The Great Canadian SEX Challenge: What Women are Reluctant to Discuss-How do the New Guidelines Deal with it?

Wendy Wolfman MD FRCS(C)
President Canadian Menopause Society
Professor Dept Ob/Gyn U of Toronto
Director Menopause and POI Units Mt. Sinai Hospital

1

Disclaimer and Conflicts

- speaker for Pfizer, Bayer and Searchlight
- Advisory Board Pfizer and Biosyent
- Received unrestricted grant from Pfizer for Fellowship and competitive research grant
- Canadian Menopause Society and co-head Education Committee International Menopause Society

2

Objectives-Sexuality 2021 Guidelines

- To discuss the etiology of sexual problems in post-menopausal women
- To discuss most common sexual problems in post-menopausal women
- To formulate options for treatment of sexual problems in postmenopausal women

3

Ms Canadian Sex Challenge(CSC)

- 50yr old G1 P1 LMP 1 yr ago some flashes
- Previously enjoyable sex q weekly but new discomfort
- Married 22 years-still likes partner
- Both healthy, working hard
- Prefers to read a book at night
- Worried he will go elsewhere
- Can you help her?



4

Suggestions:

- You have a busy office
- Do you have time for this?
- Reassure and validate that this is a normal issue that can start before menopause
- Book another appointment
- you could check TSH, possibly prolactin
- **FSH or T level not necessary**

5

Increase in Sexual Dysfunction at Menopause

4 P's-PATIENT + PASSAGE WAY+ PARTNER+ Pertinent history



Most common problems
Decreased desire and pain

Lindau S NEJM 2007;357 (8):762-774
Shifren J Ob Gyn2008;112 (5):970-978

6

Changes in sexual desire in menopause

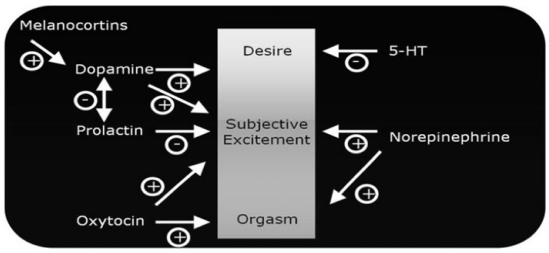
- Over 50% of women report low sexual desire but 12% in US distress, ages 45-64 varies with country
- 26% of women with surgical menopause
- 50% report vulvovaginal discomfort within 3 years of menopause

Sexual complaint AGES 45-64	Sexual problem Prevalence	Problem +distress
PAIN		14.8%
DESIRE	39%	12.3%
AROUSAL	23.9	7.5%
ORGASM	17.1	5.7%

Worsley J Sex Med. 2017;14:675–686.
Shifren J Ob/Gyn 2008;112(5)970-978

7

CNS Effects of Neurotransmitters on Female Sexual Function

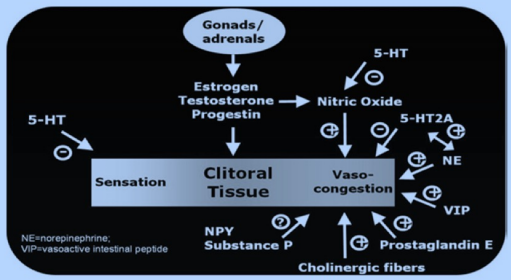


Adapted from Clayton AH. *Psychiatr Clin North Am.* 2003;26:673-682; Ben Zion IZ et al. *Mol Psychiatry.* 2006;11:782-786

5-HT = Serotonin

8

Peripheral Genital Tissue Effects of Neurotransmitters and Hormones on Female Sexual Function



Adapted from Clayton AH. *Psychiatr Clin North Am.* 2003;26:673-682; Ben Zion IZ et al. *Mol Psychiatry.* 2006;11:782-786

9

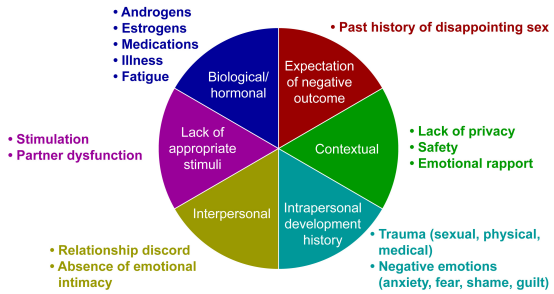
What is the clinical need?

