Menopause/HT/non-HT/OP/ERAA

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Center for Specialized Women’s Health

Knowledge = POWER
Objectives

• Review the benefits and risks of HT/non-HT
• Discuss “designer estrogens”
• Review use, indications of Flibanserin for FSIAD
When is menopause?

• Naturally (spontaneously) average age 51
• Prematurely from medical intervention (eg, bilateral oophorectomy, chemotherapy)
• At any time from impaired ovarian function
Terminology: Premature menopause

• Any menopause that occurs before age 40.
• Early menopause prior to age 45.
• 1% of women prior to age 40 have POI.
Hormone therapy terminology

Hormone therapy (HT) is the only pharmacologic therapy government approved in US and Canada for treating menopausal symptoms. HT encompasses both estrogen-alone and estrogen-progestogen therapies.

- **Estrogen therapy (ET):** Unopposed estrogen is prescribed both a) systemically for women who do not have a uterus, and b) locally in very low doses for any woman with vaginal symptoms.

- **Estrogen-progestogen therapy (EPT):** Progestogen is added to ET to protect women with a uterus against endometrial cancer, which can be caused by estrogen alone.

- **Bioidentical hormone therapy (BHT):** Consists of hormones chemically identical or very similar to those made in the body. Available from two sources: 1) FDA-approved and tested; 2) unapproved and untested from compounding pharmacies.
Hormone therapy—what we know

- HT formulation, route of administration, and timing of initiation produce different effects (e.g. transdermal route may carry lower risk for thrombosis).
- Absolute risks for HT use in healthy women ages 50-59 are low, but can include thrombosis, and PE.
- **Overall lower mortality in long term HT users. Lower DM-2 risk.**
- HT initiation in older women carries greater risks-great than 10 yrs
- Breast cancer risk increases with EPT beyond 5 years.
- ET can be considered for longer duration of use because it carries a lower risk for breast cancer.
- Consider each woman’s priorities and risk factors prior to initiating HT. Sleep disorders, formications, hair thinning, musculo-skeletal symptoms often overlooked.

Knowledge = POWER

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Menopausal symptoms & signs

Classic symptoms:
• Change in menstrual cycle pattern (early).
• Vasomotor symptoms (includes night sweats).
• Vulvo-vaginal symptoms, dyspareunia.

Other symptoms sometimes associated with menopause
• Sleep disturbances besides night sweats
• Cognitive concerns (memory, concentration).
• Psychological symptoms (depression, anxiety, moodiness).

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The Stages of Reproductive Aging +10 staging system for reproductive aging in women

<table>
<thead>
<tr>
<th>Stage</th>
<th>-5</th>
<th>-4</th>
<th>-3b</th>
<th>-3a</th>
<th>-2</th>
<th>-1</th>
<th>+1a</th>
<th>+1b</th>
<th>+1c</th>
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<tbody>
<tr>
<td>Terminology</td>
<td>REPRODUCTIVE</td>
<td>MENOPAUSAL TRANSITION</td>
<td>POSTMENOPAUSE</td>
<td></td>
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<tr>
<td>Early</td>
<td>Peak</td>
<td>Late</td>
<td>Early</td>
<td>Late</td>
<td>Early</td>
<td>Late</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>variable</td>
<td>variable</td>
<td>1-3 years</td>
<td>2 years (1+1)</td>
<td>3-6 years</td>
<td>Remaining lifespan</td>
<td></td>
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</table>

**PRINCIPAL CRITERIA**

- **Menstrual Cycle**
  - Variable to regular
  - Regular
  - Regular
  - Subtle changes in flow/length
  - Variable length persistent
  - ≥7-day difference in length of consecutive cycles
  - Interval of amenorrhea of ≥60 days

**ENDOCRINE CRITERIA**

- **FSH**
  - Low
  - Low
  - Variable
  - Variable
  - Variable
  - Variable
  - >25 IU/L
  - Variable
  - Stabilizes
  - Very Low
  - Very Low

