

# Surgical Menopause and Low Sexual Desire in Women

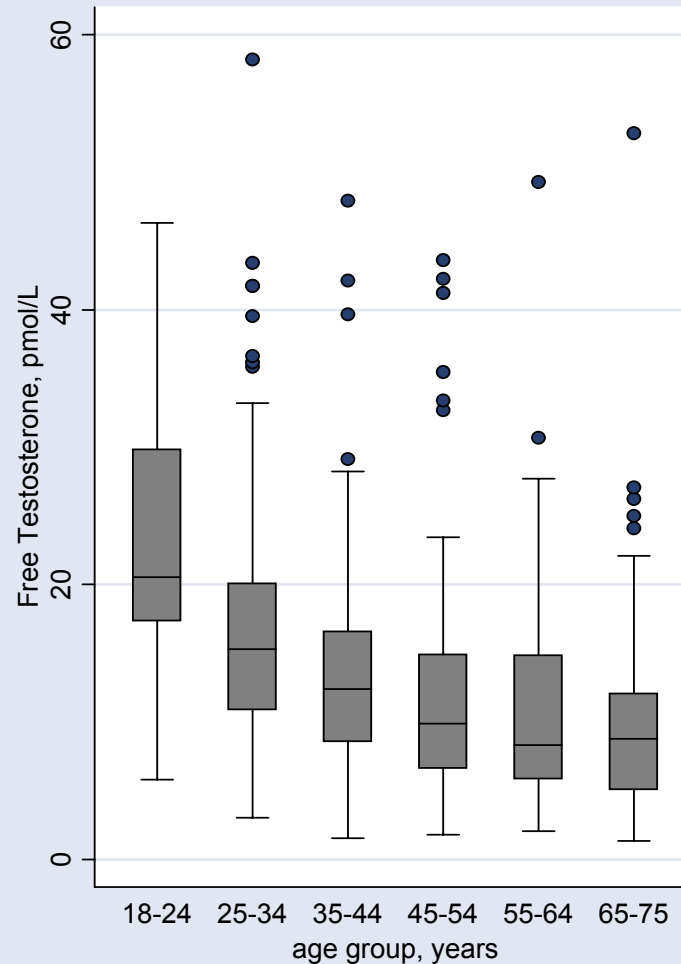
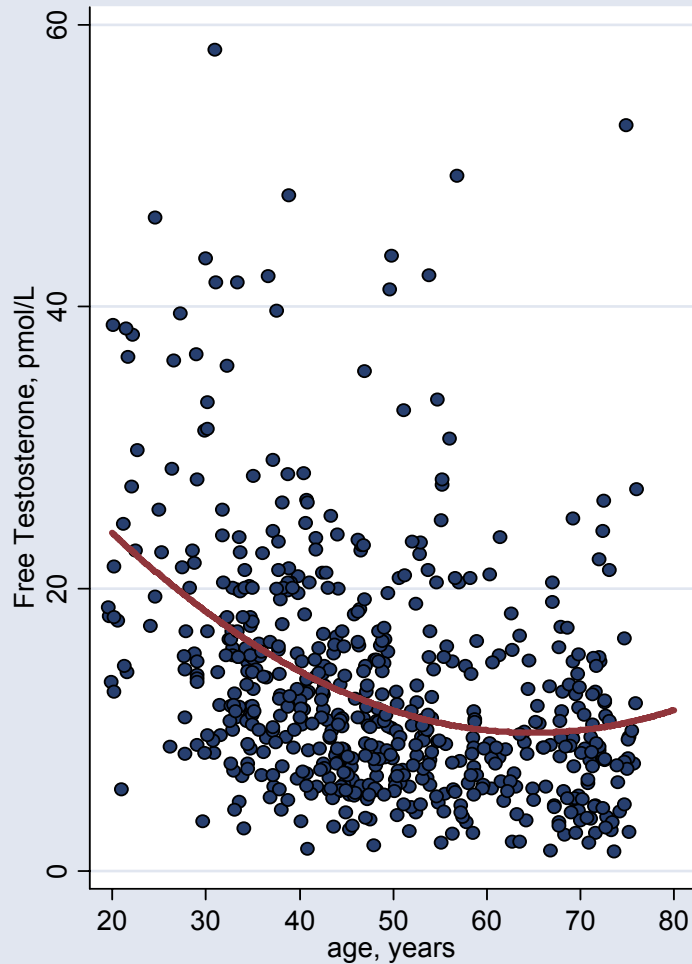
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# Role of Endogenous Testosterone

# Testosterone: Naturally produced by women

- Healthy young women produce approximately 100 – 400 mcg/day
  - 3/4 times more testosterone than oestrogen
- About half is derived from the ovaries and half from the adrenal glands
- Decline in testosterone contributes to decline in sexual desire, arousal and orgasm
- Decline in testosterone levels also affects:
  - General well- being
  - Energy
  - Mood
  - Bone physiology
  - Muscle mass
  - Hot flushes
- In SM women, testosterone production decreases by 50% within days of the surgery

