Menopause and Libido

It is quite natural for women to lose sexual desire as a result of changes in their bodies that relate to the menopause or with their stage of life, however, there are treatments to restore libido and reduce tensions, says **Dr Heather Currie**

HOW TO BOOST YOUR SEX DRIVE

The menopause can affect female sexuality and relationships by various means and sexual problems often occur both with the menopause and with ageing. Sexual problems are estimated to occur in 50% of sexually active women in middle age, yet many women do not disclose the problem.

Despite our society being much more open and able to discuss sensitive issues than ever before, many women are still too embarrassed to seek help when things are not quite right. Although some women do not feel that an active sex life is vital, often quoting that they'd rather have a cup of tea (!), 84% of women in a recent survey feel that it is important to continue an active sex life into older age.

Men often rate sexuality highly as an important quality of life issue and sexual problems often cause relationship problems, while relationship problems may contribute to sexual problems.

Problems can occur from lack of interest or desire, decreased arousal and response and discomfort. Changes associated with the menopause and changes associated with the stage of life rather than hormone changes can all play a part in sexual difficulties at the menopause. Many factors contribute to the common problem of reduced libido or sex drive. Factors that particularly affect menopausal women include sleep disturbance leading to tiredness, nuisance of heavy and irregular periods, tension with partner (which then leads to a vicious circle with reduced sexual activity often causing more tension), stress over other life events (which often happen around the time of the menopause – problems with teenage children, children leaving home, elderly parents, work pressures), menopausal symptoms signifying the ageing process and the need to come to terms with this and hormone changes affecting response.

The hormones, estrogen, progesterone and androgens, are all important in sexual desire and response; both estrogen and progesterone levels fall at the menopause and androgens fall with age, declining particularly after the age of 40 years. The fall in estrogen may also cause vaginal dryness and discomfort and this can affect desire and response. Because of the role of hormones, some women do benefit from hormone therapy but, for women especially, the other personal and relationship factors are as, if not more, important.

Continued communication with your partner is vital to work through this and find out what is the best option for you. Many women do benefit from some help at this stage, whether it is advice or specific therapy but, with guidance, there is no reason why women can't continue to enjoy an active sex life well into old age.

The lack of estrogen causing vaginal dryness and discomfort due to vaginal tissues becoming thin, less elastic, less well supported and fragile, is a frequent menopausal problem, yet women often don't report it. A previous *Menopause Matters* survey showed that more than half (51%) of menopausal and post-menopausal women suffer from bothersome vaginal symptoms, yet the majority of them (79%) had not discussed their symptoms with a health-care professional.

For almost half of these women (47%) said symptoms were so severe that they affected their sex lives. One-quarter even said that they make excuses to avoid having sex with their partner. A more recent survey showed that of women who had noticed reduced libido associated with the menopause, more than 80% believed that the vaginal dryness and discomfort was a significant contributory factor.

For vaginal dryness, there are

treatments available such as vaginal lubricants and moisturisers, that can be purchased from pharmacies. Vaginal Replens and Sylk are also now available on prescription.

To treat the underlying problem of the effects of lack of estrogen on the vagina (vaginal atrophy), vaginal estrogen in the form of a small tablet, pessary, cream or vaginal ring is effective.

Because the estrogen is given in a small dose and is concentrated in the vaginal tissues, very little, if any, of it gets into the rest of your body, and so is not likely to be associated with the risks and side effects of HRT. Vaginal estrogen therefore can be used even if you cannot or are advised not to take HRT, which circulates throughout your body (systemic HRT).

In some women, control of menopausal symptoms by systemic HRT can improve sleep pattern, increase energy levels and reduce distress; changes that can lead to an improvement in libido both by direct and indirect effects simply by restoring estrogen levels. However, some types of HRT can cause the body to produce less testosterone, which is important for libido, mood and energy levels. The tablet form of HRT can have this effect, as can the oral contraceptive pill and thyroxine. One type of tablet HRT that does not have this effect is tibolone and in fact tibolone may increase testosterone-like activity production.

Tibolone can be considered if your periods have stopped, since it is a "period-free" preparation. Also, a non-tablet form of HRT, such as a patch or gel, has a lesser effect in reducing testosterone compared with tablet HRT.

Since testosterone (one of a group of hormones known as androgens, produced both from the adrenal gland and the ovaries) is thought to play an important part in sexual interest and response, some women may benefit from testosterone replacement. There is a gradual decline in androgen production with age from the 40s to old age so that, by the time you reach 70, androgen levels are 70%-80% less than in earlier years. A 50% reduction in testosterone levels is seen following removal of the ovaries. Symptoms of androgen deficiency include persistent fatigue and low mood as well as the low libido. Testosterone replacement may be considered in women who have had their ovaries removed and women on tablet HRT who have symptoms suggestive of testosterone insufficiency may wish to try a different route or type of HRT.

Apart from the HRT preparation, tibolone, the only other licensed ways for women to take testosterone is by an implant or a patch.

The implant is a small pellet placed under the skin of the abdomen every six months. A testosterone patch is now available for women, which is changed twice weekly. It is licensed for women who have had their ovaries removed and are already taking estrogen replacement and does seem to provide benefit.

A study showed that testosterone gel improved frequency of sexual activity and sexual interest in postmenopausal women taking HRT but the appropriate dose for women has to be determined. Testosterone replacement is still controversial and subject to further research.

Although a change in the type of HRT or, for some women, a form of testosterone along with HRT is worth considering, the other factors affecting libido should not be ignored.

Women need to feel secure, loved, wanted and emotionally close to their partner to be able to fully enjoy sexual relations. A domestic dispute leading to disagreement can continue to cause disharmony; men can feel that making love allows them to show their love for their partner and make up for the disagreement, whereas women often need to have the disagreement sorted out before they will feel close enough to enjoy a sexual relationship.

The menopausal changes of weight gain, skin changes and impact of loss of fertility can all affect self-confidence in a woman, influencing how she feels about herself, her relationship and her sexuality. On the other hand, she may find that the menopause has a positive effect on sexual response by signalling the end of heavy and often painful periods, negating the need for contraception and allowing more freedom and time with her partner, especially if children have left home.

Sexual difficulties can also be due to medical problems and medications. Sexual problems affect about 30% of men, erectile dysfunction (impotence) being the most common problem. Men are often even more reluctant than women to report problems and seek treatment. As difficulties continue, tension builds up and the problem escalates. Effective treatment is available and medical help should be sought sooner rather than later.

Brief Profile of Female Sexual Function

This questionnaire was designed for women who are experiencing low sexual desire. Read each statement and choose the answer that best corresponds to your experience over the past 2-3 months. Add the numbers together to calculate your score.

		Never	Seldom	Sometimes	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

A score between 0-20 indicates that you may have low sexual desire that is concerning. This is something that you may want to discuss with your physician. Sharing the results of this questionnaire with your physician may help you to start a conversation with him or her about your concerns.

This questionnaire has been developed by Procter & Gamble Pharmaceuticals