SEXUAL MEDICINE REVIEWS

Couplepause: A New Paradigm in Treating Sexual Dysfunction During Menopause and Andropause

Emmanuele A. Jannini, MD,[1] and Rossella E. Nappi, MD, PhD[2,3]

ABSTRACT

Background: At midlife and beyond, both men and women face organic changes that can affect sexual functioning. For women, ovarian exhaustion causes estrogen deficiency, leading to genitourinary syndrome of menopause, which may include vaginal dryness, irritation/itching, inadequate lubrication, and dyspareunia. Hypoactive sexual desire disorder also can result from biopsychosocial factors. For men, erectile dysfunction prevalence increases with age, and some men develop testosterone deficiency.

Aim: In this narrative review, we summarize the literature on how menopause and andropause can affect the sexual health of both the patient and partner and describe a new paradigm ("couplepause") for addressing the sexual health needs of the aging couple as a whole.

Methods: We combined a literature review conducted using PubMed with insights garnered from our own clinical experiences.

Outcomes: We reviewed publications relating to couples-based approaches to sexual dysfunction, male perceptions of female sexual dysfunction, female perceptions of male sexual dysfunction, interactions between male and female sexual dysfunctions, sexual dysfunction and midlife changes in homosexual couples, and impact of pharmacologic treatments for sexual dysfunctions on the couple's sexual health.

Results: Both members of a couple may experience age-related changes concurrently and interdependently. In such cases, it is unhelpful, and sometimes detrimental, to treat the symptoms for only one member of the couple without also treating the other. Therefore, as an evolution of the couple-oriented approaches of Masters and Johnson and others, we introduce the concept of couplepause and the need for a new diagnostic and therapeutic paradigm that addresses the sexual health needs of the aging couple as a whole rather than treating the individual patient in isolation.

Conclusion: Taking a couple-oriented approach to evaluate and manage couplepause in the latter half of life can dramatically and simultaneously help both members of the couple to improve sexual satisfaction and intimacy. **Jannini EA, Nappi RE. Couplepause: A New Paradigm in Treating Sexual Dysfunction During Menopause and Andropause. Sex Med Rev 2018;XX:XXX−XXX.**

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Key Words: Menopause; Andropause; Sexual health; Sexual dysfunction; Genitourinary syndrome of menopause; Erectile dysfunction; Couple

INTRODUCTION

In midlife and beyond, women and men experience changes that can affect their own and partner's sexual health and relationships. Clinicians should approach these changes as a couple's issue for patients who are in long-term, stable relationships. It should be noted that sexual dysfunctions may also occur among the many aging individuals who are not in such relationships, and those needs should continue to be handled on an individual basis.

Diminished estrogen levels post-menopause can lead to genitourinary syndrome of menopause (GSM), which affects about 50% of post-menopausal women.[1] GSM encompasses vulvar-vaginal atrophy (VVA) symptoms (Table 1)[1-9] and urinary symptoms.[2,3] Common post-menopausal sexual dysfunctions include hypoactive sexual desire disorder (HSDD) and dyspareunia,[10] which may result from a complex interplay among biopsychosocial factors. Some women develop female androgen insufficiency syndrome (low testosterone), which can cause low

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[1]Endocrinology and Medical Sexology (ENDOSEX), Department of Systems Medicine, University of Rome Tor Vergata, Roma, Italy;

[2]Research Center for Reproductive Medicine, Gynecological Endocrinology and Menopause, IRCCS (Scientific Institute for Research and Care) San Matteo Foundation, Pavia, Italy;

[3]Department of Clinical, Surgical, Diagnostic, and Pediatric Sciences, University of Pavia, Pavia, Italy

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Table 1. Effects of menopause and andropause on sexual health

Vulvar/vaginal and sexual changes due to estrogen deficiency in menopause[1–6]	Sexual changes due to declining testosterone levels in andropause[7–9]
• Genital dryness, itching, irritation	• Erectile dysfunction
• Insufficient lubrication during sexual activity	• Reduced frequency of morning erections
• Post-coital bleeding	• Decreased libido
• Narrowing/shortening of vaginal vault	• Impaired ejaculatory and orgasmic function
• Loss of pubic hair	• Loss of pubic and other body hair
• Atrophy of labia and loss of vulvar fat; development of vulvar fissures	• Decreased endurance, greater fatigue
• Other vaginal changes (thinning of vaginal epithelium, development of petechiae or ulcerations, loss of rugae, increased pH, diminished elasticity, increased collage turnover, decreased blood flow, changes to native bacterial populations)	
• Recession, phimosis, or excessive exposure of clitoris	
• Hypoactive sexual desire disorder	
• Dyspareunia	

libido and mood.[11] Diagnosis of this syndrome is challenging because sensitive assays for measuring testosterone in women are not widely available, and a normal reference range is poorly defined.[11] Sexual symptoms post-menopause usually persist, and affect >60% of women in their early 60s.[12]

