

Clinicians' Forum

In this issue, Menopause Management Editorial Advisory Board members share their expertise on broaching the issue of sexual function.

Participants

Frederick Naftolin, MD

Professor, Department of Obstetrics and Gynecology
Yale University School of Medicine
New Haven, CT

Marcie K. Richardson, MD

Assistant Director of Ob/Gyn for Clinical Quality
Harvard Vanguard Medical Associates
Boston, MA

Michelle P. Warren, MD

Professor of Medicine, and Obstetrics and Gynecology
Medical Director, Center for Menopause, Hormonal Disorders and Women's Health
Wyeth Professor of Women's Health
New York Presbyterian Hospital
New York, NY

Rosemary Basson, MBBS, MRCP

Clinical Professor of Psychiatry
University of British Columbia
Vancouver, BC, Canada

Morrie M. Gelfand, CM, MD

Professor of Obstetrics and Gynecology
McGill University
The Sir Mortimer B. Davis Jewish General Hospital
Montreal, Quebec, Canada

Julia R. Heiman, PhD

Professor of Psychiatry and Behavioral Sciences
University of Washington School of Medicine
Seattle, WA

Question: How do you raise the issue of sexual function or dysfunction during routine office visits? If a major dysfunction is identified, how do you proceed?

Answers

I do it in two ways. First, I inquire about physical problems that may interfere with sexual activity, including vaginal dryness. Second, I ask questions related to social structure. This would include questions such as, "How are things between you and your husband/partner?"

In my experience, problems related to

sexual function tend to be part of a larger constellation of interpersonal relations between partners (except for physical issues for which local hormones are usually needed, as well as consideration of the general hormonal status).

Thus, I obtain a more in-depth history and then counsel the patient/couple. Personally, I do not routinely send patients to a counselor for these issues.

— Frederick Naftolin, MD



Frederick Naftolin, MD

Talking about sexual function is difficult for most people. Clinicians not only have to face their personal reluctance to discuss sex, but they are often ill prepared to deal with the questions or issues that arise. Nevertheless, if the subject comes up the conversation is often robust. Patients have concerns, if not outright dysfunction. This is particularly true around the menopause when physical, partner and psychological changes all add to the mix.

My routine-visit questionnaire asks if women are sexually active, and if they have any issues they would like to discuss. When a woman is perimenopausal or menopausal, I always ask if she is having any sexual problems.

When the answer is "Yes" I ask about desire, ease of arousal, discomfort, orgasm and how she is getting along with her partner. It is important to remember that the most important sex organ is the brain. Dyspareunia is sometimes in the realm of the gynecologist. If loss of libido is the complaint and the relationship sounds solid, I offer testosterone testing and alert the patient that levels are not always predictive and therapy is experimental.

There are several books to which I refer my patients—some that are on the NAMS reading list and others that are not. In my referral repertoire I have a good sex therapist, a vulvar specialist and several behavioral health clinicians. By

the time I get to this part of the discussion I am usually running way over the visit time, and I ask many patients to make a follow-up visit or phone appointment to explore the matter further.

— Marcie K. Richardson, MD



Marcie K. Richardson, MD

I usually bring up the question of vaginal dryness and ask about sexual function. I also give patients a questionnaire, such as the Menopause Symptom Index (MENSI), if they have time and are willing to fill it out. I do, however, find that some patients simply do not like filling out questionnaires.

The next step is to address the menopausal issues and treat them accordingly. If this is not satisfactory in resolving the problem, I will refer the patient to a sex specialist and evaluate further for other issues, including depression.

— Michelle P. Warren, MD

I would simply refer to the recent Clinical Updates in Women's Health Care: Sexuality and Sexual Disorders, from the American College of Obstetricians and Gynecologists (Spring 2003;11[2]). Pages 33 and 34 explain the importance of establishing a dialogue dependent on the actual gynecologic/obstetric context in question. These pages give examples of the different types of questions to ask if a woman is peri- or postmenopausal, depressed, or dealing with chronic illness or potentially damaging surgery, such as a radical hysterectomy. It is important to explain how the specific condition may interfere with sexual desire or enjoyment, and to ask if that is the case.

