Sexual dysfunction in organic disease

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- Female sexual dysfunction

  Desire

  arousal

  orgasm

  Pain

Etiology

- Medical factor
- Physical
- Psychological
- Emotional

- **Medical aspects**

  contraception
  pregnancy
  chronic disease
  surgery
  Aging

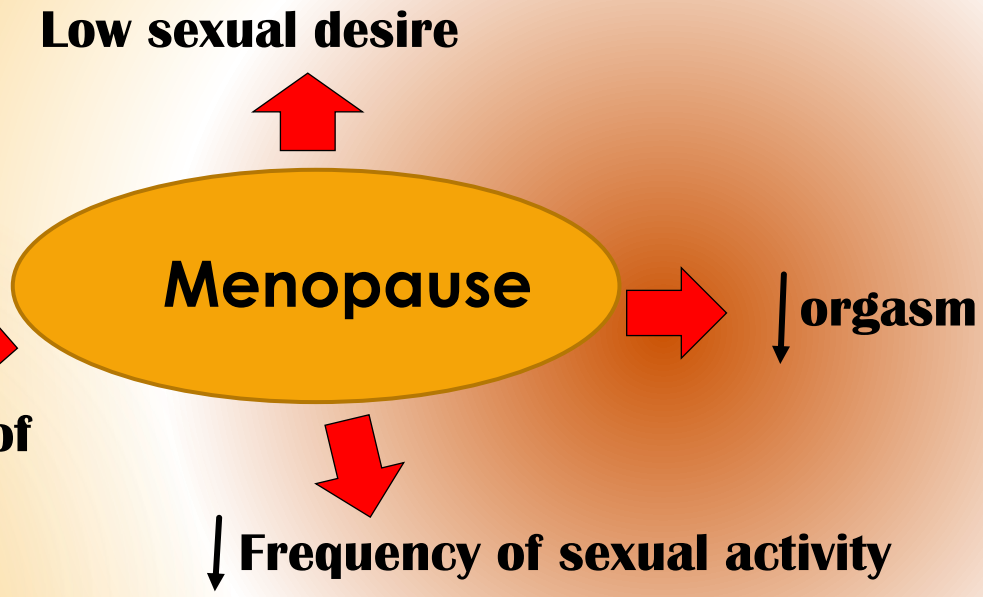
- **Psychological factors**

  Satisfaction with relation
  Self image
  Earlier negative experiences

- ✓ Prevalence of sexual problems decreased with increasing ***age*** except in trouble lubricating
- ✓ Significantly related to marital status (Divorced , widowed : elevated risk)
- ✓ Educational status (desire/orgasm/pain/sexual anxiety)
- ✓ Urinary tract symptoms: arousal /pain disorder in women
- ✓ STI

Sexual life after menopause

- personal and relationship distress:
  - psychosocial factors
  - the biological changes at menopause



Positive effect

- Good past sexual HX.
- Good physical and mental health
- Healthy marital relationship
- Higher education /social class