# Free testosterone levels decline with age



**49% reduction  
from 18-24yrs  
to 65-75yrs**

**n= 595 women**

# Impact of Surgical Menopause on Sexual Function

# Menopause: Changes in a woman's life

## Natural Menopause

- Physiological process
- Natural transition
- Gradual decline of sex hormones
- Variable presence of symptoms

## Surgical Menopause (SM)

- Medical intervention (potentially distressing)
- Sudden onset
- Decline in levels of sex hormones
  - Oestrogen
  - Progesterone
  - Testosterone
- More severe symptoms

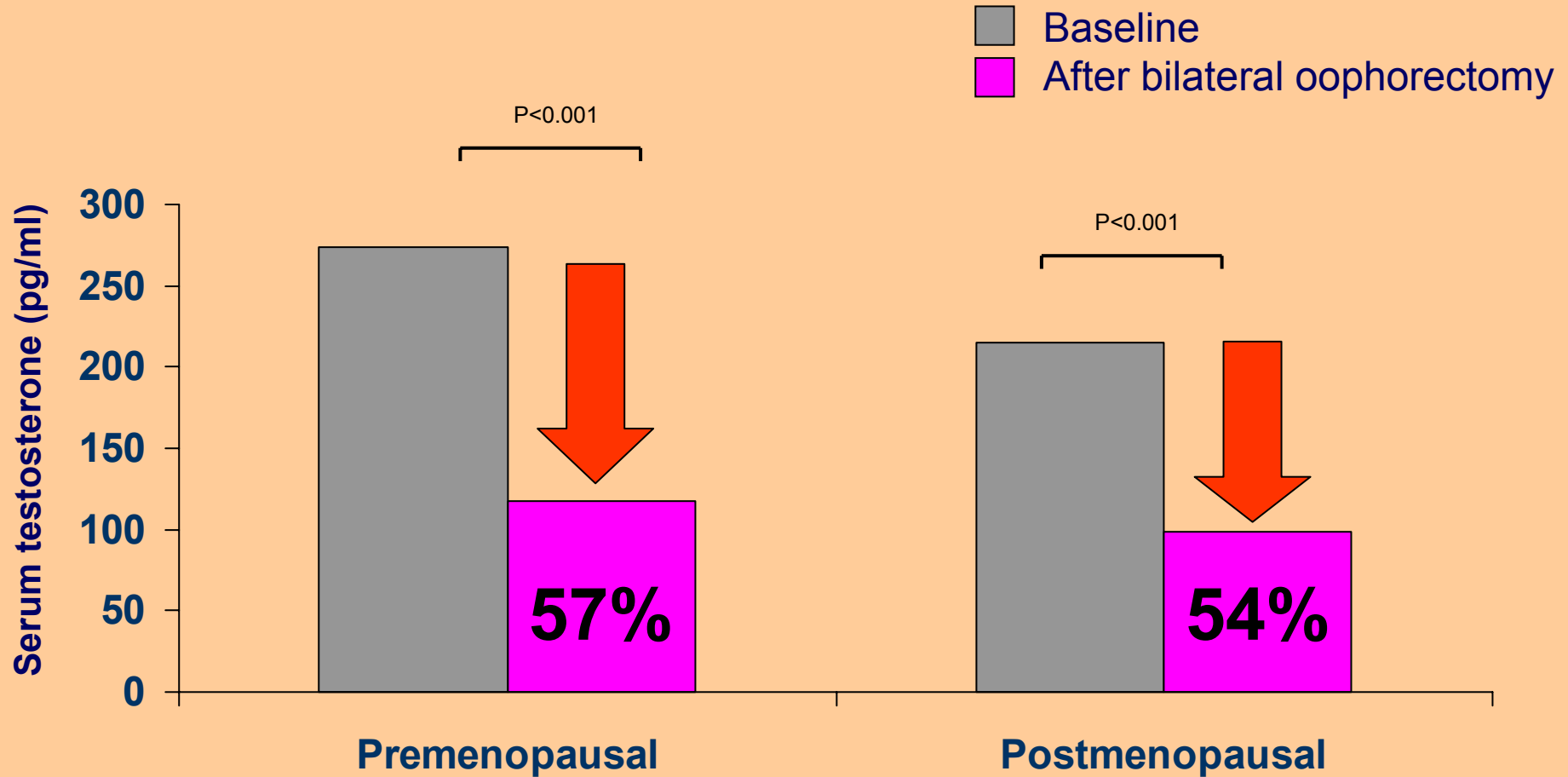
## Menopause

↓ Hormone levels  
End of reproductive phase

## Symptoms/Impact

- Hot flushes
- Mood changes
- Sleep disturbances
- Loss of energy
- Urogenital complaints
- **Sexual complaints**