- **AMH**
  - Low
  - Variable
  - Low
  - Low
  - Low
  - Low
  - Low
  - Very Low
  - Very Low

- **Inhibin B**
  - Low
  - Low
  - Low
  - Low
  - Low
  - Very Low
  - Very Low
  - Increasing

<table>
<thead>
<tr>
<th>Antral Follicle Count</th>
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<tr>
<td>Low</td>
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<td>Low</td>
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<tr>
<td>Low</td>
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<tr>
<td>Very Low</td>
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<tr>
<td>Very Low</td>
</tr>
</tbody>
</table>

**DESCRIPTIVE CHARACTERISTICS**

- Vasomotor symptoms
  - Likely
  - Most Likely
  - Increasing symptoms of urogenital atrophy

*Blood draw on cycle days 2-5. ↑ = elevated
**Approximate expected level based on assays using current international pituitary standard

Harlow et al. STRAW+10 Staging Reproductive Aging Climacteric, Fertil Steril. JCEM, Menopause 2012
Terminology: Post-menopause

• The years after the FMP resulting from natural (spontaneous) or premature menopause.

• With current life expectancy, the postmenopausal years make up 1/3 to 1/2 of the lifespan of most North American women.

• SWAN: Women with untreated Menopausal symptoms fall off work productivity ladder.
Use ET post TH

Evaluate the evidence that supports the mission statement that post TH
Estrogen is
ONLY therapy that: Treats symptoms,
Prevents disease and Decreases mortality.

- Review aftermath of the Women’s Health Initiative 13.5 years later.
- Examine the risk/benefit ratios related to cardiovascular disease and other outcomes in women with respect to Hormone Therapy.
- Understand the increased risk for CV disease in women with total hysterectomy (with or without oophorectomy) and the significance of early intervention with estrogen for CV risk reduction.
Health Outcomes After CEE: WHI

LaCroix AZ, Chlebowski RT, Manson JE, et al. JAMA 2011;305(13):1305-1314
The Mortality Toll of Estrogen Avoidance
An Analysis of Excess Deaths Among Hysterectomized Women Aged 50 to 59

Philip Sarrel, MD
Valentine Njike, MD, MPH
Valentina Vinante, MD
David L. Katz, MD, MPH
Hysterectomy in the United States

• After Cesarean Section, hysterectomy is the most common major surgery performed on women.

• More than 6 million hysterectomies have been performed in the last 10 years. Ovaries removed in 54%.
  – More than 600,000/year

• Most common age group = 40–44 y, followed by 35–39 y, 46.1 is the average age for hysterectomy. 20% are age 35 or younger.

• By age 50-54 1/3 women in USA have had a hysterectomy.

• By age 55-59, the rate is just over 40%.

• More than 15 million women under age 60 have had a hysterectomy.

Mortality Toll of Estrogen Avoidance
Findings in Hysterectomized Women Age 50-59 (2002-2011)

Sarrel PM, Njike V, Vivante V, Katz DL. 2013, in press

Decline in Estrogen Use by Hysterectomized Women Aged 50-59: 1999-2010
Sprague BL et al. 2012;120(3):595-603

87% DECLINE
MTEA = Mortality Toll of Estrogen Avoidance
MTEA: Study Variables

- Excess Mortality Rate: 0.0013 per year.
- Population year by year: 17,307,862 to 21,933,149.
- Hysterectomy Rate: 33% to 40%.