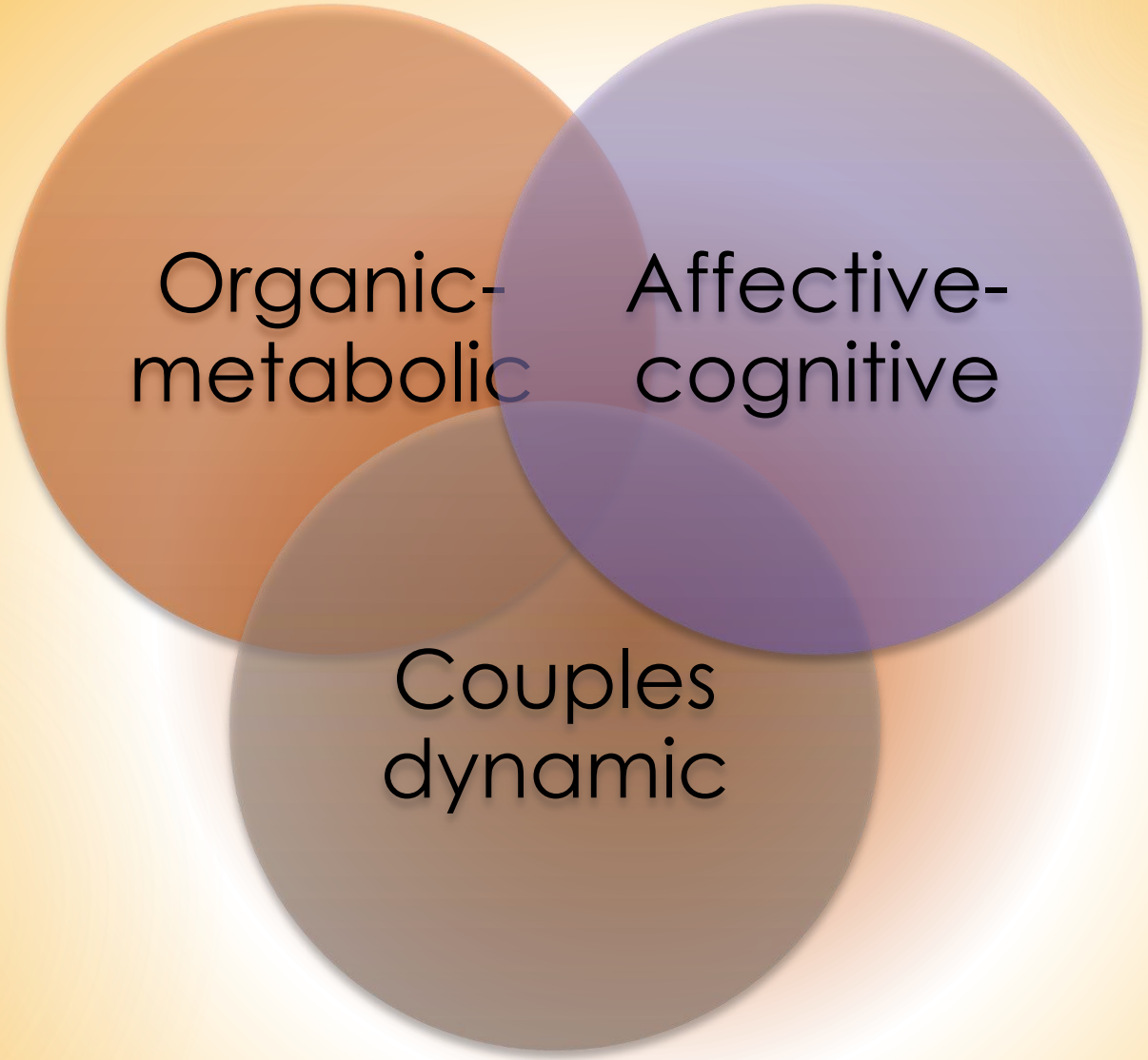
Sexual dysfunction in relation to age and menopause

1

- ✓ HSDD due to Inadequate lubrication, vaginal dryness, and dyspareunia
- ✓ changes in intensity, duration of stimulation needed for arousal and orgasm
- ✓ orgasmic response: muted or take longer to achieve
- ✓ lower frequency of sexual activity more than men
- ✓ decrease estrogen , androgen → low desire, poor arousal, dyspareunia, impaired orgasm → reduced sexual satisfaction

