



Managing the Hypoactive Sexual Desire Disorder in Women

See also pages 429,
458, and 467

Marking an initiative by a signal date, motif, or event underscores its importance and often promotes its success. For example, in its 2004 initiative to promote awareness of cardiovascular disease as a major cause of mortality in women, the American Heart Association chose the first Friday in February of each year for an annual campaign against this disease in women and selected a red dress as the campaign's motif.¹ "Go Red for Women" proved remarkably successful in engendering awareness regarding this leading cause of mortality in women and in stimulating and supporting research in this disease.¹

To signal its new initiative in women's health, the *Proceedings* is privileged and pleased to publish in this issue the review by Clayton et al² entitled "The International Society for the Study of Women's Sexual Health Process of Care for Management of Hypoactive Sexual Desire Disorder in Women." Women's health merits more attention than it receives in general medical journals, and, to this end, the *Proceedings* introduced a section dedicated to this underserved field. This section in the *Proceedings* recruits and publishes original articles, reviews, commentaries, perspectives, and correspondence on relevant issues and topics within the broad range of women's health. The current article by Clayton et al uniquely and comprehensively discusses a topic (hypoactive sexual desire disorder [HSDD]) in need of such coverage: HSDD is the most common sexual dysfunction in women, affecting 10% or more of adult women, and is attended by substantial psychological and physical ailments. Yet health care professionals and patients alike often shy away from addressing this issue in the patient care setting, and the medical literature currently lacks an encompassing treatment of this topic, such as the one provided by Clayton et al in this issue of the *Proceedings*.²

This article is the result of a collaboration of 17 international experts in the field drawn from relevant disciplines including sexual medicine, psychiatry, obstetrics and gynecology, urology,

internal medicine, and aging and brought together under the auspices of the International Society for the Study of Women's Sexual Health (ISSWSH). Each participant first undertook an evidence-based review of the literature, and then they all met for 2 days to discuss, debate, and develop appropriate guidelines; the present article is the result of such deliberations.²

Clayton et al sequentially review all aspects of HSDD including (1) its definition, clinical significance, epidemiology, and physiology, (2) screening approaches for sexual problems, (3) diagnostic strategies for HSDD, (4) the detection of potentially modifiable factors by physical examination and laboratory tests, and (5) the spectrum and significance of modifiable factors. This review then leads to an in-depth discussion of therapeutic approaches.² First- and second-line therapies include education and modification of potentially contributing factors; third-line options involve sex therapy, central nervous system agents, and hormonal therapy. Follow-up care and reassessment are outlined prior to a general overview and concluding comments. The centerpiece of the article is the process of care developed by International Society for the Study of Women's Sexual Health and delineated in Figure 1 in their review.²

Cornerstone considerations discussed by Clayton et al include the extent to which HSDD causes distress and debilitation and exists in a bidirectional relationship with depression; how the health care professional with an appropriate screening technique can determine whether HSDD is present in a given patient and, once diagnosed, can then delineate the specific subtype of HSDD that exists—generalized, situational, acquired, or lifelong—and the central roles of education and attention to potentially modifiable factors as therapeutic strategies in HSDD.²

Clayton et al also emphasize the involvement of the patient in the approach to management and decision making.² Sexual health and dysfunction are among the most intimate

and guarded aspects of a patient's life, and thus the management of the HSDD must be patient-centered. Patient-centered care, as defined by the Institute of Medicine, is "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."³ Eight essential principles, as delineated by the Picker Institute, underpin patient-centered care, and these include: "Respect for patients...; coordination...of care;...communication and education; physical comfort; emotional support...; involvement of family and friends; continuity and transition; and access to care."⁴ In the provision of such care to patients with HSDD, 3 considerations merit emphasis. First, the health care professional must have an understanding and appreciation of, and sensitivity to, human sexuality in its broadest compass, and not just from the perspective of conventional norms and practices. Second, physicians should readily consult, when and where indicated, experts in the field, given the complexity of the issues and the multidisciplinary approach that is often needed. Third, because shared decision making is the defining aim and essence of patient-centered care,⁵ patients must be entirely involved in their management in general and in the use of pharmacological agents/hormonal therapy in particular. In the United States, for example, flibanserin is the one central nervous system agent that is approved by the US Food and Drug Administration (FDA) for use in premenopausal women but is not FDA-approved for use in postmenopausal women; hormonal therapy such as transdermal testosterone is not FDA-approved. Patients must be fully informed and educated by their physicians regarding the known risks and adverse effects of pharmacological/hormonal therapy; concerns that may exist regarding possible risks of such therapies and the current uncertainty in adequately addressing them because of deficiencies in the available literature and knowledge; whether therapeutic options are FDA-approved; and, if not FDA-approved, the issues and concerns that may underlie such lack of approval.

Promoting women's health is often impeded by either commonly held misconceptions regarding a specific issue or by a lack of requisite inquiry directed to specific areas. An example of the former was the

erroneous belief that cardiovascular disease is not a dominant cause of mortality in women, a myth dispelled, in part, by "Go Red for Women."¹ An example of the latter is sexual disorders in women. The present work of Clayton et al is especially meritorious as it directs attention to this field; it provides a comprehensive review and informed guidelines on HSDD; and it demonstrates how collaborative study by a society of experts dedicated to this field can meaningfully advance this aspect of women's health.² The *Proceedings* is committed to publishing such important and timely contributions and all others that advance the literature on women's health by providing either a broad perspective of a topical area or the focused study of a specific issue. Relevant to this initiative are 2 other articles in this issue of the *Proceedings* that we wish to bring to the attention of our readers: the article by Murphy et al⁶ regarding the risk factors for positive margins in women undergoing conservative surgery for breast cancer and the article by de Mooij et al⁷ on a novel management model for women with low-risk pregnancies.

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