MTEA : Annual Calculations and Best Point Estimates

• “Reasonable range of all assumptions: 40,292 to 48,835 excess deaths between 2002 and 2011”

• Sarrel PM, Njike V, Vinante V, Katz DL. AJPH. 2013;103:1583-88. July 18, 2013:e1-e6
Decreased Mortality in Hysterectomized Women Under Age 60 Using Hormone Therapy

Percent Change in Mortality Risk

- WHI: -27
- RCT-Meta: -27
- DOPS: -46
- KAISER: -46
ET Reduces Mortality: Literature Review

WHI-CEE trial, 11 years: reduction = 27%
DOPS, 16 years: reduction = 46%
Tuomikoski P, 1-8 years: reduction = 43%-54%
Salpeter SR, et al. reduction = 27%
  – 8 prospective observational studies-212,717 women followed for 2,935,495 women-years.
  – 19 RCTs, mean age of 54.5- 83,043 woman year.
Explaining How Estrogen Therapy Reduces Mortality

• Cardiovascular Effects: Reduced CHD and MI.

• Other Estrogen Actions:
  – Reduced breast cancer mortality: WHI (63% reduction in mortality from invasive breast cancer); DOPS (62%)
  – Reduced psychiatric, osteoporotic, and colon cancer related mortality.
Myocardial Infarction Event Risk in WHI After Mean Follow-Up Time of 10.7 Years as a Function of Age Group When Therapy was Initiated

Estrogen alone (CEE) vs Placebo

(P = .007)

 Absolute Risk of Myocardial Infarction
(Number of events in CEE group vs. placebo per 10,000 women per year)

Ages 50-59  Ages 60-69  Ages 70-79

Median estrogen use: 5.9 years

Causes of Death in Women

- Cardiovascular: 53%
- Other Cancers: 18%
- Other Causes: 25%
- Breast Cancer: 4%
Cancer

Menopause is not associated with increased cancer risk

But because cancer rates increase with age and cancer is second leading cause of death in women, screen for the following cancers regularly:

– Breast cancer: mammogram every 2 years, ages 50-74 (USPSTF)
– Colorectal cancer: colonoscopy (every 10 y) or fecal occult blood test, sigmoidoscopy, or barium enema (every 5 y) beginning at age 50 (45 for black females). Don’t forget Lynch syndrome.
– Endometrial cancer: evaluation of any postmenopausal bleeding with pelvic ultrasound and/or endometrial biopsy (Beware of women on “BHT” unopposed estrogen).
– Ovarian cancer: no satisfactory screening tests, but timely evaluation needed if presenting with bloating, pelvic pain, or urinary urgency.
CV Risk in women from hormonal perspective

- At each age from 40 to 54 years, postmenopausal women have a 2-4 fold greater risk of CVD than premenopausal women.
- The perceived differences between observational studies and randomized trials is explained by the timing hypothesis.
- HT appears to be beneficial when underlying vascular tissue is healthy and neutral or detrimental when initiated in women with diseased vasculature – a “dual effect of HT.”
- Timing, that is, early initiation of HT relative to menopause reduces CHD and total mortality.
Differences Between Women in Major HT Observational Studies and Clinical Trials

Timing of Initiation of HT in Relation to Stage of Atherosclerosis

- **Premenopausal Years**
- **Postmenopausal Years**

### Years Since Menopause Onset
- 5
- 10
- 15
- 20

#### Observational Studies
- Fatty Streaks
- Fatty Plaques

#### Clinical Trials (1° and 2° Prevention)
- Atherosclerotic Plaques
- Unstable Plaques
- Clinical Events

### Stages of Atherogenesis
- Favorable Lipid and Endothelial Effects of Estrogen Predominate
- Prothrombotic and Proinflammatory Effects of Estrogen Predominate

**Favorable Influence of Initiating Exogenous Estrogens**
**Adverse Influence of Initiating Exogenous Estrogens**

Adapted with permission from Figure 2 from Manson JE et al. *Menopause*. 2006;13(1):139-147.