2

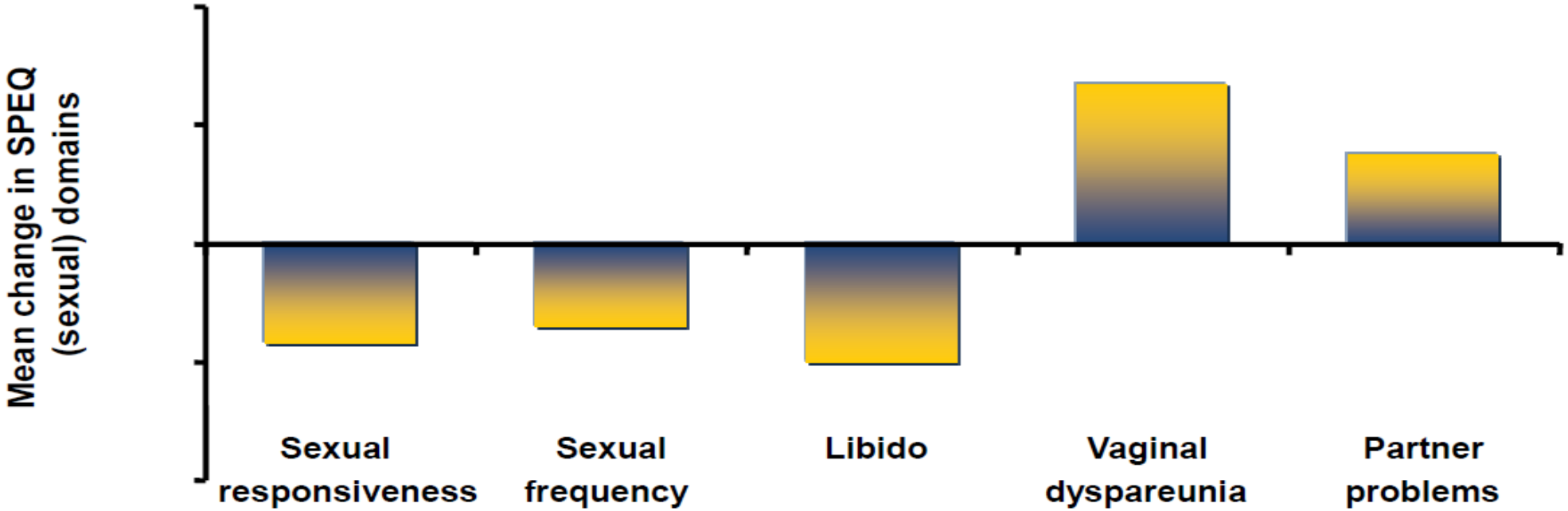
- ✓ emotional and cognitive aspects of sexuality
- ✓ type of menopause (natural or surgical)
- ✓ achievement of reproductive goals, education, body image, and self-esteem



