



# Low Libido

## Something To Talk About

By E.J. Aspuru, M.D., FACOG

### Introduction

For many physicians, discussions with patients regarding decreased libido are uneasy, mostly because decreased libido is a multifaceted problem. The perception exists that there is no quick way to evaluate all of the contributing factors to the problem, and there is no simple medical solution. As a result, a number of physicians may fail to ever bring up the topic, even with patients they've known for years. Similarly, many patients may fear that their physicians will be uncomfortable if they bring up questions about their

sexual function or that the physician may dismiss their concern. However, with roughly 40 - 50% of women in various surveys having some form of sexual dysfunction, decreased libido is an issue physicians should proactively address during a comprehensive women's health visit.

Libido is the desire or the drive to have sexual activity and is believed to be triggered in the hypothalamus by activation of the dopamine system. It is one phase of the female sexual response cycle, which includes desire, arousal, orgasm and resolution. Worldwide, the lack of libido is one of

the most commonly reported types of female sexual dysfunction. In women, the desire for sex is rarely spontaneous and is more frequently precipitated by emotion, physical closeness or by arousing imagery. In fact, desire does not always precede arousal. It is important to identify which phase is the primary source of sexual dysfunction and if the dysfunction is leading to distress in the patient. For the majority of women, lack of desire is the principal cause of decreased libido.

### Risk Factors

Risk factors for decreased libido may include, but are not limited to, the following:

- Age (complaints of decreased libido peak in women between 45-64 years of age)
- Menopause (particularly surgical menopause) and associated symptoms of hot flashes and vaginal atrophy

Percentage of Women Reporting Frequency of Vaginal Sex, N=2393

Age Group	18-24	25-29	30-39	40-49	50-59	60-69	70+
<b>Single</b>							
Not in past year	50.8	43.0	72.3	71.1	85.4	84.5	100.0
A few times per year to monthly	16.4	21.5	10.7	16.9	5.4	6.5	0.0
A few times per month to weekly	19.7	24.1	12.5	9.9	7.0	6.5	0.0
2-3 times per week	8.2	1.3	4.5	2.1	2.2	2.6	0.0
4 or more times per week	4.9	10.1	0.0	0.0	0.0	0.0	0.0
<b>Partnered</b>							
Not in past year	12.9	10.6	14.8	20.6	21.1	14.8	30.8
A few times per year to monthly	16.1	11.7	13.6	13.7	18.3	11.1	15.4
A few times per month to weekly	31.2	36.2	43.2	24.5	36.6	48.1	23.1
2-3 times per week	32.3	28.7	18.2	31.4	18.3	18.5	7.7
4 or more times per week	7.5	12.8	10.2	9.8	5.6	7.4	23.1
<b>Married</b>							
Not in past year	11.8	3.5	6.5	8.1	22.0	37.9	53.5
A few times per year to monthly	14.7	11.6	16.3	21.7	23.7	20.0	25.4
A few times per month to weekly	14.7	47.7	50.2	46.6	36.2	35.9	18.3
2-3 times per week	35.3	35.2	21.9	20.8	16.9	6.2	1.4
4 or more times per week	23.5	2.0	5.1	2.7	1.1	0.0	1.4

National Survey of Sexual Health and Behavior (NSSHB). Findings from the National Survey of Sexual Health and Behavior, Centre for Sexual Health Promotion, Indiana University. Journal of Sexual Medicine, Vol. 7, Supplement 5.



- Poor body image of self (particularly true of women treated for breast or pelvic cancer) or poor body image of partner
- Relationship dissatisfaction and distrust
- Depression, anxiety and stress
- Fatigue
- Medications including Selective Serotonin Receptor Inhibitors (SSRIs), Benzodiazepines, antipsychotic medications, oral contraceptives, antiepileptic medications, aromatase inhibitors, etc.
- Substance abuse
- Physical discomfort, including vaginal atrophy, vaginal shortening after hysterectomy, or pain following radiation for endometrial or cervical cancer
- History of physical and/or sexual abuse
- Endocrine problems, including adrenal insufficiency
- Cultural and religious issues

## Screening and Diagnosis

The diagnosis of decreased libido requires an open, proactive conversation with the patient consisting of a thorough medical and sexual history, in addition to a physical exam. The history should include a review of medications, an evaluation of mental health and potential psychological contributors, and a review of physical health and limitations that may lead to decreased sexual desire. Such a comprehensive history and physical may need to be scheduled at a separate, future visit. Because androgen levels do not appear to be directly correlated with sexual desire in women, ordering testosterone or other labs has limited value in investigating decreased libido. Asking open-ended questions is the easiest way to elicit a patient's concern regarding low libido. Giving permission to speak about sex by asking questions such as, "Do you have any concerns about your sex life or about your sex drive?" is the most basic way to convey openness and comfort with the topic.

