

NAMS PRACTICE PEARL

Clinical Management of Hypoactive Sexual Desire Disorder

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Although a woman's healthcare provider has the best opportunity to address hypoactive sexual desire disorder (HSDD), most women are reluctant to discuss their loss of sexual desire. The feeling is often mutual, because limited education and misunderstanding persist, leaving few providers feeling competent to assess and treat this condition. The purpose of this Practice Pearl is to improve the clinician's understanding of and confidence in discussing HSDD, including symptoms, etiology, burden, diagnosis, and treatment.

A case in point. At her annual gynecologic exam, a 57-year-old woman reluctantly discloses her concern about a loss of sexual desire. She experienced spontaneous menopause at age 52 and has been in a happy marriage to a man for 25 years. She used to initiate sex regularly and was responsive to her husband's advances. However, over the past 10 years, her desire has markedly decreased to where she now reports having almost no desire at all. There is no clear medical, situational, or psychological explanation for her lack of desire. She still engages in "duty sex" two to three times per month out of a sense of sympathy for her husband's needs but avoids it when she can. She is distressed by her loss of sexual desire and wants to want sex again.

Hypoactive sexual desire disorder. Hypoactive sexual desire disorder (HSDD) often has a negative effect on a woman's emotional health and quality of life.^{1,2} It has been a recognized condition for more than 3 decades. It is defined as a persistent or recurrent deficiency (or absence) of sexual fantasies and desire for sexual activity that causes distress and is not better attributed to a medical or psychiatric condition or the use of a substance or medication or as a consequence of a conflicted relationship.³

Prevalence and etiology. Estimates of prevalence indicate that 7.4% to 12.3% of women meet the criteria for HSDD (low sexual desire with distress), with the highest prevalence in women in midlife (45-64 y) and beyond.⁴

The etiology of female sexual dysfunction is often multifactorial, and evaluation and treatment of HSDD should take biological (eg, hormone status, medical conditions, medications), psychological (eg, depression, anxiety, stress, substance abuse, history of sexual abuse, or trauma), interpersonal (eg, relationship quality, partner sexual function), and cultural (eg, sexual norms, religious values) factors into account.⁵ The woman's history should be evaluated using a biopsychosocial approach for possible contributors to low sexual desire.

Although a number of factors may contribute to the development of HSDD, women with HSDD have different patterns of brain activation. Low sexual desire results from hypofunctional excitation, hyperfunctional inhibition, or a combination of the two.⁶ Sexual desire is thought to be regulated by neuromodulators (neurotransmitters and hormones) of both excitatory pathways (eg, dopamine, norepinephrine, melanocortins, oxytocin) and inhibitory pathways (eg, serotonin, opioids, endocannabinoids).⁷

Assessment. Diagnosing low sexual desire with associated distress is challenging because women often fail to discuss these issues with their healthcare providers (HCPs). A woman's HCP can initiate the general discussion and assessment of sexual health concerns and HSDD by explaining that sexual health is an important aspect of overall health and that assessment of sexual function is a routine part of good medical care. An initial assessment can be accomplished quickly during an office visit with a few brief questions: "Many of my patients have sexual concerns at midlife—what concerns do you have?" or, "How do you feel about your current level of desire and your ability to get aroused or to orgasm?" To facilitate open discussion, offer patient-friendly materials in the waiting and examination rooms, include questions about sexual health topics on intake forms, and train staff to be comfortable with sexual topics.

In addition, consider using a screening questionnaire to identify a diagnosis of HSDD. The Decreased Sexual Desire Screener (DSDS) consists of five questions and is available online.⁸ Although screening for HSDD is easily performed as part of an office visit, if problems are identified, a follow-up visit may be encouraged to address sexual concerns and to provide office-based counseling or medication management.⁵

Overlap of female sexual disorders is common: HSDD impairs sexual arousal that impairs orgasm or may lead to sexual pain (eg, attempting penetration without adequate lubrication because she is not interested or aroused). Likewise, by reducing associated dryness/pain, treating the genitourinary syndrome of menopause (GSM) can increase desire. A complete assessment/history can help delineate the primary problem, establish the diagnosis, and assist in developing an approach to individualize treatment.

Additional evaluation. Although a physical examination is not required to make the diagnosis of HSDD, it may be helpful in postmenopausal women in order to rule out other factors that would better explain their loss of sexual interest. For example, women with dyspareunia because of GSM may report less sexual desire as a byproduct of painful sex. Midlife is a time when myriad chronic medical conditions initially manifest.

Physical examination and in some cases laboratory testing such as thyroid and prolactin levels may help rule out other comorbid conditions. Testosterone and sex hormone-binding globulin levels are not required for the diagnosis of HSDD but are recommended if a clinician is considering off-label testosterone therapy as a baseline for monitoring therapy.⁹

If psychological or interpersonal/relationship problems appear to be a source of the low desire, referral for counseling for the couple or assessment/treatment by a psychotherapist experienced in couples therapy and/or sex therapy is warranted.

Treatment. Treatment for HSDD may include psychotherapy, pharmacotherapy, or a combination of both. Flibanserin, the only FDA-approved pharmacologic option, is a nonhormone, once-daily-at-bedtime, 100-mg oral therapy indicated for acquired generalized

HSDD in premenopausal women. Flibanserin is a multifunctional serotonin agonist and antagonist with a presumed mechanism of action that involves decreased serotonin levels and increased dopamine and norepinephrine levels in selected brain regions. Although clinical trials have shown that flibanserin incrementally improves sexual desire in postmenopausal women, it is not FDA approved for use in this population. Prescribers and pharmacists are required to certify through a risk evaluation and mitigation program because of the risk of hypotension or syncope when flibanserin is combined with alcohol.¹⁰

Testosterone is another off-label treatment for low sexual desire in women, although no FDA-approved testosterone products are currently available for women. A number of studies have shown transdermal testosterone to be effective in treating HSDD in postmenopausal women. The use of off-label testosterone products in women requires careful monitoring for androgenic adverse effects because of inconsistent dosing from titrating male products or compounding testosterone products.

Other pharmacologic options that may be on the horizon include bremelanotide. Bremelanotide, a melanocortin-4-receptor agonist, is an investigational drug that has demonstrated acceptable safety and efficacy in the treatment of HSDD in premenopausal women.

A case in point. After the diagnosis of HSDD, the HCP discusses potential treatment options with the patient. Psychotherapy is recommended to help resolve interpersonal issues that, although not likely the cause of the HSDD in this particular case, may result from HSDD and serve to maintain low levels of desire. Because there are no FDA-approved pharmacologic options for postmenopausal women, the clinician and patient, in collaboration with the patient's partner, together must determine an appropriate course of action, including consideration of off-label treatments such as transdermal testosterone or flibanserin.

Summary. Although HSDD has biopsychosocial etiologies, HCPs can accurately screen, diagnose, and treat this condition. Providers of midlife women's healthcare are uniquely positioned to identify and counsel patients with HSDD. Treatment options are psychotherapy, pharmacotherapy, or a combination. Treating symptomatic GSM, if present, may be helpful in addressing low sexual desire related to dyspareunia. There are no FDA-approved pharmacologic options for postmenopausal women. Off-label treatments most commonly include flibanserin and testosterone.

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Disclosures

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