Age- related changes in midlife

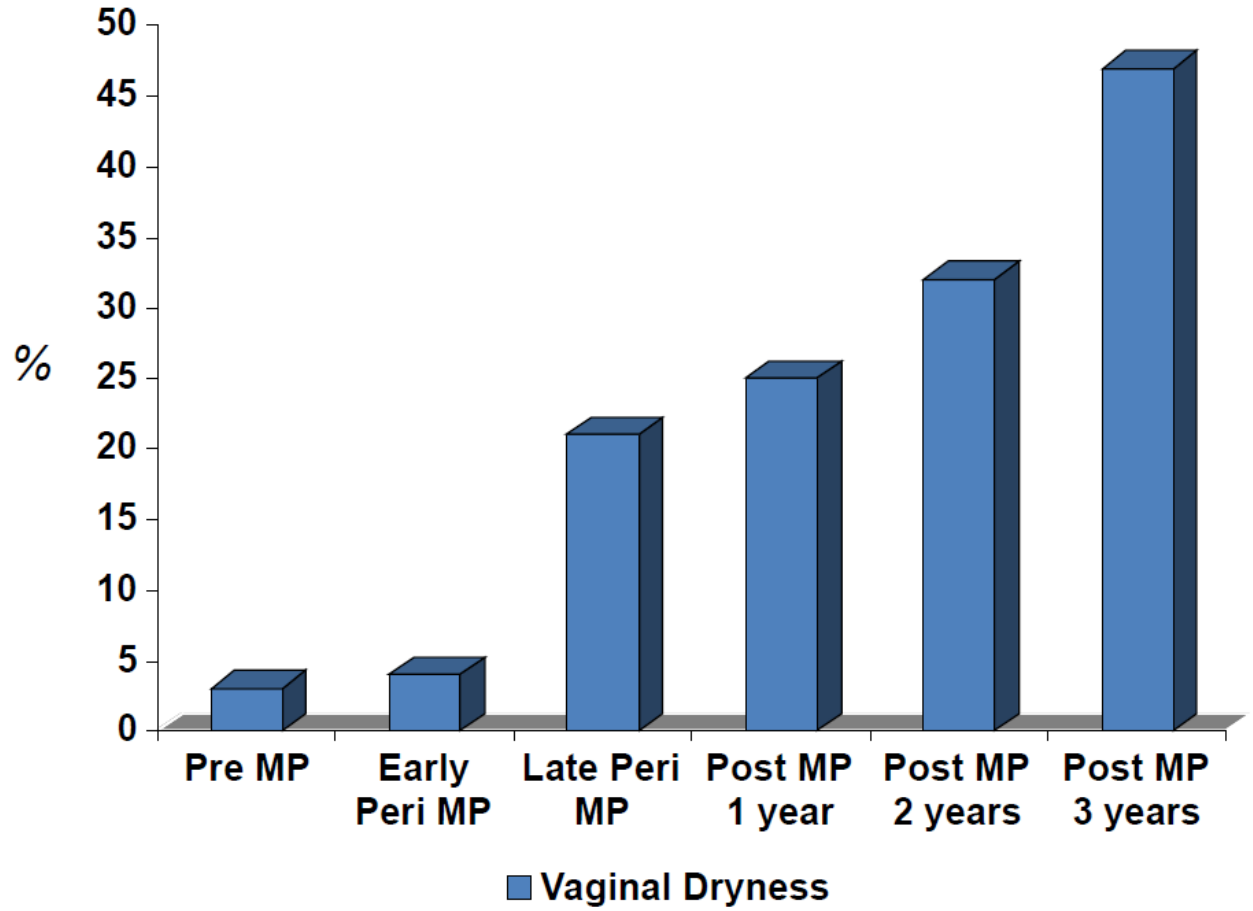
The Effect of Menopausal Transition on Sexual Functioning- The Melbourne Women's Midlife Health Project

