Loss of Libido

Description

Libido is conscious or unconscious sexual desire. Loss of libido is a sexual dysfunction relating to loss of sexual desire or sexual drive and is also termed hypoactive sexual desire disorder (HSDD). Loss of libido must not be confused with other sexual dysfunctions as these can impair libido. Erectile Dysfunction is dealt with in a separate article.

Epidemiology

- It is a common problem but it is difficult to quantify because definitions may vary and few of those who experience loss of libido consult a doctor even when it may be the cause of relationship difficulties.
- There is a wide 'normal' range. Studies have reported a prevalence in men between 1-20%. \(^\text{[2]}\)
- The Global Study of Sexual Attitudes and Behaviors (an international survey of various aspects of sex and relationships among adults aged 40-80 years) reported a prevalence of 26% to 43% of women. \(^\text{[2]}\)
- A review of articles revealed some interesting points:
  - In Hong Kong a telephone survey showed a high prevalence of sexual problems generally and in women a 25% prevalence of loss of interest in sex. Sex-related knowledge, perceived importance of sex, perceived physical health status and sexual satisfaction were predictors of sexual problems. \(^\text{[3]}\)
  - Gender differences and strong cultural influences were apparent. Moreover, sexual problems and sexual satisfaction were associated with mental health, quality of life indicators and overall life satisfaction. \(^\text{[3, 4]}\)
  - It is normal for sexual drive to diminish with the passage of years but the degree is highly variable. \(^\text{[5]}\) This effect is significantly more marked in women than in men. \(^\text{[6]}\) Diminished sexual potency and vaginal dryness may contribute to reduced libido.
  - It also seems that qualitative aspects of sexual activity may change and improve with age. \(^\text{[7]}\) It would be a mistake to link libido with either 'performance' or sexual satisfaction.

Presentation

It is fairly uncommon for a patient to present directly with a complaint of loss of libido. It is more likely to be a component of other complaints. Many people are still reluctant to discuss such matters and feel embarrassed. It is often introduced into the consultation by patients as an apparent afterthought. The following are likely to need consideration:

- What does the patient mean by loss of sexual drive? Is it loss of the will or loss of the way?
- Is there a problem with performance? If so, which came first?
- How long ago did it start? Was it gradual or sudden? Has it been progressive?
- How is the relationship? If it is problematical, which came first?
- Has there been criticism from the partner or even a sympathetic discussion?
- How does the patient feel about the loss of libido? Perhaps the patient feels that it is not really a problem, except for the demands of the partner.
- What sexual difficulties have been experienced (including erectile dysfunction or dyspareunia)?
- Whose idea was the consultation? Is the patient here willingly or under duress?
- Are there any other problems of health? Are there any chronic diseases? What medication is taken? Has there been any recent change?
- What is their alcohol intake?
- If a woman of appropriate age, ask about symptoms of the climacteric.
- If appropriate, ask about contraception. There may be fear of pregnancy.
• Ask about mental health too. Screening for depression in general practice can be performed with just two questions:
  • During the last month, have you often been bothered by feeling down, depressed or hopeless?
  • During the last month, have you often been bothered by having little interest or pleasure in doing things?

• Ask about work. Are there pressures there? Are there financial problems or family difficulties?
• Ask what may be the most revealing question of them all. ‘What do you think is the reason for your loss of sexual drive?’
• Difficulties with sexuality may lead to problems with libido.

**Differential diagnosis**

• Any form of mental illness is likely to be associated with loss of libido. The most common of these is depression. Other features of depression may be clear, or a tool such as the Hospital Anxiety and Depression (HAD) Scale may be needed to test the diagnosis or to convince the patient.[8]
• Libido is associated with well-being. Hence, illness will depress libido. Loss of libido is very common during cancer treatment.
• Overwork, chronic tiredness and anxiety can all depress libido.
• Falling levels of hormones may impair libido. This can occur in the climacteric or with the treatment of prostate cancer.
• Some drugs may induce loss of libido, perhaps through an element of depression. Antihypertensives are the most notorious.
• Loss of libido after having a baby is not uncommon. Hormonal fluctuation can be a problem. There may have been vaginal trauma and there may still be some tenderness. There may have been a change in self-image. Mothers with small babies are often very tired and may be frequently disturbed at night.
• **Chronic high intake of alcohol** depresses sexual desire and cirrhosis can depress androgen levels.
• If sex is not fulfilling then interest will wane. There may be erectile dysfunction, premature ejaculation, failure of ejaculation or performance anxiety due to criticism.
• **Dyspareunia**, often due to vaginal dryness or even susceptibility to recurrent cystitis, may take the pleasure from sex and hence the drive.
• Libido will suffer if there are problems within a relationship. Sex may be less attractive to one who thinks that the partner is having an affair.
• Sex may have become ritualistic and mundane. There may be differences in ambition and imagination between partners when considering how to enliven their sex life.