When a major sexual disorder appears to be present, it is important to quickly establish whether this is a lifelong problem or an acquired one. When the problem is acquired, it is necessary to ask

Prevention of osteoporosis in postmenopausal women

The safety of FOSAMAX® (alendronate sodium) tablets 5 mg/day in postmenopausal women 40-65 years of age has been evaluated in three double-blind, placebo-controlled clinical trials involving over 1,400 patients randomized to receive FOSAMAX for either two or three years. In these studies the overall safety profiles of FOSAMAX 5 mg/day and placebo were similar. Discontinuation of therapy due to any clinical adverse experience occurred in 7.3% of 642 patients treated with FOSAMAX 5 mg/day and 5.3% of 648 patients treated with placebo.

In a one-year double-blind, multicenter study, the overall safety and tolerability profiles of once weekly FOSAMAX 35 mg and FOSAMAX 5 mg daily were similar.

The adverse experience from these studies, considered by the investigators as possibly, probably, or definitely drug related (≥ 1% of patients treated with either once weekly FOSAMAX 35 mg or FOSAMAX 5 mg/day or placebo are presented in the following table.

Adverse Experience	FOSAMAX 35 mg Weekly		FOSAMAX 5 mg Daily		Placebo
	No. (%)	% (95% CI)	No. (%)	% (95% CI)	
Headache	18	1.8	18	3.2	1.0
Abdominal pain	17	2.0	24	4.2	0.2
Joint pain	14	1.6	16	2.8	4.2
Back pain	13	1.5	14	2.5	1.4
Nausea	10	1.2	10	1.8	0.8
Constipation	9	1.0	9	1.6	0.4
Diarrhea	8	0.9	8	1.4	0.2
Upper respiratory tract infection	8	0.9	8	1.4	0.2
Flu	8	0.9	8	1.4	0.2
Upper extremity pain	8	0.9	8	1.4	0.2
Lower extremity pain	8	0.9	8	1.4	0.2

Consistent use with osteoporosis (FOSAMAX 5 mg/day) in two studies (of one and two years) compared to premenopausal osteoporosis (women's health) (WHI), the safety and tolerability profile of continued treatment with FOSAMAX 5 mg once daily and estrogen + progestin (n=354) was consistent with those of the individual treatments.

Discontinuation of treatment due to adverse experience
In two one-year, placebo-controlled, double-blind, multicenter studies in patients receiving glucocorticoid treatment, the overall safety and tolerability profiles of FOSAMAX 5- and 10 mg/day were generally similar to that of placebo. The adverse experiences attributed by the investigators as possibly, probably, or definitely drug related in ≥ 1% of patients treated with either FOSAMAX 10 mg/day (n=157) or FOSAMAX 5 mg/day (n=161), or placebo (n=155), respectively, were: Gastrointestinal abnormal pain (3.2%, 1.8%, 0.6%), acid regurgitation (2.5%, 1.5%, 1.3%), constipation (1.2%, 0.6%, 0.0%), diarrhea (1.3%, 0.0%, 0.0%), dizziness (0.6%, 1.2%, 0.6%), flatulence (0.6%, 0.6%, 1.3%), nausea (0.6%, 0.6%, 0.6%), vomiting (0.6%, 0.6%, 1.3%).

The overall safety and tolerability profile in the glucocorticoid-treated osteoporosis population that continued therapy for the second year of the studies (FOSAMAX: n=147) was consistent with that observed in the first year.

Upper GI Abnormalities
In clinical studies (osteoporosis and Paget's disease), adverse experiences reported in 175 patients taking FOSAMAX 40 mg/day for 3-12 months were similar to those in postmenopausal women treated with FOSAMAX 10 mg/day. However, there was an apparent increased incidence of upper gastrointestinal adverse experiences in patients taking FOSAMAX 40 mg/day (17.7% FOSAMAX vs. 10.2% placebo). One case of esophagitis and two cases of gastritis resulted in discontinuation of treatment.

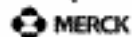
Additionally, musculoskeletal (bone, muscle or joint) pain, which has been described in patients with Paget's disease treated with other bisphosphonates, was considered by the investigators as possibly, probably, or definitely drug related in approximately 1% of patients treated with FOSAMAX 40 mg/day versus approximately 1% of patients treated with placebo, but rarely resulted in discontinuation of therapy. Discontinuation of therapy due to any clinical adverse experience occurred in 6.4% of patients with Paget's disease treated with FOSAMAX 40 mg/day and 2.4% of patients treated with placebo.