Game Changer: DOPS Oct 2012 and long term WHI data 10/2013

Finland Studies

- 10 year study Danish women
- Oral EPT 10 yrs.
- “Effect of HRT on CV events in recently postmenopausal women: a randomized trial”
- Reduced death rate, reduced MI CHF and no increase in cancer or VTE on HRT users compared to placebo.
Breast Cancer Risk in WHI After Mean Follow-Up Time of 10.7 Years as a Function of Age Group When Therapy was Initiated

Estrogen alone (CEE) vs Placebo

There were fewer invasive breast cancers in the estrogen alone group compared with the placebo group in all 3 age groups ($P=.96$)

- Ages 50-59
- Ages 60-69
- Ages 70-79

Absolute Risk of Invasive Breast Cancer

(Number of events in CEE group vs. placebo per 10,000 women per year)

Median estrogen use: 5.9 years

Women’s Health Initiative (WHI) 2002: The Headlines

**The New York Times**

**Patients Weigh Quitting Drug After Research Indicates Risk**

**Detroit Free Press**

Hormone Therapy Poses Threat to Women’s Health, Study Says

**The New York Times**

Many Taking Hormone Pills Now Face a Difficult Choice
Incremental Direct and Indirect Cost of Untreated Vasomotor Symptoms (VMS)

- Employer-based health insurance records 13 million individuals.
- 69 U.S. Fortune 500 companies.
- Case Cohorts: Untreated VMS vs non-VMS (Control) N= 252,273; mean age = 56 years.
- Measures: Number of health care visits and work loss costs for 12 months from index date.

Philip Sarrel; Patrick Lefebvre; Marie-Hélène Lafeuille Jonathan Gravel; Mei Sheng Duh; Peter M. Aupperle; David Portman. *Menopause: The Journal of NAMS*. 2015
Incremental Direct and Indirect Cost of Untreated Vasomotor Symptoms (VMS): Important Findings

• 1.5 million more outpatient visits (12 months) by women with untreated VMS.

• Cost per-patient-per-year of direct healthcare costs and indirect work loss cost (PPPY)= $2,000.00 more for women with untreated VMS.

• Total cohort cost (252, 273 women in each group): almost $400,000,000 more for women with untreated VMS.
SSRI Therapy

Summary of Efficacy

• SSRIs  Mixed results-labeled for Psych indications
  – *Paroxetine  7.5 mg dose Brisdelle at night labeled for VMS
    • Most studies performed
    • Highest affinity for the NE receptor
    • Do not use with Tamoxifen

*strong inhibitor of CYP2D6 with reported impact on tamoxifen metabolism
“Alternatives” to HT (cont’d)

• Complementary & Alternative Medicine
  – Soy isoflavones-no benefit, in high doses pills/supplements may affect endometrium
  – Traditional Chinese medicine
  – Herbs
    • Black cohosh- 6 months Remifemin
    • Cranberry
    • St. John’s wort-drug interactions
    • Valerian-rare liver side effects
    • Vitex-more for PMDD

• Over-the-counter hormones (dietary supplements)
  – Topical progesterone-no uterine protection-some wild yam
  – Melatonin-no pharmaceutical grade
Alternatives to hormone therapy (cont’d)

• Lifestyle changes
  – Try relaxation techniques (eg, yoga, meditation, paced breathing)
  – Eat a healthy diet
  – Get regular exercise
  – Avoid hot flash triggers (eg, caffeine, alcohol, spicy food)
  – Keep cool
    • Dress in layers (eg, light or cotton clothing)
    • Sleep in cool room (eg, fan, thermoregulating pillow)
• Reduce sexual discomfort and increase sensitivity with moisturizers, lubricants (olive oil), and vibrators
Tissue Selective Estrogen Complex (TSEC) Duavee

• SERM-Bazedoxifene coupled with CE at 0.45 with 20mg BZD
  – effective and safe Tx for menopausal Sx in women with intact uterus in the SMART trial
  – FDA approved to prevent osteoporosis

• Bazedoxifene competitively inhibits binding of 17B–estradiol
SERMs

Estrogen Agonists Estrogen Antagonists

- Clomiphene/Clomid
- Tamoxifen/Nolvadex
- Raloxifene/Evista
- Ospemifene/Osphena
- Bazedoxifene (BZD) coupled w CE/Duavee
Treat CV condition first; once stabilized
Can use ET/HT if indicated-in women over age 60 combo HT/statin best


What are the harms of menopausal hormone therapy when used for the primary prevention of chronic conditions?

