ACTA SCIENTIFIC MEDICAL SCIENCES (ISSN: 2582-0931)

Volume 3 Issue 8 August 2019

Mini Review

Sexuality and Menopause

Shaikh Zinnat ara Nasreen*, Safinaz Shahreen, Saleheen Huq and Sabereen

Professor and Head, Department of Obstetrics and Gynaecology, Z.H.Sikder Women's Medical College and Hospital, Bangladesh

***Corresponding Author:** Shaikh Zinnat ara Nasreen, Professor and Head, Department of Obstetrics and Gynaecology, Z.H.Sikder Women's Medical College and Hospital, Bangladesh.

Received: June 3, 2019; **Published:** July 04, 2019

DOI: 10.31080/ASMS.2019.03.0342

There is marked decline in all the domains of Sexual function like desire, arousal, orgasm and pain in both women and men, as they grow older. The androgen milieu and sexual desire seem to be tightly linked so both decline with age. Menopause is milestone in women's life; withdrawal of hormone exacerbates the female sexual dysfunction than men [1]. Menopause happens so dramatically that women feel a great challenge to cope with that than their counterpart. But sexual well being of menopausal women depends not only on menopause or hormone deficiency. The Biopsychosocial model has tremendous role on female sexuality [2]. Biopsychosocial model includes the personal attitude towards sex, social belief, religious culture, and relationship with the partner, comorbidities of partner or herself. Interpersonal relationship is the most important criteria for the sexual well being for women. Study shows that women place high value on sexual intimacy in their relationship [3,4].

PRESIDE study [5] Revive study showed that Vaginal dryness of menopause adversely affect the enjoyment 72% and women felt sexual spontaneity about 66% [6]. Diminished sexuality of women may break the relationship and women may suffer from severe mental depression. But irony is women suffer silently, they don't express or share the problem. In some community it is a taboo so many women refrain from sex. On the contrary health providers do not ask or unaware of the issue. So the issue remains unresolved and keeping the FSD, difficult to address. Very few women complain but that is actually the tip of iceberg.

- Female Sexual dysfunction is classified as DMS (Diagnostic and Statistical Manual of Mental Disorder) 5th Edition.
- Female sexual interest and arousal disorder
- Female sexual orgasmic disorder
- Genito-pelvic pain/penetration disorder
- Substance/medication-induced sexual dysfunction.

The International vaginal health; insight, Views, and attitudes (VIVA) study reported the prevalence of specific symptoms including vaginal dryness (83%) and pain during sex (42%) [7].

Sexual behavior is controlled by a hormonally response neural network. Endocrine, neurological, psychiatric conditions, cancer medication and surgical procedures, alcohol intake, local diseases, deficient estrogen- testosterone, bio psychosocial factors all these have influence on sexuality. Nothing happens without desire again painful sex affects desire and all other domains of sexual cycle. The decrease in circulating estrogen levels during and after the menopause transition, along with the age-associated decline in androgen, independent of menopause, significantly contribute low desire, poor arousal, dyspareunia, impaired orgasm and consequently reduced sexual satisfaction [8]. In addition, menopause may impact emotional and cognitive aspects of sexuality through personal experiences including age at menopause, type of menopause, physical and mental health, achievement of reproductive goals, education, body image, and self-esteem norms and experience. Psychosocial factors are important factors for sexuality [9]. Also partner issues strongly correlate with FSD and quality of life [10]. Nonetheless, it is need to be aware that unpatented postmenopausal women may also experience sexual concerns and difficulties that need to be addressed [11,12].

Diagnosis

For diagnosis history taking need to be very meticulous and empathetic focusing on her cultural, social, religious belief, personal relationship and comorbidities. Finding the source of the issue for a doctor is more than half the battle (Figure).

After detailed history taking clinical examination should be done. We need to follow the DMS-5 classification (5th edition,

American psychiatric press, USA, 2013). Minimum investigations are done to exclude other causes than menopause for FSD.