Data Reported From a Longitudinal, Population-based Cohort of Australian Women, aged 45–55 years , n=438



SPEQ = Shortened version of the Personal Experiences Questionnaire.
*p<0.05 for post-menopausal compared with peri-menopausal women.

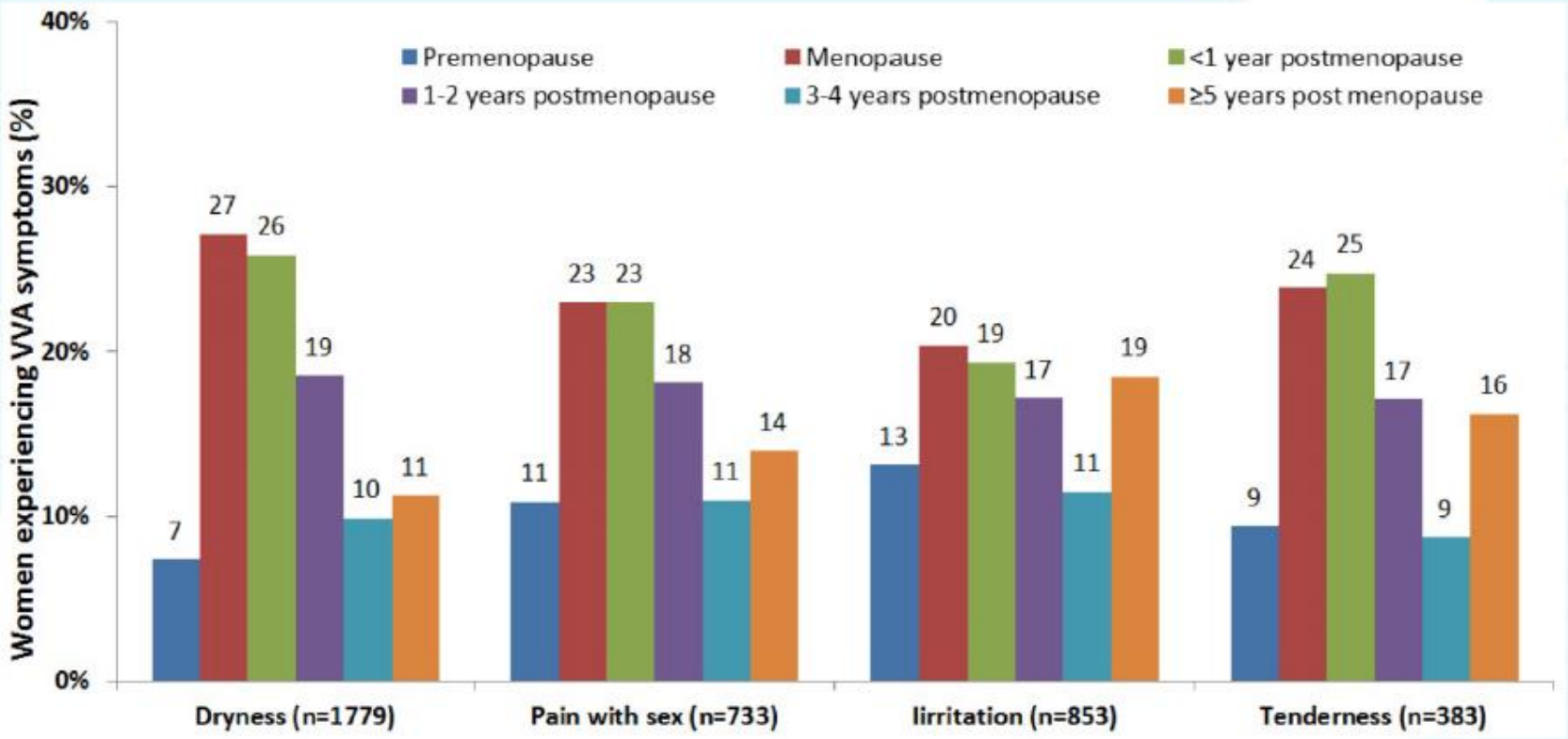
Vaginal Dryness & Menopause



Dryness increases significantly in late perimenopause and postmenopause ($P < .001$).

Dennerstein L, et al. Obstet Gynecol. 2000;96:351-8.

Figure 2. Onset of VVA symptoms in Europe (above) and the US (below)



Poster presented at the 4th International Consultation on Sexual Medicine, 19–21 June 2015, Madrid, Spain.

Low lubrication
vaginal dryness

Low desire

Low testosterone

Estrogen deficiency.

Menopause

Sexual Function & Dysfunction in Middle Aged Women (MWMHP)

After 11 years

81%

of the women had low sexual function

BUT

Only **17 %** were sexually distressed

(female sexual distress scale – FSDS ≥ 15)

Conclusion:

If sexual distress is present,
it may have a significant negative impact on women ‘s life and her relationship

But: The biggest problem is

that only a minority of women seek help for sexual complaints

Basic questions:

- Are you sexually active?
- Any sexual problem :pain ,dryness ,difficulty getting aroused ,sexual desire ,satisfaction ,orgasm
- Any sexual problem in spouse

Many problems in postmenopausal women are due to PE/ ED

Medical exam

- **Full pelvic examination**
  - Ultrasound
  - External genital exam
  - Pain trigger point
  - Pelvic floor
  - Vaginal PH
- **Lab test(TSH/FBS/Iron/D3/FSH/LH/Prolactin)**
- **Total testosterone/SHBG/Free T(for T therapy)**
- **Others as indicated**

Key predictors:

