

Leiblum SR, Koochaki PE, Rodenberg CA, Barton IP, Rosen RC. Hypoactive sexual desire disorder in postmenopausal women: US results from the Women's International Study of Health and Sexuality (WISHeS). *Menopause*. 2006;13:46-56.

### Q How common is hypoactive sexual desire disorder?

**A** This disorder is prevalent in women at all reproductive stages. Younger, surgically postmenopausal women were at greatest risk among 4 demographic groups analyzed (TABLE). Prevalence ranged from 26% in surgically postmenopausal women aged 20 to 49, to 9% in naturally postmenopausal women.

Hypoactive sexual desire disorder (HSDD) should be recognized as an important quality-of-life issue, particularly for those at increased risk, this report concluded. WISHeS is the first study to report the prevalence of HSDD in US women using well-validated questionnaires, and to assess sexual, relationship, and quality-of-life correlates. Psychosocial distress and significant decrements in general health status, including aspects of mental and physical health, were linked to HSDD.

#### What makes hypoactive sexual desire a disorder?

HSDD is diminished desire for sexual activity, including sexual fantasies. It is considered a disorder only if it causes marked distress for the patient or serious interpersonal relationship problems.

HSDD is associated with these problems:

- greater emotional and psychological distress,
- lowered sexual and partner satisfaction, and
- diminished general health, both mental and physical.

#### Details of the study

The findings were derived from a cross-

**TABLE**

#### Hypoactive sexual desire disorder rates in US women

AGE 20-49	%
Premenopausal	14
Surgically menopausal	26
AGE 50-70	
Naturally postmenopausal	9
Surgically postmenopausal	14

sectional, randomized convenience survey mailed to US women in 2000, as part of the larger Women's International Study of Health and Sexuality. Respondents were 952 women (most were married and Caucasian) who comprised 28% of the total identified as potential participants. The response rate was 77%.

Results from hysterectomized (without oophorectomy) and perimenopausal women were not included in this analysis, but will be reported elsewhere. No socioeconomic data were given.

Although the study was funded by Procter & Gamble, it was conducted by an independent, survey-based research group.

#### 3 types of questionnaires were used:

- Overall health status was measured by Short Form-36
- Profile of Female Sexual Function
- Personal Distress Scale

The relationship between sexual desire and frequency of sexual activity also was assessed, as well as relationship satisfaction.

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#### FAST TRACK

**Diminished health, both physical and mental, was linked to hypoactive sexual desire disorder**

## EXPERT COMMENTARY

**JoAnn V. Pinkerton, MD**, Professor of Obstetrics and Gynecology, Director of Women's Midlife Health, University of Virginia, Charlottesville. Dr. Pinkerton is a member of the OBG MANAGEMENT Board of Editors.

The finding that HSDD is substantially higher in young, surgically menopausal women (26%) than in premenopausal women the same age (14%) makes this an important study. Previously, estimates put the prevalence at 20% in the general population. Although it occurs in both sexes, the disorder is more common in women.

**Contributing factors** include medical problems such as heart disease or any disabling illness. Antihypertensives, antidepressants, and oral contraceptives also may lower sexual desire.

**Role of testosterone.** Endogenous testosterone levels and sexual function are not clearly linked, but exogenous testosterone—regardless of route of administration—positively affects sexual function after spontaneous or surgically induced menopause.<sup>1,2</sup>

**Nonmedical contributors.** HSDD may be associated with communication issues or power struggles between sex partners. A lack of affection, poor emotional intimacy, or inadequate time alone together may precipitate HSDD, as can a very restrictive upbringing concerning sex, or negative or traumatic sexual experiences.

Depression, fatigue, or excessive stress may also inhibit sexual interest.

### Experimental treatments

Treatment depends in part on the duration of the problem and its causes. No drug therapy has been approved for HSDD in women, although testosterone and other therapies are being studied. Psychotherapy is reported to be mildly effective.

**Continuous transdermal testosterone** (300- $\mu$ g patch) improved sexual desire, arousal, and orgasm frequency in women after oophorectomy, with no significant side effects.<sup>3</sup>

A 24-week study<sup>4</sup> determined that surgically menopausal women (n=283) who receive transdermal testosterone 300  $\mu$ g daily along with estrogen experienced 1 additional episode of satisfying sexual

activity every 4 weeks, as well as decreased distress and improved desire. Studies are underway to determine whether the findings are clinically significant and to establish longer-term safety and efficacy. The testosterone patch lacks FDA approval.

### Don't forget about prevention

Women who have not undergone premature surgical menopause can help prevent HSDD using these measures:

- Reserving time for nonsexual intimacy such as weekly dating to maintain a closer relationship
- "Separating" affection and sex so that affection is not interpreted as an invitation to proceed to intercourse
- Increasing communication through books, classes, or reading or watching materials with romantic or sexual content
- Reserving time for both talking and sexual intimacy earlier in the evening before exhaustion sets in, to encourage closeness and sexual desire.