## Non-Pharmacologic Management

Management of decreased libido could include giving patients a more

realistic idea of how often other patients in their age range or social situation might desire sex. Quite frequently, females will compare their sex drives to when they were teenagers and had no financial, family or home responsibilities. Many women may not even consider that they have a problem with their sex drive until their partners complain of perceived decreased desire in these women. Resetting realistic expectations may address the problem. Moreover, encouraging spouses to help with childcare and household responsibilities can be surprisingly effective in boosting libido. Patients with hectic schedules frequently still enjoy sex, while their lack of desire may be a reflection of their overscheduled lives. Scheduling periodic "date nights" in which neither parent has these all-too-common responsibilities can also go a long way to improving the desire for sex. Similarly, setting cell phone alarms to remind themselves to consider sexual activity on a particular night can be helpful for patients whose demanding lives may distract them from regular thoughts about intimacy.

Because decreased sex drive can also result from relationship dissatisfaction, depression, substance abuse or from a history of sexual abuse, addressing these issues by providing resources can be very helpful. Referrals to



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couples' counselors, psychotherapists, support groups, rehab facilities or sex therapists can lead to an eventual increase in libido. Stress reduction, through regular exercise, yoga or other relaxation techniques, may also be beneficial. While poor body image or physical discomfort may be at the root of some patients' low sex drive, referral to a nutritionist, personal trainer or to a pelvic physical therapist may increase sexual interest as these conditions improve. Additionally, vibrators, dilators, lubricants and other novelty items might not only help bring newness to a long-term sexual relationship, but these devices may also help in patients with reduced elasticity, such as menopausal women or those patients completing pelvic radiation therapy.

### Medical Management

When a number of physicians contemplate medical therapy for low libido, many would consider exogenous androgens, such as testosterone. Although levels of endogenous androgens are not believed to have a direct correlation with sex drive, boosting serum concentrations of androgens with exogenous testosterone is thought to be effective in treating postmenopausal women for decreased sex drive, as well as for problems with arousal and orgasm. To be clear, the FDA has not approved any androgen therapies for female sexual dysfunction. In fact, Estratest (estrogen combined with methyltestosterone) was taken off the market in 2009. Nevertheless, various forms of testosterone are in use today in postmenopausal patients: oral, compounded, micronized testosterone which requires a prescription, topical, compounded 1% or 2% creams and ointments, intramuscular testosterone injections and testosterone implants. Because levels of testosterone in men are 10 times higher than those in women, practitioners should not use transdermal products formulated for men, such as gels or skin patches, in their female patients. Although not yet approved by the FDA and currently unavailable in the U.S., transdermal testosterone in the form of a matrix pouch that delivers 300 micrograms of testosterone per day has been shown to be effective for short-term treatment (< 6 months) of decreased libido. Dehydroepiandrosterone (DHEA), which is available over-the-counter, has also been shown to improve sex drive in premenopausal women with adrenal insufficiency. Nevertheless, patients should be warned that there can be various inconsistencies in both compounded and over the counter products and that data on safety and efficacy may be limited.

Females should be appropriately counseled that androgen therapy can have the following side effects:

- Androgenic: hirsutism, acne, clitoromegaly, deepening of voice, increase muscle mass and temporal balding
- Metabolic (the majority of androgens are aromatized to estrogens): endometrial hyperplasia, endometrial cancer, breast cancer, cardiovascular disease and hepatic disease
- Endocrine: decreased serum HDL  
(in oral testosterone users)

In fact, women who are on androgen therapy should have monitoring of serum lipids and liver function tests. When considering the above side effects, it should also be noted androgen therapy is never recommended in premenopausal women with low libido because of the additional risk for accidental exposure of an unborn fetus, as well as scant data on efficacy.

Other physicians may consider estrogen with or without progesterone therapy for treatment of decreased libido in menopausal patients. While the Women's Health Initiative (WHI) Study found that systemic estrogen with or without progesterone did not improve sexual function, many menopausal female patients may suffer from hot flashes leading to sleep disruption and fatigue or from vaginal atrophy leading to sexual discomfort, which may all impact sexual desire. Although postmenopausal hormone therapy carries with it risks that will not be addressed in this article, improvement in hot flashes and vaginal atrophy through the use of various oral, transdermal or vaginal hormone preparations can indirectly lead to an improvement in libido.

For patients of childbearing age with decreased libido while on oral contraceptive pills, switching their contraception to a non-oral form may produce less of an increase in sex hormone binding globulin (SHBG), which in turn may lead to additional free testosterone available to promote sex drive.

Herbal supplements, such as Avlimil, may have estrogenic components, but similar to compounded products, their safety and efficacy is unproven.

For patients with sexual dysfunction as a result of SSRI treatment for depression or anxiety, switching to Bupropion may lead to an increase in sex drive in comparison with their sex drive on the SSRI.

### Summary

With nearly 40 - 50 percent of women having elements of sexual dysfunction across different age ranges, physicians



owe it to their patients to broach the topic of low libido, the most common component. When decreased sex drive is undermining a patient's relationship or causing distress, intervention of some kind, either non-medical or medical, is required. Physicians need to better communicate to patients that while there are many possible causes of low libido, they are almost all treatable. Although the physician may prefer the team approach to treatment by referring to and consulting other providers, the physician still needs to recognize the need to make patients feel at ease while proactively initiating the evaluation of their sexual function. Following appropriate screening, diagnosis and treatment of low libido, the resulting rewarding sex life can be very important to an adult woman's overall well-being at every stage of life. ■

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