- Globally-2030- 1.3 billion menopausal women over 50- 47 million/year
- Sexual satisfaction =better general health
- HSDD associated with decrease in QOL-mental health, vitality, social function and bodily pain subscales
- Affected more likely to be depressed, dissatisfied with home, marital life, and partner
- Impacts other household members

Nappi R. Maturitas 2016;94:87-91
Davison SK J Sex Med 2009
Hill K. Maturitas. 1996;23: 113–127.

11

Components of midlife women's sexual interest/function (Biopsychological Model)



Basson R *J Sex Marital Ther* 2001;27:33-43; Dennerstein L *Climacteric* 1999;2:254-62

12

Causes of Female Sexual Dysfunction

- **No partner, relationship or partner illness**
- **Psychological disorders-depression** or anxiety
- **Medical illness**
- Previous sexual or physical abuse
- Stress and fatigue
- **Medications**-oral estrogens, corticosteroids, OCP's, antidepressants, narcotics, antihypertensives, aromatase inhibitors, antiepileptics,
- Substance abuse
- **Pain-Atrophic vaginitis**
- BSO and POI

Basson R Lancet 2007;369:409-424
Kingsberg SA Urol Clin N Am 2007;34: 497-506Women's
Parish S Int J of Women's Health 2013;5:437-47

13

Common medical issues associated with dysfunctions in peri/menopause

- Breast cancer survivors
- Depressed patients
- Patients with POI

Lorenz T. Mayo Clinic Proc. 2016;91(9):1280-1286
Nappi R. Climacteric 2019;22(3):289-295
Benetti-Pinto CL*J of Sex Med* 2015;12(3):685-689
Baumgart J. Menopause2013;20(2):162-168

14

Initial Approach

- modified PLISSIT model outline
  - Permission to discuss, Limited Information
  - provide empathetic listening, open-ended questions
  - History, **Identify and categorize the problem**- acute or chronic, -desire, arousal, pain, orgasm?
  - Specific Suggestions
  - **Intensive** Therapy- Is problem too complicated or longstanding?-refer

Simon J Climacteric 2018;21:415-427
Parish S,Mao Clin Proc. 2019; 94:842-856

15

Evaluation History and Physical

- multifaceted approach addressing comprehensive history
- Categorize but Dysfunctions can overlap
- Targeted physical exam:
  - Vulva, localized tender areas, ulcers, skin lesions
  - Hypertonicity of the pelvic floor
  - Palpable lesions
  - Other medical causes

Simon J Climacteric 2018;21:415-427

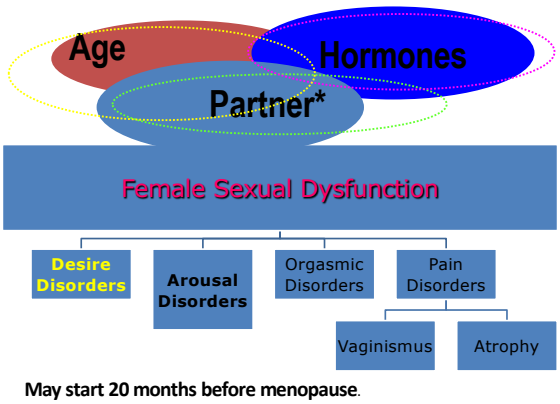
16

2.Sexual dysfunction management

1.Education on effects of menopause and aging
2.Discussion on options- foreplay, non-penetrative alternatives, vibrators, erotic literature, mindfulness, relaxation techniques
3.Treatment for genitourinary syndrome of menopause
4.consider referral to other supportive health care providers including couples therapists, psychologists (CBT, mindfulness)and sexual therapists

The NAMS 2017 HT Position StatementMenopause2017;24:728-53.
2021 Sexuality Chapter
Davis SRJ C JOGC lin Endocrinol Metab. 2019;104(10):4660-4666.
Kingsberg SA, J Sex Med 2017;14:1463-1491

17



May start 20 months before menopause.

