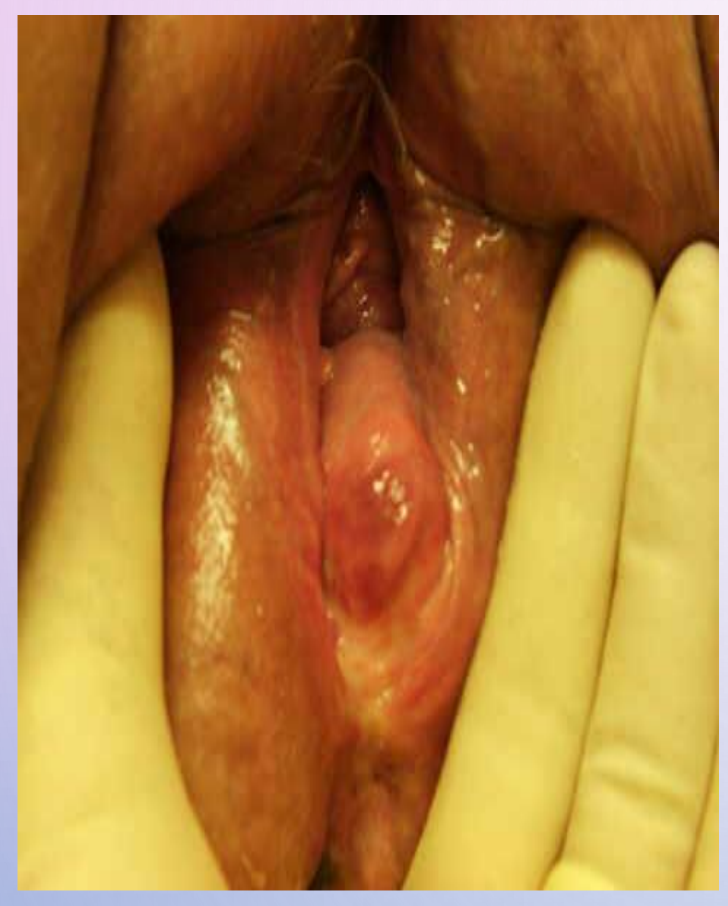


Image courtesy of Barbara Dehn NP

RECTOCELE

- VAGINAL PRESSURE
- DISCOMFORT
- PROTRUSION?
- HEMORRHOID?
- CONSTIPATION
- DIFFICULTY W BM
- DYSPAREUNIA

REVIVE Survey of 3000 Women

- Only 7% talked with HCP
- 59%: VVA interfered with sex
- 85%: “Loss of intimacy” w partner
- 47%: Affected their relationships
- 29%: Negative impact on sleep
- 27%: Negative impact on their general enjoyment of life

Nappi & Kokot-Kierepa, *Climacteric.* 2012

Nonhormonal treatment

- ***Use it or Lose It***
- Regular sexual activity promotes blood flow
- Masturbation or use of a vibrator to maximize stimulation
- Cleansing with water but not soap

Stika CS *Dermatol Ther* 2010;23:514-22.