**Examination**

Examination is likely to be unrewarding unless there are specific indicators from the history. However, it may be reassuring to the patient to show that the doctor is taking the issue seriously and there is no physical abnormality.

**Investigations**

If the diagnosis is already clear then further investigations are not required.

• A tool such as the HADS may be useful.
• FBC is a good, general screening test. A raised MCV may point to excessive alcohol consumption.
• U&E will check for renal disease and Na and K may be deranged in adrenal disease.
• LFTs may also suggest excessive intake of alcohol, especially if gamma GT is raised.
• TFTs may demonstrate hypothyroidism.
• Follicle-stimulating hormone (FSH), luteinising hormone (LH), prolactin and either estradiol or testosterone may indicate hormonal inadequacy. This may be due to drugs or alcohol.
• If erectile dysfunction appears to be a problem, and poor performance may have led to loss of interest then fasting glucose and cholesterol are in order, as there is a strong link between erectile dysfunction and both diabetes and coronary heart disease.
Associated diseases

- Probably the most frequent co-existent disease to discover is depression.
- Hormone inadequacy, including hypothyroidism, is less common.
- Problems with relationships are common.

Management

Management depends upon cause.

- If there are problems with the relationship then counselling may be required. An agency such as Relate, may be very valuable. See separate article Sex Therapy and Counselling.
- If the problem is overwork, financial worries and associated anxiety, lifestyle needs to be considered. The relationship between work and the rest of life needs to be examined by the patient and spouse. If there is worry over financial matters these may need appropriate professional help and advice.
- Depression may need treatment. Some antidepressants have been associated with loss of libido but it may be difficult to know if the cause is the drug or the underlying depression.
- Antipsychotics such as phenothiazines and haloperidol raise prolactin. Raised prolactin is associated with dampened sexual arousal.
- Counselling may be required with regard to alcohol use.
- If hypotensive treatment is thought to be a problem, a change in the type of medication may be tried.
- If hypothyroidism has been diagnosed then thyroxine is started to suppress the level of TSH.
- Oestrogen appears to bring some benefit in menopausal women but its specific effects on libido as opposed to the other sexual functions during the menopausal phase require further research.\(^9\)
- A transdermal testosterone patch was been shown to be effective for HSDD in naturally menopausal women.\(^10\) Initially licensed for use in women who had surgically-induced menopause and were also on HRT, it has since been withdrawn in the UK for commercial reasons.\(^11\)
- The literature supporting the use of testosterone for the treatment of HSDD in men is equivocal. Some studies support benefit whilst others do not. This variability may well be due to the interaction between exogenous testosterone and the homeostatic mechanism governing the level of its naturally occurring counterpart.\(^12\) Whilst testosterone preparations are available for the management of hypogonadal states, none are available for the treatment of males with HSDD per se who have normal androgen levels and are eugonadal (ie have two morphologically normal testes).\(^13\)
- If there seems to be an underlying problem of a psychosexual nature then an appropriate referral may be offered. Relate may be a useful source of help. Medication (such as sildenafil) may be valuable if there is erectile dysfunction.

A review in the Journal of Sexual Medicine, concerning female hypoactive sexual desire, concluded, 'There is a rapidly expanding knowledge base concerning the diagnosis and treatment of HSDD. However, the contemporary clinician is faced with the absence of an approved treatment for this disorder and the lack of clear guidelines concerning the indications and safety of the use of non-approved agents'.\(^14\) A multidisciplinary approach to treatment has been recommended by others which reflects the diverse factors in causation.\(^15\)

Hormones and libido

The suggestion that the cause of impaired libido is a deficiency of hormones is usually overly simplistic. It is likely that there is an interplay between hormonal, neurobiological and psychosocial factors. In general, dopamine, oestrogen, progesterone and testosterone play an excitatory role in sexual desire, whereas serotonin and prolactin have an inhibitory effect.\(^16\)

The changes in reproductive capacity and their relationship with reproductive behaviour are complex.\(^17, 18\)

There was some interest in the role of tibolone in sexual function in women but further research suggests that its benefits are outweighed by long-term safety concerns.\(^19\) A Cochrane review did not find evidence to support the use of either tibolone or selective oestrogen receptor modulators (eg, raloxifene) in the treatment of low libido in perimenopausal or postmenopausal women.\(^20\) Another Cochrane review found that dehydroepiandrosterone may slightly improve sexual function in perimenopausal and postmenopausal women but was associated with significant androgenic effects.\(^21\)
Further reading & references


1. Hypoactive Sexual Desire Disorder; PsychNet-UK
8. Hospital Anxiety and Depression Scale (HADS); GL Assessments

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