- VTE is the major risk of HT EPT greater than ET
- Increase risk for breast cancer diagnosis with over 5 years of oral estrogen/progestin-(specifically MPA) however, the WHI-EPT arm still showed mortality reduction for women on HT with a uterus who took HT for at least 5 years and started within 10 years of menopause. Consider “designer” HT.
- Increase risk for gallstones and increase in triglyceride level in some women with oral HT.
- Increase in uterine cancer in unopposed estrogen in women with a uterus.
- Increased risk MI/stroke esp women under age 60 when taken off HT. Mikkola TS, Tuomikoski P, Lyytinen H, et al “Increased Cardiovascular Mortality Risk in Women Discontinuing Postmenopausal Hormone Therapy” JCEM 2015; http://dx.doi.org/10.1210/jc.2015-1864

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HT Discontinuance & Symptom Recurrence

• 50% chance of symptoms recurring when HT discontinued
• Vasomotor symptom recurrence similar whether tapered or abrupt discontinuance
• Decision to resume HT must be individualized
If you stop your patient’s HT then...

You are responsible for checking and following GU status and bone status and sleep/mood! If no VMS and no HT because your patient is on NSRI or SSRI again, you are responsible for checking GU/bone, etc.

If other endocrinopathies and/or history of mental illness and/or sleep disorders, Beware about stopping HT!
Explaining HT Risk

- Potential absolute risks for use of HT are very low, especially for ET in hysterectomized WHI.
- In WHI, risks for EPT were “rare,” except for stroke in women over age 60.
- For younger women (<50 y) or those at low risk of CHD, stroke, osteoporosis, breast cancer, or colon cancer, absolute risks is likely to be even smaller than seen in WHI.
- Each regimen, route of administration, and timing of therapy has distinct beneficial and adverse effects.
Other clinical caveats...

• Be aware of risk of endometrial cancer, with intentional or unintentional unopposed estrogen.
• Be aware of other common midlife conditions that can mimic or worsen menopausal symptoms.
• Refer high risk patients: breast cancer, uterine cancer, stroke, CV disease, VTE who have menopausal issues.
Benefits of HT outweigh risks

-in younger, symptomatic women-lower dose, multiple options for individuation

-Greatest risk of HT related to venous thromboembolism (same for ERAAs-SERM)

-Compounding HT not safer, just less studied and less regulated

-GOLD standard for VMS, GU atrophy and Bone
HT vs HC

• VTE major issue with both.
• Difference in transdermal HC-likely higher VTE risk compared to transdermal HT.
• Beware when using HC for HT in women with POF (better to think of this as POI)-it is OK to use HC for HRT in women with POI but NOT for contraception.
Decision Points...

- Menopausal? Yes or No.
- Uterus? Yes or No.
- Indications for HT? Yes or No (VMS, GU, Bone, QOL).
- If HT is the woman under 60 or within 10 yrs of Menopause? Yes or No (? estrogen deficiency)
- If using HT Oral or Transdermal? Cycled or Continuous?
- If PM and no HT then check GU and bone!
Special Populations

Early menopause
Primary ovarian insufficiency
*BRCA* after oophorectomy
Age older than 65 years
Data regarding hormone therapy in women aged older than 50 years should not be extrapolated to younger postmenopausal women.

Observational studies suggest benefits outweigh risks on bone, heart, cognition, vulvovaginal atrophy/genitourinary syndrome of menopause, sexual function, and mood.

Hormone therapy recommended until at least median age of menopause (52 y).

Younger women may require higher doses for symptom relief or protection against bone loss.