Figure : www.floliving. Com/the 7 foods that-will boost-your-sex-drive.

Lack of interest in sex

Decreased arousal is common in menopause.

Although sexual desire triggers arousal but in menopause desire will follow arousal, health care providers need to keep it in mind while treating them. Lack of orgasm in non-aroused women makes sex less pleasurable. So it is vital for women to be aroused for enjoyable sex.

Pain disorder

Withdrawal of hormone makes the vaginal wall very thin friable, less elastic, dry and it becomes prone to mechanical damage during sex. Lack of Lubrication is important factor for painful intercourse.

Treatment

Treatment strategies focuses on

- Providing sex Education
- Sexual behavior, response, performances
- Enhancing stimulation
- Use of erotic VDO, books, masturbation
- Providing Destruction Technique
- Use of erotic and nonerotic, fantasies, exercises
- Minimizing pain.

Team approach is most important and most FSD can be solved if underlying physical and psychological causes are corrected.

Multidisciplinary and holistic approach with Sex therapist, psychologist's gynecologists, counselors and cognitive behavioral therapy (CBT) are important.

General treatment

Lifestyle modification with maintenance of optimum body weight is the cornerstone. Daily exercise, Avoidance of stress, mental recreation, buildup of Self-confidence- improves the sexuality of these women. Enhancing good relationship with partner is the most important factor, treatment of comorbidities of both partners need to be ensured.

Alternative therapy

Sex Toys and Devices may help in arousal. Use of vibrator stimulates clitoris, also clitoral vacuum suction, Dilators are helpful but very expensive. Sessions with sex therapists and sex councilors are much effective.

Medical therapy

Estrogen is the 1st choice for genitourinary syndrome (GSM) of menopause or vulvo-vaginal atrophy (VVA). Local DHEA (dehydroepiandrosterone), moisturizer, and lubricants are also helpful. Local DHEA cream is very effective treatment for dyspareunia secondary to VVA but oral DHEA has no significant role [13,14].

Systemic non-hormonal therapy Ospemifene is effective (approved by US and EU). Daily oral 60mg/day Ospemefene are effective to enhance libido.

Botox is not yet evidenced based but many women may get good result. G-shot may stimulate sexual organ, again it is not yet evidenced.

Laser therapy is very promising to correct underlying hypoestrogenic changes of vagina. But it cannot stimulate brain for desire or orgasm.

Tibolon – use is limited for its of recurrence of breast cancer (J steroid biochem mol boil 2014; 142: 99-106).

Flibanserin (addyi), used for increased desire or sex drive (FDA approved) 100 mg dose at bed time, centrally acting oral multifunctioning serotonin agonist. 50-60% women respond to flibanserin. It is safe and effective [15].

Sildenafil (Viagra) are being used but unlike in men, expected result is not found in women for improving sexual dysfunction (NEJM, Journal watch, women's health, October 16, 2001).

Testosteron is the key hormone for desire and arousal, so it can be used if there is no contraindication. Testosteron, administered trans dermally as a cream, patch or gel or as an implanted pellet, improves sexual well-being in postmenopausal women with low sexual desire associated distress [16].

It should be not continued beyond 6 months if women do not get any respond.

Bupropion 300 - 400 mg daily improves sexual interest. It reduces serotonin inhibition.

Potential future therapies include bremelanotide and combination of testosterone/sildenafil or testosterone/buspirone (Martha Rosenberg, Centre for Health journalism).

Conclusion

Positive sexual function at midlife can enhance personal and relationship quality, improve longevity and enhance quality of life.

Female sexual dysfunction causes many sufferings to these groups of women; even it breaks the relationship and leaves the women isolated with extreme inferiority complex. Self-reporting is rare and history taking is not so simple so health providers need to be proactive and they should possess not only the necessary wide medical knowledge, but also need empathy and compassion.

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