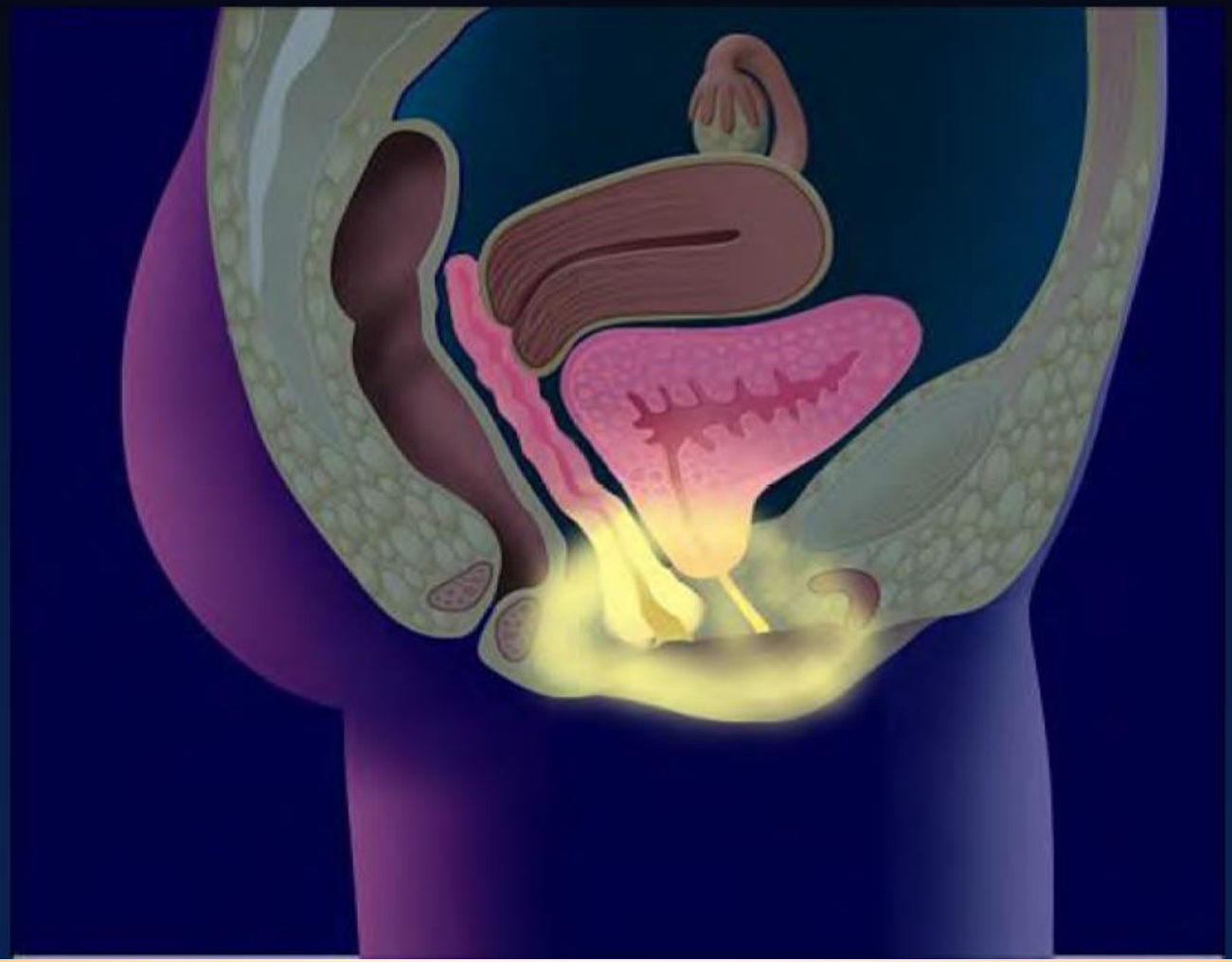
of sexual response
- Prior level of sexual function
- Change in partner status
- Feelings for partner
- E2 Level

of dyspareunia
- Prior level of dyspareunia
- E2 level

of frequency of sexual activities
- Prior level of sexual function
- Change in partner status
- Feelings for partner
- Level of sexual response

Treatment

Estrogen Receptor Concentrations in Select Adult Genital Tissues



Estrogen therapy

- VVA/GSM is natural sign of aging, has significant biological, psychological and social consequences.
- Systemic Est
- Local Est
  a. current low dose therapies are effective & FDA-approved Result in
  b. minimal systemic absorption in local E
  c. long-term safety without medical risk or endometrial stimulation.

Androgens

- Testosterone preparations:
  - IM
  - subcutaneous implants
  - transdermal testosterone patches
  - oral formulations
  - often in combination with estrogen therapies

systemic T: Increase libido

Vaginal T: Decrease vulvovaginal atrophy

- ✓ There is no testosterone level for diagnosis of HSDD or for use as a treatment target.
- ✓ Total testosterone concentration is the best practical assay.
- ✓ Total testosterone and SHBG should be measured before initiating therapy.
- ✓ Proper dosing should attain and maintain total testosterone levels in the premenopausal physiological range.

- ✓ Compounded testosterone, pellets, IM injections ,oral formulations are not recommended.
- ✓ Additional testing and alternative strategies may be required to assess failure to respond to typical testosterone treatment, particularly when testosterone or SHBG levels are high
- ✓ If an approved female formulation is not available, one-tenth of a standard male dose can usually achieve the normal premenopausal physiological range.

Contraindication

- signs of clinical androgen excess (acne, hirsutism, androgenic alopecia)
- using an antiandrogenic medication (finasteride, dutasteride).
- hormone-dependent neoplasia should only be recommended in consultation with oncologist
- Women with a high SHBG concentration are less likely to experience treatment benefit

- ✓ DHEA: production declines with increasing age
- ✓ low levels of DHEA associate with low desire

- Oral DHEA not recommended for HSDD in postmenopausal women with normal adrenal function
- vaginal DHEA (FDA approved) only effective for dyspareunia because of vulvovaginal atrophy.