Ovarian conservation when possible

- Women with early menopause and primary ovarian insufficiency have health risks that may include persistent vasomotor symptoms, bone loss, vulvovaginal atrophy, mood changes, and increased risk of heart disease, dementia, stroke, Parkinson disease, ophthalmic disorders, and overall mortality.

- Ovarian conservation is recommended, if possible, when hysterectomy for benign indications is performed in premenopausal women at average risk for ovarian cancer.

Hormone therapy and BRCA after oophorectomy

- Limited observational evidence suggests that hormone therapy use does not further increase risk of breast cancer in women with a family history of breast cancer or in women after oophorectomy for BRCA 1 or 2 gene mutation
No general rule to discontinue hormone therapy after age 65

- The recommendation to use the Beers criteria to routinely discontinue systemic hormone therapy after age 65 is not supported by data.
- Decisions regarding whether to continue hormone therapy beyond the age of 60 years should be individualized:
  - After appropriate evaluation
  - Counseling about potential benefits and risks
  - Ongoing surveillance
VVA new term “Female Genital Syndrome of Menopause”

- Symptoms such as vaginal dryness, vulvovaginal irritation/itching, and dyspareunia are experienced by an estimated 10% to 40% of postmenopausal women.
- Unlike vasomotor symptoms, which abate over time, vaginal atrophy is typically progressive.
VVA/GSM

• During peri-menopause decreased levels of estrogen may cause the tissues and the lining of the vagina to become thinner, drier, and less elastic.
• Secretions are reduced, resulting in decreased lubrication.
• Without vaginal sexual activity after menopause, the vagina may become shorter and narrower.
Vaginal mucosa estrogenized vs Vaginal mucosa hormonally deficient
## Newer Products for Vaginal Atrophy and Menopause

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Drug Category</th>
<th>Pharma Sponsor</th>
<th>Current Status</th>
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<tbody>
<tr>
<td>Ospemifene (Osphena)</td>
<td>Estrogen Agonist/Antagonist First NON-estrogen oral</td>
<td>Pfizer, Inc.</td>
<td>Released 6/2013 60mg daily po with food</td>
</tr>
<tr>
<td>BZA/CEE (Duavee)</td>
<td>TSEC</td>
<td></td>
<td>Released 2/2014 0.45CE/20mgBZD daily po FDA approved 11/2016</td>
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<tr>
<td>Intragosa (vag DHEA 0.5%)</td>
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POSTMENOPAUSE

New findings intracrinology

LHRH → CRH → ACTH

Adrenal → Cortisol

Intracrinology

DHEA → E₂ → DHT

Peripheral tissue

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Differential diagnosis

r/o infection, skin disorders, cancer
Lichen Sclerosis
Not Atrophy, needs biopsy
Painful Intercourse / Dyspareunia & Vaginismus

- Muscle Stimulation
- Inflation
- Clitoral Stimulation
- Dermatologic

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Males and Females are Different

Addyi
HSDD and the “little pink pill”

Most common type of FSD.

– First in class Flibanserin (Addyi) 100mg at night approved for pre-menopausal women
– Have to be “certified” and instruct women not to ingest

ETOH www.AddyiREMS.com

R/O other co-existing medical, hormonal, psychiatric or Relationship issues
CONTRAINDICATED with Moderate or Strong CYP3A4 inhibitors (eg Fluconazole)
Overlap of Female Sexual Dysfunctions

- Sexual desire disorder
- Sexual arousal disorder
- Dyspareunia
- Orgasmic disorder
- Vaginismus