# Testosterone levels drop by approximately 50% after oophorectomy



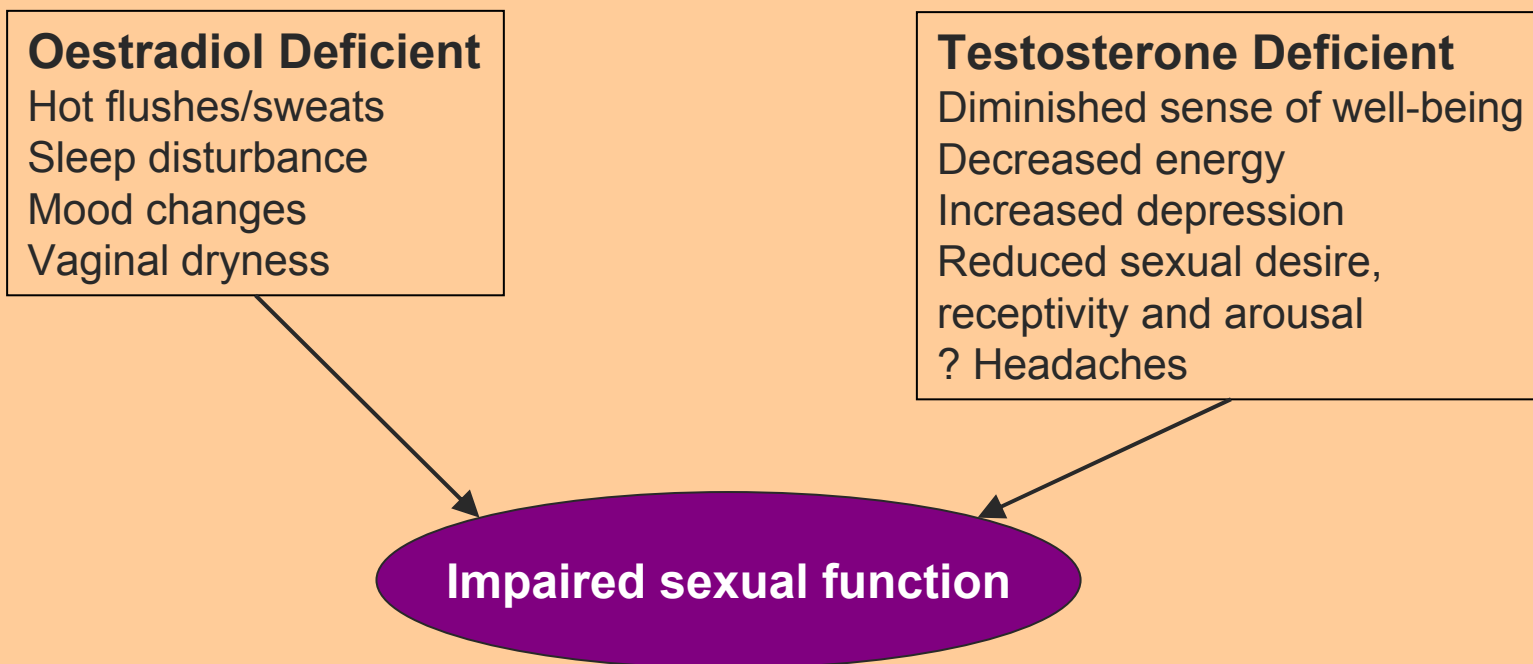
# Focus on Surgical Menopause

- Prevalence of SM and who does it affect?
  - **250,000 women** in the UK between the **ages of 20 and 54** have had their ovaries removed
  - 31,401 hysterectomies were performed in the UK (2004/2005)
  - Approximately one million women in the UK have experienced a surgical menopause

# Surgical Menopause in USA

- Chen WY Manson JE 2006 JNCI
- **“Premature Ovarian Failure in Cancer Survivors: New Insights, Looming Concerns”**
- 598 000 hysterectomies 1994-1999 in women below 40 (1/3 with BSO) i.e. 100 000 pa!
- ie. Every year in US 33 000 left menopausal and 66 000 left with increased risk of POF.

