The Most Common FSD: Low Interest

Female sexual dysfunctions are highly prevalent, multi-dimensional, interrelated and associated with personal distress. Symptoms include problems with desire, with arousal, with orgasm/ejaculation and with pain during intercourse.

Female sexual function (interest in sexual activity) is associated with psychologic factors (mind, relationship) and biologic factors (brain, hormones, blood flow, nerves). On the other hand, female sexual dysfunction, especially low interest, is associated with problems with mind and/or relationships and problems with brain, hormones, blood flow and/or nerves. If a woman complains of sexual dysfunction, such as low interest, it follows that: 1) mental health care professionals should assess the mind and the relationship and 2) medical health care professionals should assess the integrity of the hormonal milieu, nerves and blood flow.

Of the first 3000 women with sexual dysfunctions evaluated at the Institute for Sexual Medicine, the 10 most common complaints include: 1) loss of desire since childbirth, 2) loss of desire while using anti-depressants, 3) loss of desire while using birth control pills, 4) loss of desire since transition or since menopause, 5) loss of arousal since transition or since menopause, 6) never had orgasm, 7) lost orgasm since childbirth, anti-depressants, birth control pills, 8) sexual pain since childbirth, 9) sexual dysfunction after hysterectomy and 10) sexual dysfunction after breast cancer treatment.

The following represent 10 common statements from women with sexual dysfunction and low sexual interest: 1) I am tired of being an actress, 2) I could write a book “101 ways to avoid sex with my husband”, 3) I dread having sex, 4) I even hate being touched, 5) I don’t care about sex, I do this only to keep the peace, 6) He takes this personally – even though I really love him, 7) We live a brother-sister relationship, 8) Not only am I not interested if I ever have sex again, it hurts so much, it is raw and burning at the vaginal opening, 9) I do this out of pure guilt and 10) My lack of a sex drive is causing great distress in the relationship.

Sex steroid hormones are critical for genital (clitoris, labia, vagina) structure and function. Sex steroid hormones induce protein synthesis – the proteins cause the genitals to: grow, become more sensitive, have more blood vessels, act on the brain to have libido, act on the bones, muscles, skin, mood, etc. Without sex steroids, genital tissues shrink/atrophy, become poorly sensitive and poorly engorge,

Conditions associated with reduced levels of sex steroid hormones in women with sexual dysfunction are: 1) Combined oral contraceptive pills, 2) Infertility treatments with “lupron”, 3) Childbirth, 4) Hysterectomy and bilateral oophorectomy, 5) Chemotherapy for cancer, 6) Hormone ablation therapy for endometriosis, 7) Eating disorders – bolemia, anorexia, 8) Transition and menopause, 9) Depression, major life stress, relationship conflicts, 10) Drug treatment for depression, 11) Drug treatment for epilepsy, 12) Thyroid disease (i.e. hypo- or hyper-thyroidism), 13) Lyme disease, HIV, diabetes mellitus, chronic fatigue syndrome, rheumatoid arthritis (RA), systemic lupus erythematosus (SLE) and HIV-AIDS, and 14) Major metabolic/nutritional disorders (e.g. iron or vitamin D deficiency)

Of the first 3000 women with sexual dysfunctions evaluated at the Institute for Sexual Medicine, those who have sexual dysfunction and low sex steroid hormone blood values have complaints of: loss of desire, decreased frequency of sexual activity, painful intercourse, atrophy of genital tissues, diminished sexual responsiveness, difficulty achieving orgasm and decreased genital sensation. Other symptoms include: less memory, less sense of smell, taste, hearing, worse vision, tiredness, fatigue, less energy, depressed mood and osteoporosis/osteopenia.

Double-blind, placebo-controlled, multi-institutional international trials have documented that androgen therapy in women with sexual dysfunction and androgen insufficiency (hypogonadism) can significantly improve sexual dysfunction during sexual activity compared to placebo. Side effects have been minimal, including no change in hirsutism or acne over baseline.

To fully evaluate androgens, we ask patients to undergo the following blood tests: DHEA-S, androstenedione, free testosterone, total testosterone, sex hormone binding globulin, dihydrotestosterone, estradiol, estrone, FSH, LH, prolactin, TSH, progesterone. Treatment with androgens is suggested if the woman with sexual dysfunction demonstrates sex steroid blood test values either below or in the lower quartile of the reference range. Patients on treatment should have follow-up blood test values every 3 months to assess the biochemical response to treatment.

In our experience, 70% of women with low interest secondary, in part, to low sex steroid blood test values will experience restoration of sexual function with normalization of the sex steroid hormone milieu