MENOPAUSE AND SEX

The loss of ovarian hormones following menopause can lead to changes in a woman's body and sexual drive.

You may find that arousal is less intense and the skin is less sensitive to touch. Orgasm can be harder to achieve, if at all. This can be a natural phenomenon of ageing, similar to your ability to run a marathon as you get older. Topical oestrogen can improve the quality of the vaginal tissue. Couples need to be careful with their choice of lubricants, as many contain preservatives or additives that can lead to dermatitis.

There are many reasons why a woman might 'go off' sex in the perimenopause or postmenopausal phase. If we think of the different aspects of the body that are affected by menopause:

- Vasomotor symptoms can affect the ability to sleep and the quality of sleep. At times, women will be too tired to contemplate sex with their partner.
- Psychological symptoms can also affect sleep, such as a desire to be alone and feeling impatient.
- Physical symptoms include pain, fatigue, and muscle aches.
- Sexual function, including arousal, desire, and comfort, can all be adversely affected by the menopause.
- Anxiety and depressive symptoms lead to irritability and intolerance towards a partner and a loss of confidence, affecting the desire to be adventurous or pleasing.
- Vaginal dryness can make sex painful, and the loss of sensitivity means reaching orgasm takes longer.
- Sexual activity often declines with age, due to male or female factors, or both. A study found that sexual dysfunction occurs four times more commonly in women who suffer from genito-urinary symptoms of menopause (GSM) compared to those who don't. The CLOSER study, a large international survey, showed that up to 27% of women are concerned about vaginal discomfort ruining their future sexual lives.
- Menopause-associated psychosexual complaints may include decreased sexual desire, arousal, orgasm, or frequency of intercourse, pain, post-coital bleeding (bleeding after intercourse), lower self-esteem, and a negative impact on relationships. Talk to your GP or gynaecologist when these concerns arise to prevent decreased sexual function from becoming sexual dysfunction and in particular, post-coital bleeding, to rule out potentially serious causes.

Disorders of female sexual function are complex and often require multidisciplinary input. The Study of Women's Health Across the Nation (SWAN) was a longitudinal study of more than 3000 multi-ethnic American women followed through the menopause transition. This study found that the major changes in sexual functioning that occurred with menopause were:

- An increase in vaginal and pelvic pain with sexual intercourse.
- A decrease in sexual desire.

There was no significant difference in arousal, emotional satisfaction, or physical pleasure. SWAN and other studies demonstrate that problems with sexual function are common, with low sexual desire being the most common complaint.

In women, testosterone is made by the ovaries and by the adrenal glands. Although it is considered a male hormone, women have more testosterone than oestradiol. Testosterone levels decrease with age such that a woman in her 40s will have half the level of a woman in her 20s. Although the menopause per se does not appear to dramatically alter testosterone, it is the hormone most researched in terms of sexual desire. Studies have shown there is an association between sexual desire and testosterone levels in some, but not all women. A minimal improvement in sexual satisfaction has been noted in women using testosterone cream.

In women who take low-dose testosterone to improve sexual desire, the most common side effect is hair growth, which may be at the site of application or in areas typical of being prone to excess hair growth, such as the chin and lip. Studies have demonstrated the safety of testosterone use for up to three years. AndroFeme® is TGA-approved in Australia for the treatment of postmenopausal women experiencing low sexual desire with associated personal distress, also known as hypoactive sexual desire dysfunction, or HSDD. An estimated 1 in 3 Australian women aged 40 to 64 experience HSDD. For women for whom testosterone therapy is effective, it usually results in a subtle increase in desire after several weeks. A significant number of women will be non-responders. If no effect is seen after six months, treatment should be ceased.

Vaginal oestrogen therapy is highly effective in improving symptoms and sexual function.There is no high-quality evidence that systemic oestrogen therapy improves sexual function over and above its effect on vaginal health and vasomotor symptoms.

Living an overall healthy life is very important. Women should maintain good energy, sleep well, keep physically active and eat well.