# Differentiating oestradiol deficiency from testosterone deficiency in menopausal women



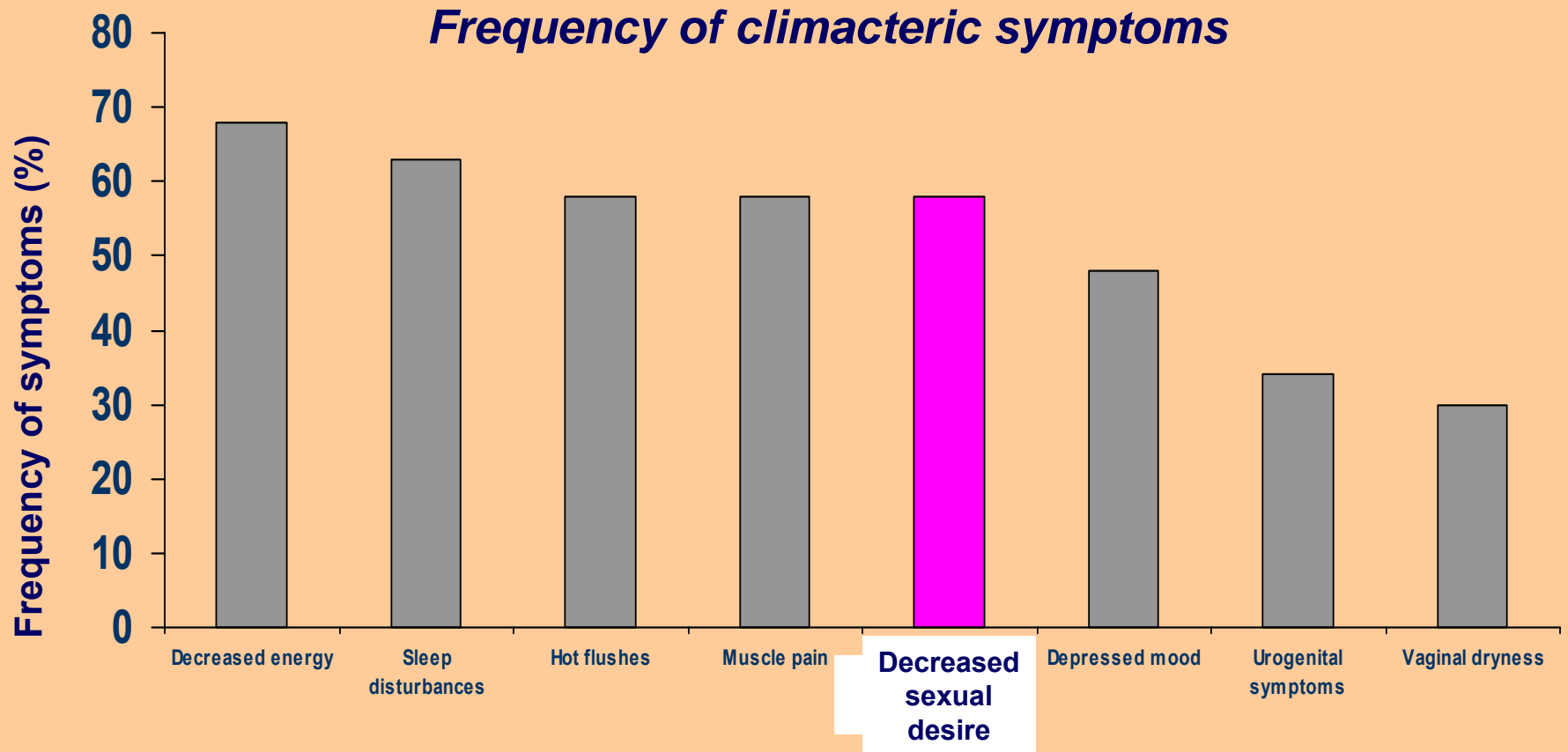
Bachmann G, et al. ( 2002) *Fertility and Sterility*. 77: 660-665

Dennerstein L, et al, (2000) *Obstet Gynecol*. 96: 351-358.

Utian W.H, et al. (2002) *Menopause*. 9: 402-410

Bachmann G (2004) *Menopause* 11: 120.

# Low sexual desire is a key symptom of menopause



**n = 603 menopausal women aged 49-59 years (MRS-Rating)**

# Hypoactive Sexual Desire Disorder : Prevalence, Impact and Potential Causes

# Classification of Sexual Dysfunctions

## APA DSM - IV

- Sexual Desire Disorders
  - Hypoactive Sexual Desire Disorder (HSDD)
  - Sexual Aversion Disorder
- Sexual Arousal Disorders
  - Female Sexual Arousal Disorder
  - Male Erectile Disorder
- Orgasmic Disorders
  - Male/Female Orgasmic Disorder
  - Premature Ejaculation
- Pain Disorders
  - Dyspareunia
  - Vaginismus

# The definition of Hypoactive Sexual Desire Disorder

**HSDD** is the persistent or recurrent **deficiency** and/or absence **of sexual thoughts/fantasies** and/or **desire for or receptivity to sexual activity** which causes **distress or interpersonal difficulty**<sup>1,2</sup>

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV-TR. 4th ed. Arlington, Va; 2000.

2. Basson R, et al. Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. Journal of Urology 2000;163: 888–893.

# Potential causes of Hypoactive Sexual Desire Disorder

## Major Biological Causes

- ◆ **Hormones**
  - Low androgens (e.g. oophorectomy)
  - Hypothyroidism
- ◆ **Psychiatric disorders**
- ◆ **Chronic Disease**
- ◆ **Medications**
  - SSRI
  - Aromatase inhibitors
  - Anti-hypertensive
  - Chemotherapy

## Psychological Causes

- ◆ Relationship issues
- ◆ Intrapersonal issues

## Sociocultural Causes

- ◆ Poverty/Low income
- ◆ Working conditions
- ◆ Sexual norms

# COSMOPOLITAN

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**40 ways to  
orgasm this  
weekend**

(are you woman enough?)