Tibolone

- Synthetic steroid :selective tissue estrogenic activity regulator
- As an estrogen , androgen and progesterone in multiple tissues
- Treating mood and sexual desire
- Long term safety ???
  - Previous breast cancer
  - Women over 60 y(Increased risk of stroke)

Psychosocial therapy

- Basic counselling :
  - physiologic and psychologic change
  - Couple relationship
  - Change in desire
- Psychosexual management
  - Behavioral T
  - Psychosexual therapy
  - Couple T

Neurokinin 3 (NK3) receptor signalling play a key role in positive and negative feedback loops regulating the hypothalamic-pituitary-gonadal (HPG) axis.

the absence of estrogen ➡ greater proportion of the brain chemical neurokinin 3 (NK3) ➡ trigger a disruption in the brain's ability to regulate body temperature.

Hot Flash

- **Other non hormonal drug**

- SSRI
- SNRI
- Clonidine
- Herbal products can affect physical and sexual state

Targeting KNDY Neurons

- Fezolinetant Neurokinin 3 receptor antagonists
- New treatment/ non-hormonal therapies for the treatment of vasomotor symptoms in menopausal women
- Thermoregulation (4-12 week)
- FDA approved: 2024

Premature Ovarian Insufficiency and Early Menopause

- Menopausal hormone therapy (MHT) is strongly recommended for early menopause, at least until the age of natural menopause
  I. relieving symptoms
  II. preventing long-term medical conditions.
- Physiological replacement of estrogen (and progesterone if the uterus is intact)
- The controversies surrounding the use of MHT concerning benefits and risks should not apply to the premature and early menopause population

Myths about sexuality

- Sex must be spontaneous
- Sex must always end in intercourse
- Men want always sex
- Women want never sex
- Sex is four young bodies only

Biomedical interventions:

- ✓Estrogen local and systemic
- ✓Estrogen-Testosteron
- ✓PDE-5 Inhibitors
- ✓Bremelanotide
- ✓Flibanserin

Correcting myths

Basic Counselling, Information, Education

Meno-pause

Is not Sex-pause

No upper age limit for sexual activity

Pelvic organ prolapse and Sexual Function

Prevalence FSD in POP : 25-63%

The higher stage POP (**regardless of vaginal topography but dependent body image**)

Correlation between SF/pelvic floor disorder

- Higher score in POP:
  a. decreased arousal
  b. Infrequent orgasm
  c. Increased dyspareunia(due to body image and self steam more than change in anatomy)

No correlation with vaginal dimension and sexual activity or SF

Associated factor

- menopause(deceased sexual interest/arousal)
- low lubrication
- low androgen: low desire/genital sensation/ responsiveness
- Depression , social factor

Effect of surgery of pop surgical

- Dissection → tissue damage ,devascularisation ,denervation
- Decreased vaginal blood flow and fibrosis
- Mesh → dyspareunia, tissue contracture ,mesh erosion

Attention

a. **Patient selection specially in**

1. **pelvic floor dysfunction(muscle spasm ,trigger point, interstitial cystitis)**
2. **Vulvodynia**
3. **Chronic constipation**
4. **Obstructive lower urinary tract syndrome**

This patients maybe has more complication and less satisfaction especially in Coitus UI

Prevalence of urinary Incontinence : 43-45%

Sexual dysfunction:

- 29% in SI
- 71% in UI
- MUI(mixed)lower quality of life(QOL)

UI & FSD

- **Direct affect**
  - Desire
  - Lubrication
  - Orgasm , Sexual satisfaction
- **Indirectly**
  - Dermatitis and vulvar irritation
  - Dyspareunia
  - Fear engaging in sexual activity

- 34% : HSDD
- 23% : Arousal disorder
- 11% : orgasmic deficiency
- 7% : Lower desire , lubrication , sexual satisfaction

Prevalence Coitus urinary incontinence (CUI) :10-27%

- ✓ During in orgasm related to Detrusor over activity
- ✓ During penetration or thrust related to SI
- ✓ More effect On QOL

Treatment

- Biofeedback
- Functional electrical stimulation
- Pelvic floor muscle exercise
- Vaginal cones
- Energy base devices

Pelvic Rehabilitation Program(PRP)