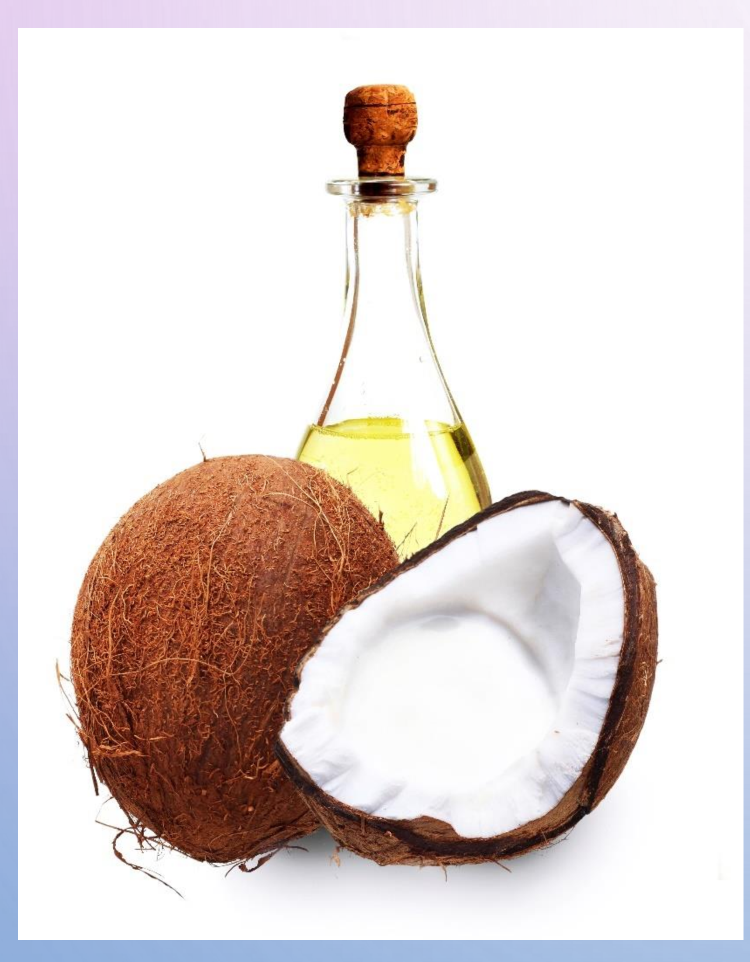
Vaginal Moisturizers

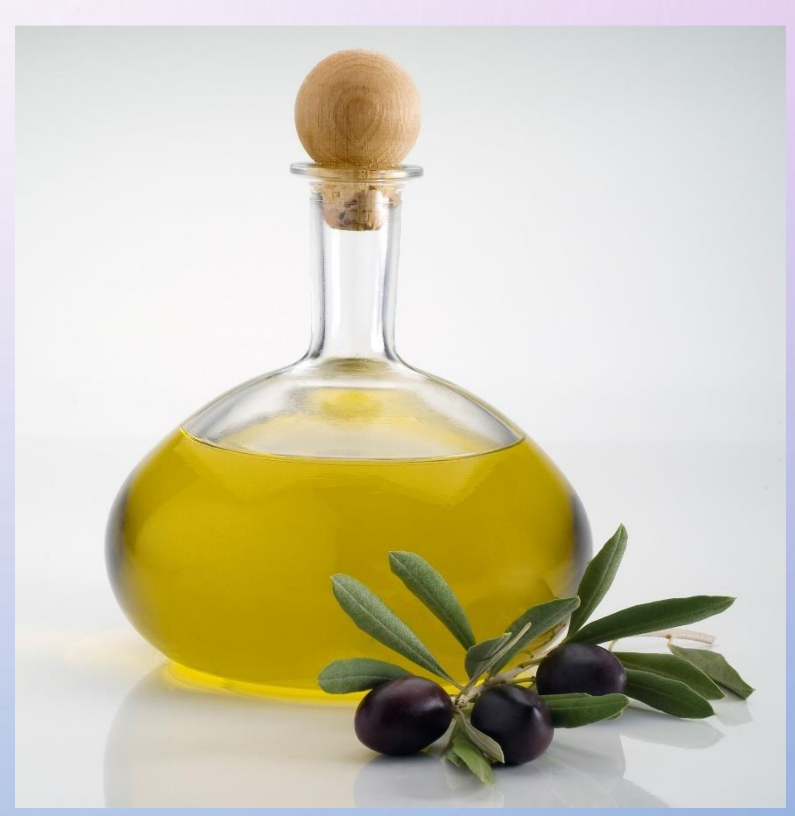
- ON-GOING Treatment: MUST STRESS THIS
  - Non-hormonal
  - No prescription
  - Attracts moisture to vagina
  - Improves pH
  - Use 2-3 times/week for maintenance
  - Works well within a routine and regimen

Vaginal Lubricants

- Lubricants: reduces friction
- Water or silicon based
- Many women use Olive or Coconut oil
- Flavored lubricants for Oral intimacy
- Use with sex to help with gliding
- Warming versions (with niacin) increases blood flow and arousal

Really? I can use that?