**COSMO SHOPS**

**FIGURE-FIXING  
COATS SPECIAL**

The shape, size, price  
and style to suit you **NOW**

**30  
NO-EFFORT  
CELEBRITY  
DOs**

**No 1  
LOVE  
SECRETS  
OF THE  
HAPPIEST  
COUPLES**

*Cosmo loves  
Fabiana Tambosi*

WOMEN

MEN



Switch A

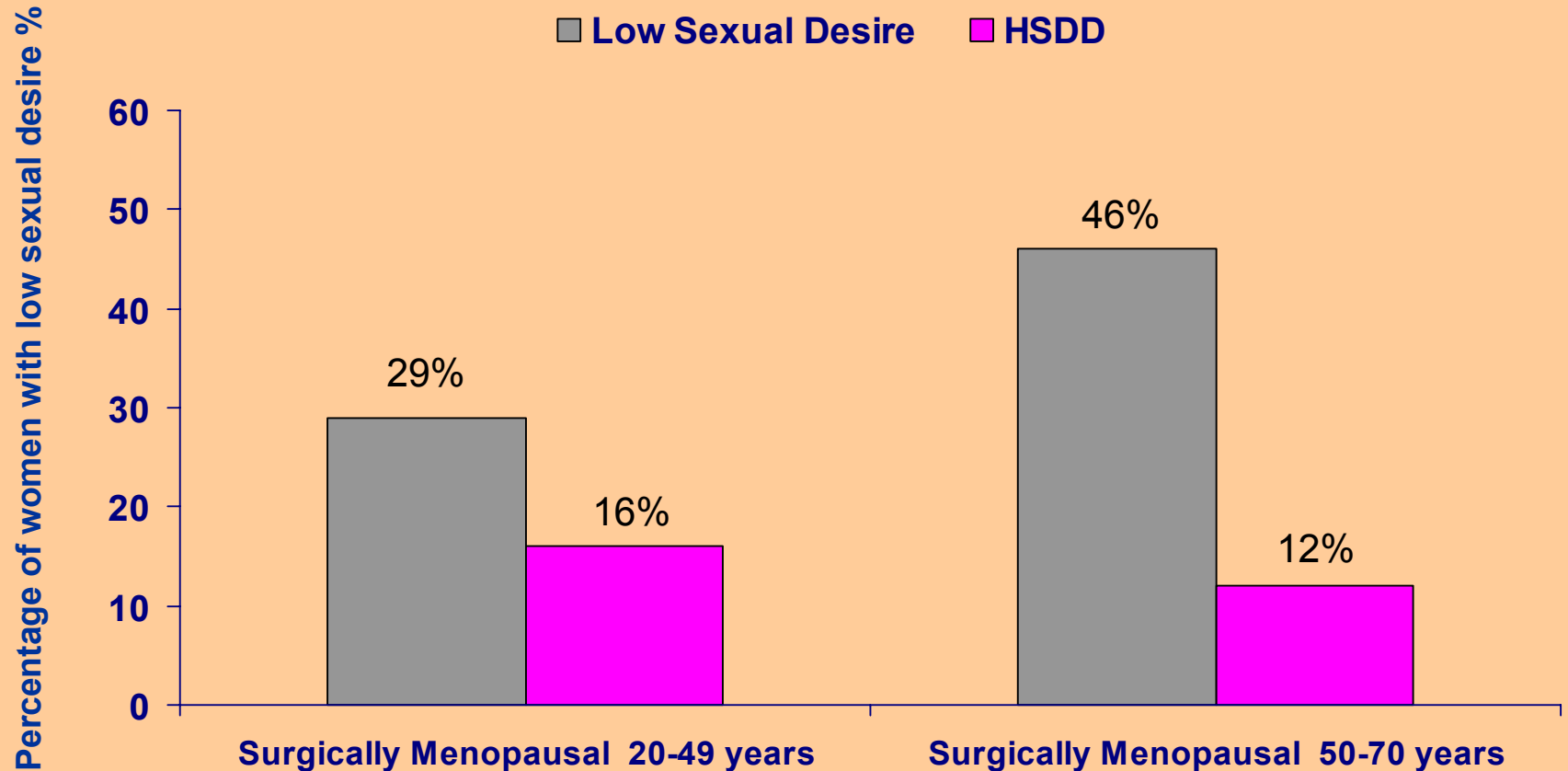


Switch B

Switch C

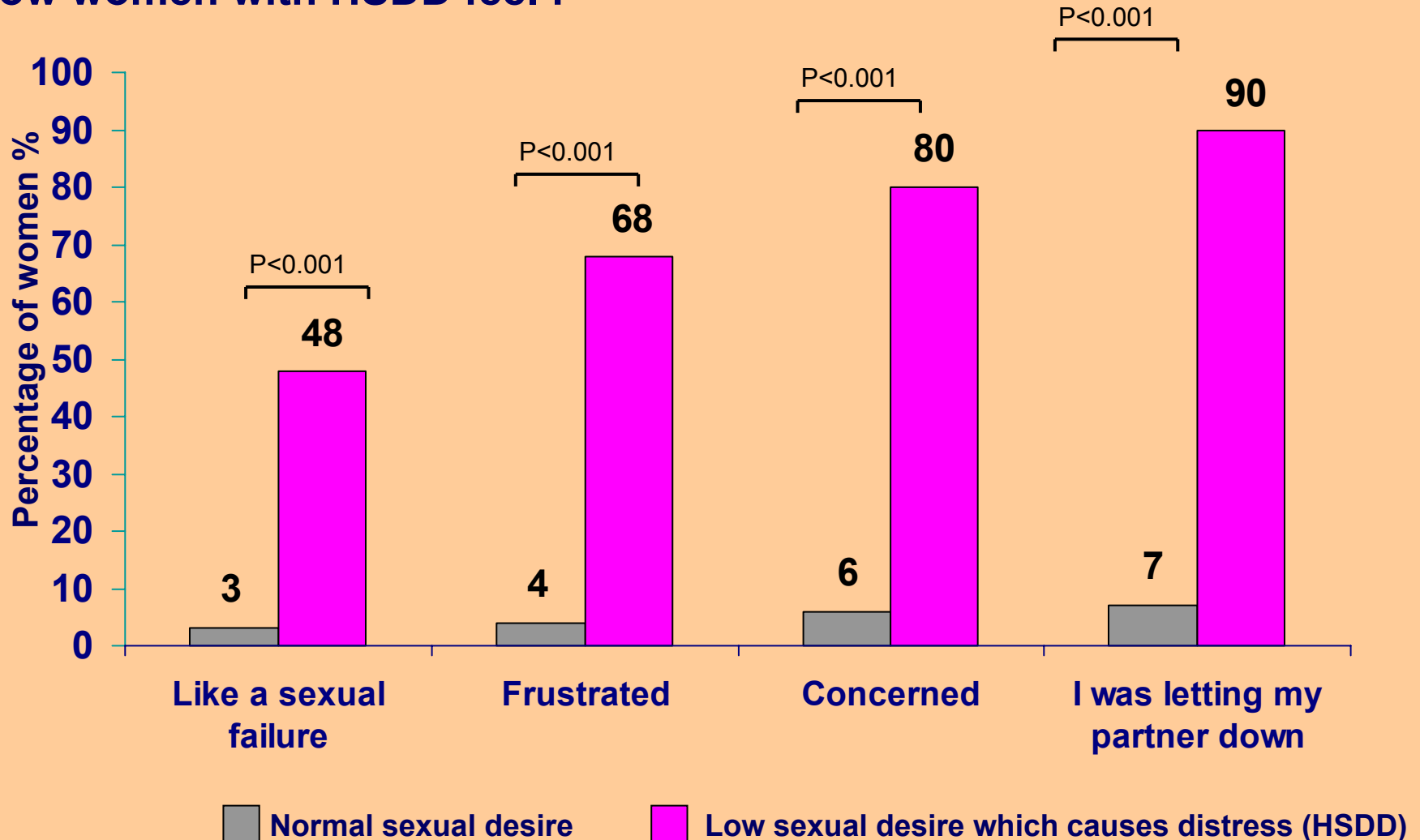


# Amongst surgically menopausal women with low sexual desire, 1 in 3 reports being distressed about it and are classified as having Hypoactive Sexual Desire Disorder (HSDD)



# Low sexual desire which causes distress strongly impacts on women's well-being and relationship

How women with HSDD feel :



# The impact of HSDD

“I made up excuses to avoid having sex. I avoided doing anything that would get my partner sexually excited”

“I dreaded having sex....having sex was a chore...”

“I felt distressed about sex and I was frustrated about my sex life”

“I felt sexually numb...it was difficult for me to get aroused. Sex was not satisfying or fulfilling”

These statements (not verbatim quotes) were developed based on interviews with women with low sexual desire which caused them distress and with women with normal sexual desire, and were used to validate the Profile of Female Sexual Function (PFSF©), an instrument that distinguishes between these two groups of women. (McHorney CA *et al.* Profile of female sexual function: a patient-based, international, psychometric instrument for the assessment of hypoactive sexual desire in oophorectomised women. *Menopause*. 2004; 11:474–483.)