At midlife and beyond, men generally experience a gradual decline in testosterone levels, sometimes referred to as andropause.[7] Because not all men develop testosterone deficiency and not all men with below-normal testosterone levels have clinical symptoms,[7,13] the term "andropause" remains somewhat controversial and some professional associations prefer the terms "late-onset hypogonadism"[8] or "testosterone deficiency."[9] Nonetheless, "andropause" is a well-recognized term by patients and physicians alike, as well as some professional societies such as the European Menopause and Andropause Society. Diminished testosterone activity may cause physical and emotional changes (Table 1) that can affect men's sexual health and intimate relationships, including erectile dysfunction (ED), decreased libido, and impaired ejaculatory or orgasmic function.[7,9] ED correlates with age: the incidence is about 6–15% at ages 40–49 years, 19–22% at 50–59 years, 30–44% at 60–69 years, and 37%–70% among men age ≥70 years.[14–16]

Midlife physical, psychological, and relational changes affect the sexual health of both members of a couple, whether they occur in one member or both. In our clinical experience, and some reports,[17,18] sexual symptoms in one partner may worsen the other partner's symptoms (eg, not feeling desired can lead to doubts about one's attractiveness and contribute to lack of desire, or if the male partner has untreated ED, the female partner may be less motivated to treat VVA). In addition, the International Survey of Relationships, an international survey of 200 midlife couples, found that a person was more likely to be sexually satisfied and happy in their relationship if their partner reported good health, good sexual functioning, and happiness with the relationship, although the partner's sexual functioning had a greater influence on male sexual satisfaction vs female sexual satisfaction.[18,19] Therefore, by addressing sexual health needs of a patient without considering the potential impact on or contributions of the partner's health, clinicians are not fulfilling real-life needs of older couples (Figure 1A). We suggest that experts in sexual medicine, andrologists, obstetricians/gynecologists, endocrinologists, urologists, and other physicians and psychosexologists who treat menopause or andropause symptoms begin thinking in terms of couplepause, a new paradigm that considers

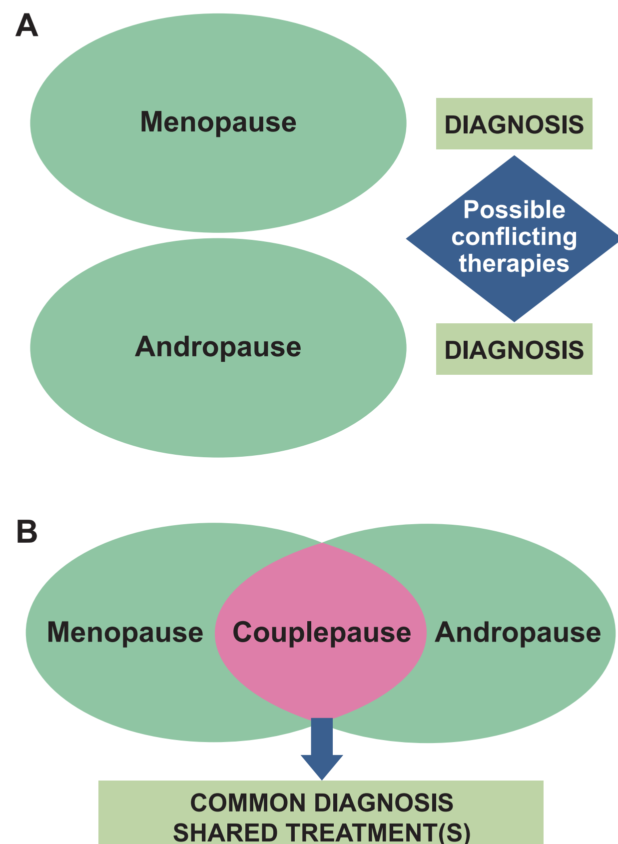

Figure 1. Current approach (A) to managing menopause and andropause. Couplepause (B) is the new diagnostic and therapeutic paradigm where the risks of conflicting therapies are minimized and the therapeutic success improved.

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