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David Edwards
MBBS MSc DRCOG
GP, Specialist in male and female sexual dysfunction, The White Horse Surgery, Chipping Norton, Oxfordshire

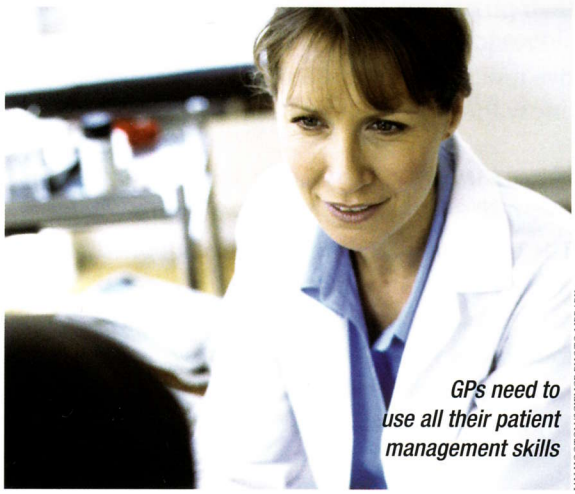
Current management options for women with HSDD

It could be considered that, since the highly successful introduction, over ten years ago, of the phosphodiesterase type 5 inhibitors (which have revolutionised the treatment of erectile dysfunction [ED]), there has been a gender inequality in the pharmacological options available for treating sexual dysfunction. In particular, there are gaps in our pharmacopoeic armour for treating women suffering from hypoactive sexual desire disorder (HSDD).

Recently, efforts have been made to try to find suitable substances that could be used to treat HSDD. John Dean clearly and succinctly dealt with historical perspectives on, and diagnostic criteria for, this condition in a recent issue of this journal.[1] This article will look at the current treatment options that are available for woman with HSDD – which is distressing not only for the patient, but also for her partner. I have known marriages break up because of HSDD. I am aware of patients that have been frightened off from initiating relationships because of it. It should be noted that the diagnostic criteria for HSDD include the fact that the disturbance causes 'marked distress or interpersonal difficulty'.[1]

Diagnosing HSDD

Obviously, before any form of treatment can be initiated, whether it be psychosexual and/or pharmacological, a medical diagnosis is required. Traditionally, help has been offered by clinicians with an expertise in female sexual dysfunction (FSD) – which means that patients often have had to wait a long time before they were able to get an appointment. Furthermore, due to the limited access to such experts and, on occasion, to a GP's lack of knowledge regarding patient referral, some women with HSDD have remained undiagnosed.



GPs need to use all their patient management skills

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The decreased sexual desire screener (DSDS)[2] was developed to provide healthcare professionals who are neither trained nor specialised in FSD with a brief questionnaire to assist them in making the diagnosis of generalised acquired HSDD in both pre- and postmenopausal women (see Table 1). The DSDS has been validated in North American and European studies.[3]

Although efforts are being made to provide education to ensure that clinicians are comfortable discussing sexual health matters with their patients, some healthcare practitioners would still rather not deal with such matters. Nevertheless, practitioners have a professional responsibility to find out who their local expert is (whether it is a hospital-based physician or a GP or therapist in a neighbouring surgery) and refer patients to them where appropriate.

It may be useful to recognise that female sexual problems (such as desire, arousal, orgasm or vaginismic difficulties and pain during intercourse) can coexist, and to appreciate that men who have sexual dysfunction often have partners who also have sexual difficulties.

The importance of using one's 'diagnostic antennae'

Primary care is usually the initial health-seeking place for women with HSDD. However, very rarely is the condition presented to the GP as the initial complaint. Indeed the patient may not

Box 1. Sexual dysfunction websites useful for both patients and clinicians

- British Association for Sexual and Relationship Therapy (www.basrt.org.uk): links to 'find a therapist' and many other useful features
- Sexual Advice Association (www.sexualadviceassociation.co.uk): useful fact sheets on a variety of sexual problems and links to other organisations
- Institute of Psychosexual Medicine (www.ipm.org.uk): links to 'find a doctor', information about further education for doctors
- British Society for Sexual Medicine (www.bssm.org.uk): guidelines for erectile dysfunction; guidelines for testosterone replacement therapy and female sexual dysfunction will be published soon