### REFERENCES

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2. Goldstat R, Briganti E, Tran J, Wolfe R, Davis SR. Transdermal testosterone therapy improves well-being, mood, and sexual function in premenopausal women. *Menopause*. 2003;10:390-398.
3. Shifren J, Braunstein GD, Simon JA, et al. Transdermal testosterone treatment in women with impaired sexual function after oophorectomy. *N Engl J Med*. 2000;343:682-688.
4. Simon J, Braunstein G, Nachtigall L, et al. Testosterone patch increases sexual activity and desire in surgically menopausal women with hypoactive sexual desire disorder. *J Clin Endocrinol Metab*. 2005;90:5226-5233.

Dr. Pinkerton is a speaker for Merck and Solvay; a consultant for the Council on Hormone Education, Duramed, Merck, and Roche; and has received research funding from Solvay and Wyeth-Ayerst.

### Web resources on sexual health

International Society for the Study of Women's Sexual Health [www.isswsh.org](http://www.isswsh.org)

Society for the Scientific Study of Sexuality [www.sexscience.org](http://www.sexscience.org)

American Association of Sex Educators, Counselors, and Therapists [www.aasect.org](http://www.aasect.org)

International Academy of Sex Research [www.iasr.org](http://www.iasr.org)

### FAST TRACK

**Testosterone, by any route, positively affects sexual function after spontaneous or surgical menopause**

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Fretts RC. Etiology and prevention of stillbirth. *Am J Obstet Gynecol.* 2005;193:1923–1935.

## Q Can stillbirth be predicted?

**A** Not entirely, although the main causes have been identified: intrauterine growth restriction, malformations, infection, and “unexplained” abruption. Black women are twice as likely to experience stillbirth as women of other races.

### EXPERT COMMENTARY

**Ronald S. Gibbs, MD**, Professor and Chairman, Department of Obstetrics and Gynecology, University of Colorado Health Sciences Center

Stillbirth is the cause of about half of all perinatal deaths in the United States (6.4 per 1,000 births). In the past 50 years, the stillbirth rate has decreased about 4-fold, but is still roughly 10 times more than the rate for sudden infant death. The World Health Organization defines stillbirth as fetal loss in pregnancy beyond 20 weeks.

#### Cause depends on gestational age

Over the past 4 decades, the causes of stillbirth have shifted away from Rh disease and intrapartum loss and toward “unexplained” abruption, intrauterine growth restriction, malformations, and infection.

Categorizing stillbirths by gestational age gives a different rank order of causes. For early stillbirths (24–27 weeks), leading causes are infection (19%), abruption (14%), and anomalies (14%). For late stillbirths ( $\geq 28$  weeks), the leading causes are “unexplained” (26%–40%, depending on gestational age), fetal malformations (14%–19%), and abruption (12%–18%).

#### Common risk factors

- **Black race**—the risk doubles even with adequate prenatal care
- **Advanced maternal age**, even after accounting for medical conditions
- **Obesity**, even after controlling for gestational diabetes and hypertension
- **Thrombophilia**—odds ratios range from 1.8 to 12
- **Infection and “immunologic exposure,”** including parvovirus B19, toxoplasmosis, and listeriosis

- **Advanced reproductive technology**, even among singletons
- **Multiple gestation**
- **Medical diseases**, particularly systemic lupus erythematosus

Fortunately, optimal care of women with hypertension and diabetes has reduced the risk of stillbirth to “marginally elevated” levels, compared with the general population.

#### Practice recommendations

Fretts proposes these practices:

- Encourage smoking cessation.
- Assess risk factors, including screening for and treatment of diabetes and hypertension, and screening for congenital anomalies and intrauterine growth restriction.
- Consider obese women and women older than 35 years at higher risk.
- Because many stillbirths occur in women with no apparent risk factors, screen even low-risk patients with fetal kick counting in late pregnancy.
- Be vigorous in screening for and management of pregnancies affected by intrauterine growth restriction.
- Use a liberal antepartum testing strategy even in women at moderately increased risk (such as age  $> 35$  years).
- When stillbirth occurs, perform “appropriate and comprehensive stillbirth assessment,” most importantly an autopsy. Other tests to use selectively: fetal fasting glucose, hemoglobin A<sub>1C</sub>, Kleihauer-Betke, urine toxicology, and thrombophilia evaluation. “TORCH titers” to detect infection almost never further diagnosis if there are no findings from autopsy or the placenta.
- Induce labor within 24 hours of fetal death, to decrease maternal anxiety.

Avoid expectant management if possible. A more individualized approach may sometimes be appropriate. ■

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### FAST TRACK

**Because many stillbirths occur in women with no risk factors, screen even low-risk patients with fetal kick counting in late pregnancy**