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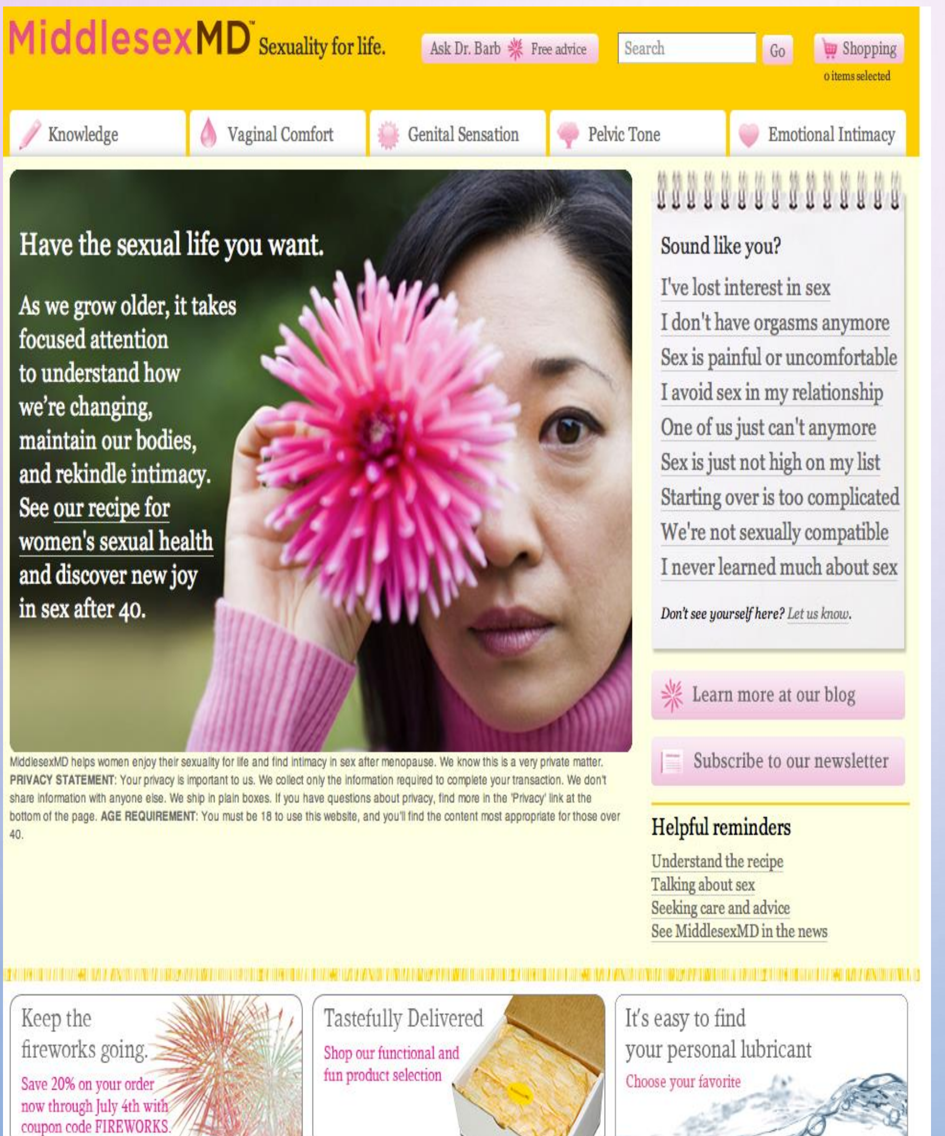
This is taking FOREVER!

- Many women give up
- Many partners get tired
- Normalize for women
- Validation: over 50% of women over 35 use a lubricant
- Vibrators and toys are more commonplace than women think
- Resources: local shops, books, on-line

Creativity with Intimacy

- Number of physical changes with aging that affect intimacy
- New products available to help
- Wedge pillows for support
- Vibrators because it just takes longer
- RecoverSex.com for illustrations of positions
- Finger vibrators, Rings, clitoral stimulators

MiddlesexMD®



MiddlesexMD.com

Dr. Barb DePree
Ob-Gyn/NAMS Certified Menopause Practitioner

Sexuality for Life

Treatment with localized Estrogen

- Restores vaginal blood flow & decreases vaginal pH
- Improves thickness, elasticity of tissue
- Many women on systemic HT *ALSO* need vaginal estrogen
- Low-dose, local vaginal ET *does not* increase serum levels of Estrogen
- No need for progestogens

Rahn, D. D., Carberry, C., Sanses, T. V., Mamik, M. M., Ward, R. M., Meriwether, K. V., … Murphy, M. (2014). Vaginal Estrogen for Genitourinary Syndrome of Menopause: A Systematic Review. *Obstetrics and Gynecology*, *124*(6), 1147–1156.