<table>
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<th>FSD</th>
<th>DSM-IV-TR Definition</th>
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<td>Sexual desire disorders</td>
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<tr>
<td>Hypoactive sexual desire disorder</td>
<td>Deficiency or absence of sexual fantasies and desire for sexual activity</td>
</tr>
<tr>
<td>Sexual aversion disorder</td>
<td>Aversion to and active avoidance of genital sexual contact with sexual partner</td>
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<tr>
<td>Sexual arousal disorder</td>
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<tr>
<td>Female sexual arousal disorder</td>
<td>Persistent or recurrent inability to attain, or to maintain until completion of sexual activity, adequate lubrication-swelling response of sexual excitement</td>
</tr>
<tr>
<td>Orgasmic disorder</td>
<td></td>
</tr>
<tr>
<td>Female orgasmic disorder</td>
<td>Persistent or recurrent delay in, or absence of, orgasm following normal sexual excitement phase</td>
</tr>
<tr>
<td>Sexual pain disorders</td>
<td></td>
</tr>
<tr>
<td>Dyspareunia</td>
<td>Genital pain associated with sexual intercourse</td>
</tr>
<tr>
<td>Vaginismus</td>
<td>Recurrent or persistent involuntary contraction of perineal muscles surrounding outer third of vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted</td>
</tr>
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</table>

## Subtypes of Female Sexual Dysfunctions Described by DSM-IV-TR

<table>
<thead>
<tr>
<th>Defined by Onset</th>
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<tbody>
<tr>
<td>Lifelong</td>
<td>Sexual dysfunction has been present since the onset of sexual functioning</td>
</tr>
<tr>
<td>Acquired</td>
<td>Sexual dysfunction develops only after a period of normal functioning</td>
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<table>
<thead>
<tr>
<th>Defined by Context</th>
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<tbody>
<tr>
<td>Generalized</td>
<td>Sexual dysfunction is not limited to certain types of stimulation, situations, or partners</td>
</tr>
<tr>
<td>Situational</td>
<td>Sexual dysfunction is limited to certain types of stimulation, situations, or partners</td>
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FOD + HSDD = FSIAD

• Female Sexual Interest Arousal Disorder
• F52.22
Physiology of Sexual Function
Central Nervous System


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Addyi for Pre-Menopausal women

- Get certified [www.addyi.com](http://www.addyi.com)
- 100mg at night with NO ETOH for 12 weeks
- Pharmacist has to be certified
- HSDD is real NOT a Flibanserin Deficiency Disorder
- Side effects of hypotension, syncope, headache, GI distress minimized by taking at HS and less than or similar to other drugs in the CNS class of meds.
Flibanserin Q’s

• Why is ETOH contraindicated with Addyi?
  a. Hepatotoxicity, b. Teratogenicity, c. Hypotension d) Hypersensitivity

• What is the purpose of the Addyi REM pt-provider agreement?
  a. For MDs to counsel, b. For charting c. For safety d. For pharmacist to counsel  e. All of the above

• How often must pharmacists counsel pts about need to avoid ETOH?
  a. Never b. Only if pts asks about ETOH c. With 1st script d. With every script

• What is the primary counseling message for the pt?
  a. Do not drink ETOH until you know how it will affect you b. Limit your ETOH while taking Addyi c. Do NOT drink any ETOH d. Do not drink ETOH at night at the time you take Addyi

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Off Label Therapies and Future Therapies

• Bupropion (Wellbutrin) for patients who have trouble climaxing after arousal esp in women on SSRIs
• PDE5I like Sildenafil (Viagra) or Tadalafil (Cialis) in women on SSRIs or women with vasculogenic arousal problems (DM, MS)
• 1% vaginal DHEA (phase 3 study in vaginal ring)
• Bremelanotide (under study-taken on as needed basis)
• Lybrido (T/sildenafil)
Anorgasmia

• Anorgasmia is the medical term for regular difficulty reaching orgasm after ample sexual stimulation, causing personal distress.
  
  – Fewer than one third of women consistently have orgasms with sexual activity.
  
  – Orgasms often change with age, medical issues or medications.
  
  – “ClitGva”
  
  – OTC Zestra lotion to genitals
  
  – Off label vaginal DHEA 1%
It’s all in the eye of the beholder
Be Strong • Be Healthy • Be in Charge

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