Table 1. Decreased sexual desire screener*

Q1. In the past, was your level of sexual desire/interest good and satisfying to you?	No	Yes	'No' to Q1, 2, 3 or 4 = not generalised acquired HSDD
Q2. Has there been a decrease in your level of sexual desire/interest?	No	Yes	
Q3. Are you bothered by your decreased level of sexual desire/interest?	No	Yes	
Q4. Would you like your level of sexual desire/interest to increase?	No	Yes	'Yes' to all Q1–4 and 'no' to all Q5 factors = clinician to use best judgement to confirm a diagnosis of generalised acquired HSDD
Q5. Please check all the factors that you feel may be contributing to your current decrease in sexual desire/interest:			
A. An operation, depression, injuries, or other medical condition	No	Yes	
B. Medication, drugs or alcohol you are currently taking	No	Yes	
C. Pregnancy, recent childbirth, menopausal symptoms	No	Yes	
D. Other sexual issues you may have (pain, decreased arousal or orgasm)	No	Yes	'Yes' to all Q1–4 and 'yes' to any Q5 factor = clinician to use best judgement to determine diagnosis
E. Your partner's sexual problems	No	Yes	
F. Dissatisfaction with your relationship or partner	No	Yes	
G. Stress or fatigue	No	Yes	

* Adapted from Clayton *et al.*[2] Key: HSDD = hypoactive sexual desire disorder

necessarily consult her GP at all! She might confide in other staff, such as practice nurses, healthcare assistants, and sometimes even receptionists.

Similarly, I have had referrals from a variety of secondary care settings, ranging from the expected gynaecology and psychiatry departments to the more unusual specialties of physiotherapy or even cardiology.

What is of fundamental importance is the ability to regard the patient holistically, using one's 'diagnostic antennae' to pick up that something might be amiss from the sexual aspect. The presentation may not necessarily be handed to the clinician in a straightforward manner; it may be disguised as headache, tired all the time, chest or abdominal pain – or any number of physical or psychological labels.

Hopefully, through judicious education discovered through the media and the internet, women with HSDD will be empowered to bring their doctor offerings of newspaper cuttings or website printouts, in the same way that ED sufferers have in the last few years. While many doctors inwardly groan at such 'gifts', from the patient's viewpoint they provide a useful, non-threatening way of opening discussions; they enable them to avoid initial eye contact, as both the clinician and the patient can look at the printout while the patient can avoid embarrassment.

Some referrals come indirectly from a partner who is 'at the end of [his] tether' and, although he 'dearly love[s] her', wants the healthcare practioner to magically transform her 'back to what she used to be like'. ('Or I may leave her!') These cases are very often the most difficult to tease out. There are often ethical and confidentiality issues involving other GPs. In such cases, healthcare practitioners need all their management skills when dealing with the partner (who usually adds a closing statement such as, 'Don't tell her I came to see you') and then with the patient herself.

Managing HSDD

The management of HSDD is often a melange of several options. It is important to deal with the patient holistically and to take into account any cultural or religious beliefs. The clinician should not be judgemental about the patient's sex life. Furthermore, it is fundamental to treat the patient as an individual, tailoring the treatment specifically to her (or, more commonly, to the couple) rather than adopting a 'one size fits all' policy. It is important to look for and treat any organic problems, such as anaemia or hypothyroidism. Healthcare practitioners should also enquire about psychological factors, such as work/family pressures. Juggling work, children, parents and a demanding lover can prove almost impossible, and often sex is the aspect of life that slips away.

Box 1 lists websites that are useful both as educational tools for the healthcare practitioners and as guides for the patients.

Psychosexual therapy

For many years, psychosexual therapy has been the mainstay of treatment for HSDD. Unfortunately, it is sometimes not available as an NHS service, and when it is offered by the NHS, there is often a long waiting list. It is important to encourage patients to take their partner along – if they have one. The therapist will give information about sexual problems and how they tend to arise,

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and will explain various treatment pathways that are applicable to the couple. It is vital to ensure that the therapist is properly qualified to deal with sexual dysfunction and that he/she is a member of a suitable professional body.