Avis N Menopause2017;24(4):379-390

18

Sexual pain management

- **Address first**
- More likely in women with vulvovaginal atrophy
- Manage any visible lesions/ulcers
- Treat genitourinary syndrome of menopause
  - Lubricants, moisturizers, estrogen creams, ring, tablet, softgel tab, DHEA tab, oral SERM, pelvic physio
- If pelvic pain with deeper penetration - may require pelvic physiotherapy or referral

SOGC GSM Guideline 2021

19

CANADIAN MENOPAUSE SOCIETY
SOCIÉTÉ CANADIENNE DE MÉNOPAUSE

THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS OF CANADA

Hypoactive Sexual Desire Disorder (HSDD)

- Loss of sexual desire (sexual fantasies or thoughts or desire for sexual activity) in association with personal distress
- Most common sexual dysfunction
  - must be present for 6 months
  - Not caused by medication or other medical conditions
  - causes significant distress

American Psychiatric Association DSM 5. 5th ed. Arlington, VA: ; 2013
McCabe MP *Journal of sexual medicine*. 2016;13(2):135-142

20

Hormone Therapies (HT) and Sexual Function

- Systemic HT and low-dose vaginal estrogen therapy (ET) treat VMS symptoms and vulvovaginal atrophy
- ET does not improve sexual interest, arousal, and orgasmic response beyond menopause symptoms-(facilitates)
- transdermal ET formulations preferred to oral
- CEE + bazedoxifene relieves dyspareunia,improves VVA and some aspects of sexual function
- Some evidence for tibolone and sexual function

Santoro N J Sex Med 2016;13:168-78
NAMS 2017 Position Statement.Menopause2017;24:728-53

21

Flibanserin

- First approved medication for HSDD in premenopausal women in Canada
- equally effective in postmenopause
- -dopaminergic and norepinephrine effects
- Sexually satisfying events: 2.5 more in 28 days vs 1.5 events in placebo arm
- Improvements in decreased distress and FSI in 20% of pre-menopausal women
- Dose-100 mg qhs -side effects- hypotension and nausea

Simon J Menopause 2014

22

Global Consensus on Testosterone in Women and ISSWSH Guideline for Use of Testosterone for HSDD

- Testosterone endorsed by 11 societies
- Testosterone increases # of satisfying sexual events 1/month when used in transdermal route approximating premenopausal levels
- increases desire, arousal, orgasms, pleasure and sexual responsiveness, reduces sexual distress
- **Not injectables, oral, compounded**

Davis SR, J Clin Endocrinol Metab. 2019;104(10):4660-4666.
Parish S J of Sex Med 2021;18(5):849-867

23

How to prescribe

- off-label prescription
- Only approved testosterone in Canada is for men
- Do not have to be on estrogen
- baseline total T, repeat in 3- 6 wks
- avoid high levels< 2.4 nmol/L or less
- 4 drps of gel /tube= 1/10 dose of men-post calf or ½ pump 1% gel
- Monitor response q 6 monthly
- Stop if no benefit after 6 months

Davis SR, J Clin Metab. 2019;104(10):4660-4666
Parish S J oEndocrinol f Sex Med 2021;18(5):849-867

24

Arousal disorder management:

- lack of subjective arousal from any stimuli.
- decreased pelvic blood flow & lubrication
- Rule out reversible causes such as medications, menopausal changes or systemic disease
- no Health Canada–approved treatments
- phosphodiesterase inhibitors (low dose sildenafil) mechanical devices -sex toys or clitoral suction can be tried
- Mindfulness, as part of CB sex therapy, is promising
- May need to refer

Maserejian N.. *J of sex & marital therapy*. 2012;38(1):41-62
Kingsberg S. *J of Sex Med*2017;14(12):1463-1491

25

Anorgasmia management

- No current approved treatments
- **Primary anorgasmia** very difficult to treat
- Potential options: psycho-education, mindfulness, directed masturbation, sensate focus techniques, vibrators
- **Secondary anorgasmia-often** associated with SSRI's or psychological issues-can try switching SSRI to buproprion
- some evidence on flibanserin, testosterone

Kingsberg S. J *of Sex Med*. 2017;14(12):1463-1491.

26

Conclusion

- Sexuality is important to menopausal women
- Most common sexual disorders are hypoactive sexual desire disorder and pain.
- Sexual problems can be approached as a biopsychological model.
- Various Medical and psychological Therapeutic treatments are available to help

29