# Evaluation of Hypoactive Sexual Desire Disorder

# The importance of the doctor – patient relationship

- The doctor-patient relationship is crucial to uncover sexual problems<sup>1</sup>
- Sexual well-being is relevant to quality of life and health<sup>1</sup>
- Sexual health problems remain<sup>1</sup>:
  - Infrequently enquired about
  - Infrequently diagnosed
  - Frequently untreated

***“It is the responsibility of the physician to initiate the conversation”<sup>2</sup>***

1. [www.fsdeducation.eu](http://www.fsdeducation.eu); Educational Slide Sets, Module 1 : Menopause Transition

2. Brandenburg U, Schwenkhagen A (2006) Women’s Sexual Function and Dysfunction; ed. Goldstein, Taylor & Francis London

# What hinders the discussion of sexual concerns?

## Agreement with topic

What has stopped the discussion?	Younger % (N=633) (<45y)	Middle aged % (N=171) (45-54y)	Older % (N=374) (>54y)	P-value
Too embarrassed to raise the topic	77	65	61	<0.001
Would have discussed if physician had initiated topic	78	75	77	0.623
Tried to ask, physician did not understand	41	34	30	0.004
Not enough time with physician	63	58	47	<0.001
Physician seemed rushed for time	68	65	52	<0.001
Physician seemed impersonal	55	53	39	<0.001
Physician seemed disinterested	50	48	36	0.001
Physician seemed embarrassed	23	27	20	0.277
Physician looked too old	19	16	12	0.034
Physician looked too young	25	35	33	0.009
Feel more comfortable with female physician	70	65	57	0.000
Feel more comfortable with male physician	31	33	32	0.97

Mail survey among routine care patients (n=1196 women) of family practice clinic and obs/gyn clinic

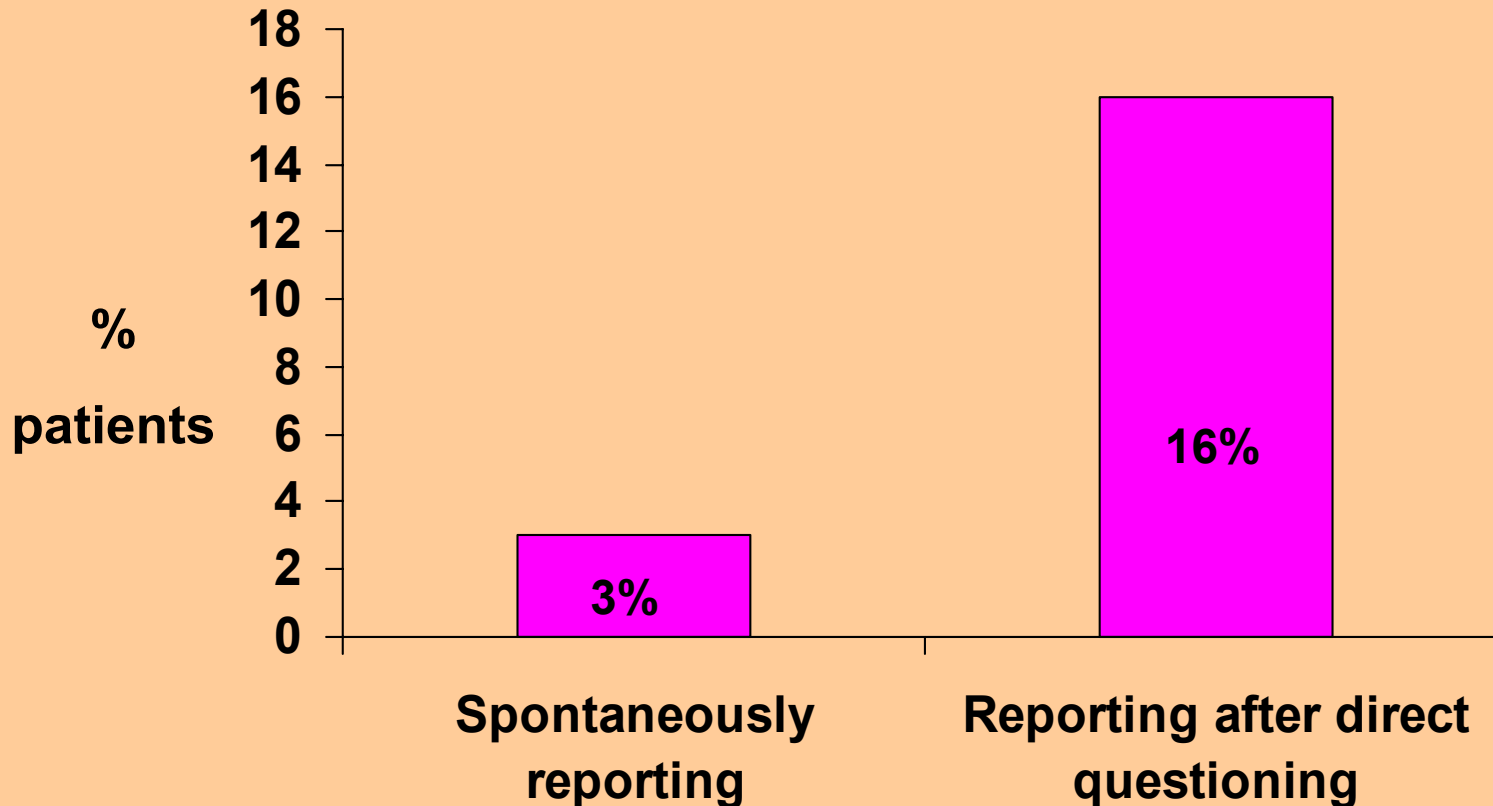
# What helps the discussion of sexual concerns?