Behavioral treatment:

- Empting bladder before sexual activity
- Avoid ingestion fluid one hour before love making
- Intercourse at female recumbent position(decreasing prolapse pressure and leakage)
- Water base lubricant/vaginal estrogen(decreased trauma)

Treatment pain after urogynecological surgery

- Analgesics
- Anti inflammatory drugs
- Muscle relaxant
- Local anesthetics injection
- Nerve block
- Steroid injection at trigger point
- Trans vaginal injection of BOTOX

Successful surgery and improvement SF : pre-existing behavioral- emotive and partner related factors

- ✓ The role of cervix in sexual function is unclear and controversy
- ✓ Important to consider both urinary and sexual health concerns

Sexual counselling skills

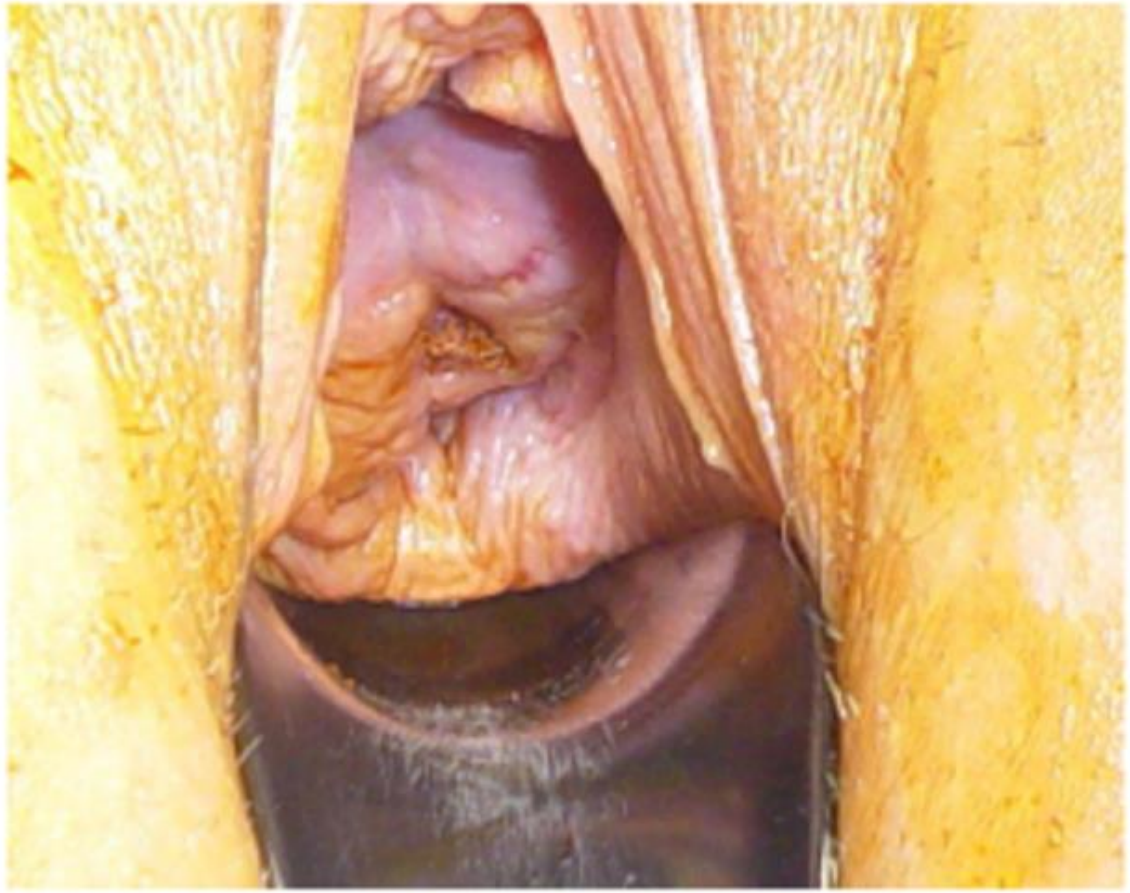
Be empathy the effects Of POP on sexual life as well as overall quality of life

View of her self , embarrassing ,relationship with partner

Describe all available treatment(surgical and non surgical)

Follow patient for improvement

hispareunia



Partner dyspareunia