Hypoactive Sexual Desire Disorder

Background

1. Definition
    - Debate in literature about what is correct definition
    - Controversy over DSM-IV criteria being outdated and based on an antiquated linear model of desire and arousal
    - "Persistent or recurrent deficiency (or absence) of sexual fantasies, thoughts and/or desire for or receptivity to sexual activity, which causes distress"
2. General information
    - A large component of women's sexual desire is responsive rather than spontaneous
    - Sexual desire is an uncommon reason/ incentive for women's initiation of, or agreement to sexual activity
    - It is very common to have comorbidities of different sexual dysfunctions
    - It is important to identify what dysfunction was present first

Pathophysiology

1. It is often difficult to isolate a precise pathogenesis of sexual dysfunction
2. Pathology of dz/ contributing factors
    - There is interplay of physical and psychological processes
    - Role of hormones (estrogen, testosterone) varies per woman
    - Neuropsychological changes
        - Overall health
        - Partner
        - Medications
3. Incidence/ prevalence
    - 30-35% of women aged 18-70 have reported a lack of sexual desire during previous 1-12 mos (population surveys)
4. Risk factors
    - Interpersonal
        - Stress
        - Poor self esteem
        - Concerns about pregnancy or STIs
        - Poor relationship quality
        - Concerns about privacy
        - Concerns about emotional or physical safety
    - Medical illnesses
        - Depression
        - Diabetes
        - Hypertension
        - Hypothyroidism
        - Hyperprolactinemia
    - Medications
        - SSRIs are a common offender
        - OCPs incr sex hormone binding globulin and in turn reduces bio-available testosterone which is hypothesized to affect some women

Diagnostics

1. History
    - General sexual disorder questions
        - Are you sexually active?
        - If sexually active: Do you have any questions, problems or concerns you would like to discuss?
        - If not sexually active: Does that bother you or your partner?
            - If they do have concerns and/or they are bothered then proceed to more specific questions
    - Specific for hypoactive sexual desire disorder
        - Are you having difficulty w/sexual interest? Does this bother you?
        - When did you first notice this change?
        - Do you feel you generally have a good relationship w/your partner?
        - Does your partner have difficulty w/
            - Sexual dysfunction?
            - Premature ejaculation?
            - Erectile dysfunction?
        - Are there any medical issues or stressors in your life that you feel may be contributing to your decr in sexual interest?
    - Quantify amount of distress
        - Mild, moderate, severe
2. Physical exam
    - General and pelvic exam
    - Infrequently identifies a cause of sexual dysfunction
    - May be more helpful in women w/associated dyspareunia
    - General
        - Signs of systemic dz that may lead to low levels of energy, desire or arousability
            - Anemia
            - Bradycardia
            - Hypothyroid
            - Depression
        - Signs of connective tissue dz that may lead to vaginal dryness
        - Disabilities that may preclude movements involved in sexual activity
        - Disfigurements that may lead to low levels of self-confidence and consequently low levels of desire
    - External genitalia
        - Sparsity of pubic hair (suggests low levels of androgens)
        - Vulvar skin disorders incl fissures suggestive of chronic candidiasis
    - Introitus
        - Cystocele, rectocele, or prolapse
        - Allodynia of crease between outer edge of hymen and inner edge of labia minora, typical of vestibulitis
    - Internal
        - Incr tone of pelvic muscles
        - Fixed retroverted uterus, nodules or tenderness suggestive of deep dyspareunia

3. Diagnostic testing
    - Lab eval
        - None is universally recommended
        - Labs ordered are led by pt H&P
        - Dx of androgen insufficiency should not be made by lab test alone, rather it should be based on 3 criteria
            - Clinical symptoms of androgen deficiency
                - Diminished sense of well-being
                - Persistent or unexplained fatigue
                - Sexual function changes
            - Dx should be made only in estrogenized women
            - Free testosterone levels should be at or below lowest quartile for healthy women
    - Testosterone level
        - Serum levels do not necessarily correlate w/sexual function
        - If you are going to test, simplest and most readily available clinical estimate of free testosterone is free testosterone index, calculated from total testosterone and SHBG
    - Vaginal infections to be r/o w/wet mount and cultures if indicated
4. Screening tools
    - Self-administered screening test for hypoactive sexual desire disorder (for postmenopausal women)
        - Brief four item questionnaire to be completed by pt
        - Score of 7 or higher is suggestive of HSDD
        - Use specific HSDD questions above as follow-up confirmatory questions if screen is positive
    - The Brief Profile of Female Sexual Function (B-PFSF)
        - Psychometrically valid, tested in different countries, and appropriate for use as a self-administered screening tool for post-menopausal women
        - 7 item self-administered questionnaire

Differential Diagnosis

1. Subjective sexual arousal disorder
2. Genital sexual arousal disorder
3. Combined genital and subjective arousal disorder
4. Persistent sexual arousal disorder
5. Women's orgasmic disorder
6. Dyspareunia
7. Vaginismus
8. Sexual aversion disorder
9. Other medical problems that confound dx
    - Depression
    - Adverse medication reaction
    - Hypothyroidism

Therapeutics

1. Psychological intervention:
    - Effective interventions are mainly psychological
    - Behavior modification
    - Cognitive behavioral therapy
    - Intensive sex therapy
    - Education about normal changes/ arousal cycle
2. Medications
    - Estrogen: for vaginal atrophy
    - Testosterone
        - Premenopausal:
            - No clear evidence that testosterone therapy improves desire in premenopausal women
        - Postmenopausal:
            - 300-ug/day testosterone patch can increase a postmenopausal woman's sexual desire and increase the frequency of sexually satisfying sexual episodes
    - Herbal supplements
        - No consistent evidence that beneficial
    - Sildenafil
        - No consistent evidence of benefit for women
3. Patient education
    - http://www.nurtureyournature.org
    - http://www.healthywomen.org
    - http://www.twshf.org
    - http://www.femalesexualdysfunctiononline.org
    - http://www.fsfi-questionnaire.com

Follow-Up/ Prognosis

1. Return to office
    - Multiple visits usually required to address problem
2. Refer to specialist if
    - Beyond ability in training or time to counsel
    - Identify a specific problem amenable to specialty intervention
    - After counseling about some simple changes in expectations and habits pt does not achieve a satisfying outcome
3. Specialists to refer to:
    - PT
    - Psychologist/ Sexologist
    - Gynecologist
    - Resource for locating specialists
        - American Association of Sexuality Educators Counselors and Therapists
        - http://www.aasect.org

Pearls

1. Female sexual desire is not necessarily spontaneous
    - Important to distinguish if pt becomes aroused in response to sexual stimuli
    - If so, lack of spontaneous desire may not be abnormal
        - See intimacy based arousal cycle in background section
2. Educating pt and partner about normal arousal cycle for women can be very therapeutic
3. There is only a problem if pt is distressed
    - Pt has low desire, but is not distressed by this, then it is not a dysfunction

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Evidence-Based Inquiry

1. What are the main benefits and risks of testosterone patches for postmenopausal women with hypoactive sexual disorder?

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