## Agreement with topic

What would make the discussion easier?	Younger % (N=633) (<45y)	Middle aged % (N=171) (45-54y)	Older % (N=374) (>54y)	P-value
Physician brings up topic	87	84	86	0.430
Physician is female	81	75	73	0.010
Physician is male	54	59	60	0.150
Physician is professional	96	96	96	0.960
Physician is comfortable with topic	99	97	97	0.015
Physician is kind/understanding	99	98	98	0.196
Having seen physician before	96	88	93	0.001
Physician seems concerned	99	96	99	0.053
Feel that doctor knows you	95	91	93	0.051

Mail survey among routine care patients (n=1196 women) of family practice clinic and obs/gyn clinic

# Just ask! Physician questioning helps the patient talk about sexual problems



\* Patients screened for sexual complaints by inclusion of two medical history questions (n=887)

# Important patient considerations

- Cultural background
- Religious beliefs
- Social background
- Sexual orientation
- Partner problems

# Reasons given by physicians for not asking about sexual problems

- Most commonly reported
  - Lack of relevant training
  - Embarrassment
  - Time constraints
  
- Other reasons also reported
  - Conservative sexual beliefs
  - Insufficient knowledge on sexual health

# Asking about HSDD with discretion

- “Many women experience sexual difficulties after having their ovaries removed, but they often find it difficult to talk to their doctor about it.
- Is this something that bothers you?
- I’d be pleased to talk with you about it.”

# The sexual conversation

- Do respond positively to concerns
- Do reinforce it is a common problem
- If asked sensitively, women will generally appreciate being asked about sexual problems
- Don't believe that "it's too complex for me to address"
- Don't be too focused on finding a solution at first visit, sexual problems can be complex
- Don't put yourself or the woman under time pressure, it's better to arrange a second visit
- Take comfort that there's always somewhere else to refer on to

# Referring patients

- To be adapted locally

# Helpful questions to initiate the sexual conversation

- Since your operation, has your love/sex life changed? Has this bothered you? If you have a partner, have any comments been made?
- Are you happy/satisfied with your love life?
- Do you still fancy/turned on by/find attractive/desire your partner?
- Are you in a relationship in which you are having sex? Are there difficulties or is there anything you would like to discuss?
- Are you experiencing any pain during sex/sexual activity?

# HSDD Toolkit for Health Professionals

Identification and support of SM women with or at risk of  
HSDD

- Slide Set for Health Professionals
- Laminated Sheet for Clinics
  - Patient Care Pathway (SM women with HSDD)
  - B PFSF / Referral Advice / HSDD Definition / Helpful Questions
- Patient Information Leaflet (SM)
  - Sexual Desire and the Menopause
  - After your Surgery...
- Management Algorithm
  - Primary care: e.g. GP or Practice Nurse
  - Secondary Care: e.g.gynaecologist

# Brief Profile of Female Sexual Function (B-PFSF)©

In this questionnaire you will be asked about your sexual feelings and sexual activity and some concerns you may have about your level of interest in sex during the past 2-3 months. Read each statement carefully and circle the number that best corresponds to your experience over the past 2-3 months.

	Never	Seldom	Some- times	Often	Very Often	Always
1.I felt like having sex	0	1	2	3	4	5
2.I was unhappy about my lack of interest in sex	5	4	3	2	1	0
3.Getting aroused took forever	5	4	3	2	1	0
4.I felt sexually numb	5	4	3	2	1	0
5.I lacked sexual desire	5	4	3	2	1	0
6. I felt disappointed by my lack of interest in sex	5	4	3	2	1	0
7.I reached orgasm easily	0	1	2	3	4	5

Please add up your responses to the questions above and record the Total Score here

A Total Score between 0 – 20 indicates that you may have low sexual desire that is concerning or distressing (also known as Hypoactive Sexual Desire Disorder). This is something that you may want to discuss with your physician.

# Contributors to Toolkit

- Ms Kathy Abernethy, Senior Nurse Specialist, Northwick Park Hospital
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- Professor Janice Rymer, Professor of Obstetrics and Gynaecology, King's College School of Medicine at Guy's and St Thomas' Hospitals, London
- Dr Kevan Wylie, Consultant in Sexual Medicine, Andrology and Psychosexual Therapy, Porterbrook Clinic, Sheffield

# Conclusions

- Testosterone levels decline rapidly after a surgical menopause
- Low sexual desire is a key symptom of surgical menopause
- Hypoactive sexual desire disorder (HSDD) can significantly impact a surgically menopausal woman's well being and her relationship
- A simple, open approach with your patient will facilitate a symptom-based diagnosis of HSDD

- Any Questions?