Localized Vaginal Estrogen

- Improvement begins within 3 weeks
- On-going improvement at 6 - 12 weeks
- Has limited systemic absorption
- No increased risk Endometrial or Breast CA
- Does not protect the bones or treat HF, NS
- Does improves sexual functioning
- Does reduce urinary symptoms

Vaginal Estrogens

- Low-dose, local, prescription vaginal ET products FDA-approved
- Estradiol vaginal cream grams (Estrace Vaginal Cream)
- CEE vaginal cream (Premarin Vaginal Cream)
- Estradiol vaginal ring 7.5 mcg/24 hours(Estring)
- Estradiol hemihydrate vaginal tablet 10 mcg (Vagifem)
- Estradiol 4 mcg and 10 mcg (Imvexxy)

- Discuss boxed warning

Treatment considerations

- Estradiol & CEE creams or Vaginal Pellets
- 1 - 2 grams per vagina every other day x 2 weeks
- *ALSO* Use small amount to rub on external genitalia
- After 2 weeks: 1 - 2 grams twice/weekly

Estradiol Vaginal Ring (Estring)

- Slightly opaque ring with a whitish core containing a drug reservoir of 2 mg Estradiol
- Once placed in the vagina: 7.5 mcg E_2 released every 24 hours for 90 days
- Many clinicians insert with a pessary
- Not to be confused with etonorgestrel-ethinyl estradiol ring (NuvaRing)
- Topical estrogen/not systemic

Ospemephine (Osphena)

- Ospemifene 60mg/day *indicated* for dyspareunia
- Two 12-week studies showed improvements with daily use (60 mg) in
  - Vaginal maturation index, pH
  - 1 year later patients sustained improvements with no cases of VTE, endometrial hyperplasia, or carcinoma

Portman, et al. *Menopause*, 2013.
Slide courtesy: Dr. Lisa Chism

Intravaginal DHEA (Intrarosa)

  - 6.5 mg Ovules *indicated* for dyspareunia
  - After 2 wks decreased pH, increased vaginal secretions, color, epithelial integrity
  - No reported change in endometrial histology
  - No significant increase in serum sex steroids
- Converts to Estradiol in the vagina
- Also found increased arousal possibly due to increased nerve fiber growth vaginal tissues

Flibanserin: Addyi

- Acts as an agonist of the $5\text{-}HT_{1A}$ receptor: a norepinephrine-dopamine disinhibitor (NDDI).
- Approved for treatment of pre-menopausal women with hypoactive sexual desire disorder (HSDD).
- Increases in SSE's Satisfying Sexual Events –
  - 1.5 to 2.5 per week
- Improvement in FSFI – *Female Sexual Function Index*
  - 3.5 to 5.3
- Decrease in distress FSDS-R – *Female Sexual Distress Scale – Revised* *from* – 9.4 to – 6.1

Katz et al. *J Sex Med*, 2013.

Vyleesi - Bremelanotide

VYLEESI is indicated for the treatment of premenopausal women with acquired, generalized hypoactive sexual desire disorder (HSDD), as characterized by low sexual desire that causes marked distress or interpersonal difficulty and is NOT due to:

- A co-existing medical or psychiatric condition
- Problems with the relationship
- The effects of a medication or drug substance
- Statistically significant Increases Desire
- Statistically significant Decrease in Distress

Vyleesi - Bremelanotide

- Nausea reported in 40% of women with 1st dose, is reduced in subsequent doses
- May cause a mild transient increase in BP after each dose (10mmHG)
- 1% of women experienced focal hyperpigmentation
- Is administered via an auto-injector

Vaginal CO_2 Laser Therapy

- Non surgical laser increases blood flow, the production of new collagen and elastin fibers
- Decreases symptoms GSM, restores vaginal flora
- Improves sexual functioning
- Reduces burning, itching, dryness and dysuria
- 17 out of 20 women who were NOT sexually active prior were able to resume sexual activity
- Improved QOL

Salvatore, S et al. *Climacteric*, 2015.

Testosterone

- Not FDA approved
- Testosterone cream compounded
- Use 1/10 the normal dose for men
- Increases # of sexual encounters
- Watch for clitomegaly, voice changes, acne, skin reactions

Prescribing Testosterone (off-label)

- Check SHBG, Albumin, Free Testosterone

Free & Bioavailable Testosterone Calculator:
http://www.issam.ch/freetesto.htm

- Avoid treating women with low SHBG
- Avoid treating women with androgenic features: hirsuitism, acne, alopecia
- Testosterone 0.5mg/per Gm of cream
- Prescribe 30 Gms in a Topi-Click
- Each click delivers 0.25 Gm (1/4) of cream = 0.125mg of Testosterone

RISTELA

- French Maritime Pine Bark Extract
- L - Arginine
- L- Citrulline
- Increases blood flow
- Studies show statistically significant improvement in Arousal, orgasm, desire, and overall satisfaction

Stanislavov R and Rohdewald P. *J Women's Health Care*. 2014
Bottari A, et al. *Panminervea Med*. 2013.

THANK YOU

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