Laboratory Test Findings
In double-blind, multicenter, controlled studies, asymptomatic, mild, and transient increases in serum calcium and phosphate were observed in approximately 16% and 10%, respectively, of patients taking FOSAMAX versus approximately 12% and 3% of those taking placebo. However, the incidences of decreases in serum calcium to < 8.0 mg/dL (2.0 mM) and serum phosphate to < 2.0 mg/dL (0.65 mM) were similar in both treatment groups.

Post-Marketing Experience
The following adverse reactions have been reported in post-marketing use:

• **Sty as a Mink hypersensitivity reactions** including urticaria and rarely angioedema. Rarely symptoms of myalgia, muscle and rarely, fever have been reported with FOSAMAX, typically in association with initiation of treatment. Rarely, symptomatic hypocalcemia has occurred, generally in association with preexisting conditions.
• **Gastrointestinal**: esophagitis; esophageal erosions; esophageal ulcers; rarely esophageal strictures or perforation; and anorectal/colorectal disorders. Gastric or duodenal ulcers, gastric ulcers and with concomitant have also been reported (see WARNINGS, PRECAUTIONS, Information for Patients, and DOSAGE AND ADMINISTRATION).
• **Sty**: rash (occasionally with photosensitivity), pruritus, urticaria, allergic skin reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis.
• **Special Senses**: rarely vision, rarely hearing.

For more detailed information, please read the complete Prescribing Information.



© 2004 Merck & Co., Inc., Whitehouse Station, NJ 08889, USA. All rights reserved.
29401830/11/0231-F05

about the personal/relationship/sexual/medical (including psychiatric) context in which this dysfunction emerged. Patients should be made aware that most dysfunctions are eminently treatable and that both partners usually need to be assessed, but that matters are often complex. At that point, a decision will be made about whether to focus on the sexual concern during the current visit, or to focus on the other gynecologic/obstetric issues that may have necessitated the visit. In the latter instance, a full biopsychosocial assessment and clarification of management options would occur at a future visit.

— Rosemary Basson, MBBS, MRCP

In discussing hormone therapy (HT) with patients, it is important to state that there are three hormones that have to be considered; those hormones are estrogen, progesterin and androgen. The estrogen hormone can be easily discussed since this seems to be one of the major indications for HT. The progesterin hormone is only used if the patient has a uterus and there is a need to prevent endometrial hyperplasia.

The third hormone, androgen, is mentioned specifically with the intent of discussing the patient's sexual function, libido, energy, and so on. The clinician explains that the hormone has been researched and is capable of adding certain positive parameters in the areas of sexual dysfunction, and it is at this time that the clinician inquires as to whether the patient feels that her sexual functioning is adequate. If she does not have anything to say about it, then that is the end of the discussion. In 90% of cases, however, the patient is very interested and replies that she notices that as she is getting older there is a change in her sexual function. Most of these women assume that age is the important factor and do not ever consider the fact that HT could help

to ameliorate or remedy some of the problems related to their sexual dysfunction.

This opens up the entire discussion, and a decision can then be made about whether to add the androgen to the estrogen replacement therapy or whether to add it to the estrogen-progesterin replacement therapy. The flow is simple; it presents no difficulty in its discussion and has been used successfully for the past 15 years.

— Morrie M. Gelfand, CM, MD

If prescribing any medications, including oral contraceptives, one could note that sometimes women have side effects including sexual problems/dysfunctions. Or, if the office visit is an annual exam, it is appropriate to mention sexual problems while covering areas such as mood. Attempt to determine if there is a problem with desire/interest, arousal, orgasm or pain. If the patient mentions something, and she would like to further discuss it, be ready to suggest a referral inside (an office nurse, for example) or outside your practice. (This is presuming that you do not wish to address sexual dysfunctions yourself).

There currently are no FDA-approved medical treatments for sexual problems, except the EROS female sexual therapy device. Individual or couples therapy can help with some problems, particularly those related to orgasm and some desire problems. In addition, it appears that some version of testosterone therapy will be available in the next two years.

Until other safe and effective treatments are available, the main function of the clinician is to perform careful diagnosis, to familiarize yourself with treatments and providers that can help, and to be glad the woman feels she can talk to you about the issue.

— Julia R. Heiman, PhD



Morrie M. Gelfand, CM, MD

Do you have a clinical question or situation that you would like to pose to our panel of experts?

Contact Laura McKeown (phone: 732-282-0703; fax: 509-463-0447; e-mail: lmckeown@menopausegmt.com).