Testosterone therapy

Studies have shown the benefits of testosterone therapy in postmenopausal women who are suffering from HSDD. This is for both surgically menopausal women using oestrogen and women not receiving any treatment who have undergone a natural menopause.[4,5]

It has been demonstrated that testosterone may be a key mediator of female sexual desire. Healthy young women have been shown to produce approximately 100–400 µg/24 hours of testosterone.[6,7] About 50% of this testosterone is produced in the ovaries and 50% in the adrenal glands.[6,7] It has also been demonstrated that, within days of surgical menopause, testosterone levels rapidly decline.[7–10]

Treating HSDD with testosterone replacement therapy has become much easier since the availability of the 300 µg/day transdermal patch Intrinsa® (Procter and Gamble, UK). Compared with the subcutaneous pellets previously used, the patch enables patients to have more control over starting and stopping the treatment. Phase III studies have shown that, in surgically menopausal women with HSDD on concomitant oestrogen, the 300 µg testosterone patch:

- Significantly improved desire and decreased personal distress at 24 weeks
- Significantly increased satisfying sexual activity at 24 weeks
- Was generally well tolerated.[11,12]

Topical preparations and devices

Urogenital problems are often a cause of pain that can lead to a lack of desire in some patients. These can be treated using topical oestrogens (tablets, pessaries, rings or creams), vaginal lubricants, or a combination of both.

Topical oestrogens have been available for many years; they are helpful in treating vaginal atrophy secondary to oestrogen deficiency commonly found in postmenopausal women. This atrophy often presents with vaginal soreness, infection, bleeding or stenosis.

Use of a vaginal dilator together with lubricants can be beneficial for women with vaginal stenosis. It is important to give patients appropriate instructions for their use and that there is a follow-up appointment. Vaginal dilators – for example, Amielle Comfort® (Owen Mumford Ltd, UK) – are now available on prescription and have superseded the old glass, test-tube-like devices that surely would have induced vaginismus (through fear of breakage) rather than treated it!

For many couples, when there is a problem with vaginal or penile dryness, vaginal lubricants form an essential part of foreplay. It is important to advise patients not to forget to apply a little to the clitoral area as well. The dryness, which can affect either or both partners, can be due to many factors, including age, changing hormone levels, lack of arousal and medications (particularly antidepressants). However, getting older does not necessarily mean dryness will occur. I see many couples in their eighties who are regularly sexually active and have no such complaints.

While there are many vaginal moisturisers, only two are presently available on prescription in the UK: Replens MD® (Anglian Pharma, UK) and Sylk® (Sylk Ltd, UK). The latter, very effective product is made from kiwi fruit, so clinicians need to be aware of the (rare) allergy risks.

Another product that, in my clinical experience, is useful both as a lubricant and moisturiser is Yes® (Yes Pure Intimacy, UK). It comes in two forms, an oil-based, thicker preparation (containing cocoa butter and shea butter together) and a water-based product (with aloe vera and three plant gums). Both are certified by the Soil Association as being organic. I often advise patients to use a thin 'basecoat' of the oil-based preparation followed by a 'topcoat' of the water-based product – what Ruth Hallam-Jones neatly termed the 'double glide technique' for treating vaginismus.

Oral medications

Over the last few years, a number of oral medications have been used to treat HSDD. Tibolone, which is used as a hormone replacement therapy, was found to have some androgenic properties, to increase sexual fantasies, and to improve sexual

Key points

- **The current treatment options for hypoactive sexual desire disorder (HSDD) include psychosexual therapy, testosterone replacement, topical preparations and devices, and oral medications.**
- **Newer developments include a transdermal patch for testosterone replacement, vaginal dilators available on prescription, and a non-hormonal drug currently undergoing Phase III trials.**
- **Careful collaboration between pharmaceutical companies, clinicians and the media will be needed to present a balanced picture regarding treatment.**