Hormone-Sex Drive Link Is Weak in Menopause

BY KATE JOHNSON

Montreal Bureau

NEW ORLEANS — Hormone levels are weakly associated with sexual desire during the menopausal transition, while other sexual desire predictors are more important, according to an analysis of data from the Study of Women's Health Across the Nation.

"This is the first really solid data to nail down the role of hormones in sexual desire," said investigator Dr. John Randolph, professor of obstetrics and gynecology at the University of Michigan, Ann Arbor. But he cautioned that while the study found a significant association between women's sexual desire and their levels of testosterone and follicle-stimulating hormone (FSH), the association was small.

"It's biologically significant but probably not clinically significant—and I'm worried how this information might be misinterpreted," he said at a press conference during the annual meeting of the American Society for Reproductive Medicine. The study found that much stronger predictors of sexual desire were satisfaction with an existing relationship, availability of a partner, and ethnicity.

The multicenter, multiethnic study, funded by the National Institutes of Health, included 3,302 women who were still menstruating at baseline, and followed them with annual serum hormone measurements and sexual desire questionnaires. The aim was to determine the role of hormone levels and their fluctuations over time in changing sexual desire over the menopausal transition. The hormones measured were testosterone, estradiol, FSH, dehydroepiandrosterone (DHEA), sex hormone-binding globulin, and the free hormone indices FEI and FTI.

The data used were from 3,290 women who had at least one and up to six annual serum hormone measurements and sexual desire questionnaires. Testosterone was positively related and FSH was negatively related to sexual desire, Dr. Randolph reported. There was no association observed with estradiol, DHEA, sex hormone-binding globulin, or the free hormone indices FEI and FTI.

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Brief Summary. See full package brochure for complete information.
Patients should be counseled that this product does not protect against HIV-infection (AIDS) and other sexually transmitted diseases.
CONTRAINDICATIONS: Oral contraceptives should not be used in women who currently have the following conditions: • Thrombophlebitis or throm boembolic disorders: • A past history of deep vein thrombophlebitis or thromboembolic disorders: • Cerebrovascular or coronary artery disease (curren or history) • Valvular heart disease with thrombogenic complications • Uncontrolled hypertension • Diabetes with vascular involvement • Headacher with focal neurological symptoms • Major surgery with prolonged immobilization • Known or suspected carcinoma of the breast or personal history of breast cancer • Carcinoma of the endometrium or other known or suspected estrogen dependent neoplasia • Undiagnosed abnormal genital bleeding • Cholestatic jaundice of pregnancy or jaundice with prior pill use • Hepatic adenomas or carcinomas, or active liver disease • Known or suspected pregnancy • Hypersensitivity to any component of this product

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strong-

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findings of minimal risk may be related to the use of oral contraceptive formulations containing lower hormonal doses of estrogens and progestogens.

8. Carbohydrate and Linid Metabolic Effects: Oral contraceptives have been shown to cause glucose intolerance in a significant persentage of users. Oral contraceptives pare in 75 micrograms of estrogens cause byearinsulinism, within lower doses of estrogen cause less glucose intolerance. Progestogens increase insulin secretion and create insulin resistance, this effect varying with different propestational agents. However, in the nonotidate woman, oral contraceptives appear to have on effect or testing blood glucose. Because of these demonstrated effects, prediabetic and diabetic women should be carefully observed while taking oral contraceptives. A small proportion of women will have persistent hypertrighyceridemia while on the pill. As discussed earlier (see WARNINGS. 1.a. and 1.0.), changes in serum trighycerides and lipoprotein tevels have been reported in oral contraceptive users.

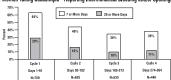
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9. Everated Blood Pressure: Women thin significant hypertrisons on the sound that the incline or hypertension increases with increase in blood pressure has been reported in many oral contraceptive users and with continued use. Data from the Royal College General Practitions and substances and users were should be monitored closely, and if significant elevation of blood pressure occurs, oral contraceptives with the increase in the sound that the incline or hypertension increases with increase in contraception. If women with hypertension effect to use and contraceptives and evaluation of the cause. (See WARNINGS, 1c.)

11. Bleeding Irregularities. When prescribing Seasonique** with continuation of oral contraceptives and evaluation of the cause. (Se

Figure: Percentage of Women Taking Seasonique™ Reporting Intermenstrual Bleeding and/or Spotting.



As in any case of bleeding irregularities, nonhormonal causes should always be considered and adequate diagnostic measures taken to rule out malignancy or pregnancy. In the event of amenorthea, pregnancy should be ruled out. Some women may encounter post-pill amenorrhea or oligomenorrhea (possibly with anyoutation), especially when such a condition was preexistent.

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Senainly transmitted diseases. Patients should be counseled that this product does not protect against HIV infection (AUIS) and other sexualty transmitted diseases.
 Physical Examination and Follow-up: A periodic history and physical examination are appropriate for all women, including women using oral contraceptives. The physical examination however, may be deferred until after initiation of oral contraceptives if requested by the women and judged appropriate by the clinican. The physical examination should include special reference to blood pressure, breasts, abdomen and pelvic organs, including cervical cytology, and relevant alboratory tests. In case of fundagnosed, persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be conducted to rule out malignancy. Women with a strong lamin history of treats cancer or who have breast notables should be monitored with particular care.
 Jujid Disorders: Women who are being treated for hyperlipidenies more difficult. (See WARNINGS 14) in patients with mitial defects of lipoprotein metabolism receiving estrogen-containing preparations, there have been case reports of significant elevations of plasma triglycerides leading to pancreatitis.
 Liver Function: If juundice develops in any woman receiving such drugs, the medication should be discontinued. Steroid hormones may be poorly metabolized in patients with impatied liver function.
 Full Retention: Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with moralitic inhight the aggrarated by fluid retention.
 Full Retention: Oral contraceptives and contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug related.
 Orandact Leisses: Contraceptive effectiveness may be reduced when hormonal contraceptives and these analysis and pr

centrations of acateminophen and increased clearance of temazepam, salifylic acid, morphine and clothoric acid, due to induction of conjugation have been noted when these drugs were administered with combination or al contraceptives.

9, Interactions with Laboratory Tests - See Package Insert for complete information,

10, Carcinogenesis: See WARNINGS. 11, Pregnancy: Pregnancy Category X. See CONTRAINDICATIONS and WARNINGS. 12, Nursing Mothers: Small amounts of oral contraceptive steroids and/or metabolites have been identified in the milk of nursing mothers, and a few adverse effects on the child have been reported, including jaundics and breast enlargement. In addition, oil contraceptives given in the postpartum period may interfere with lactation by decreasing the quantity and quality of breast milk. If possible, the nursing mother should be advised not to use oral contraceptives but to use other forms or contraceptive warened prevailed. In a postpubertal advisescents under the age of 16 and users 16 and other. Use of the contraceptive such as the contraceptive warened prevailed in the milk of nursing mothers and a few adverse effects on the child have been reported, including jaundics and breast enlargement. In a postpubertal advisescents under the age of 16 and users 16 and other. Use of the contraceptive such as a contraceptive of the contraceptive such as a contraceptive and are believed to be drug related. *Nature a *Nature and such as a contraceptive such as a domininal cramps and bloading) *Braakfinough bleeding *Spotting *Change in mensitual flow *Amenorinae *Temporary interfility after dissontinuction of treatment *Edemantitud reterions *Makamach

OVERDOSAGE: Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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Low DHEA Level **Doubles Sexual Dysfunction Risk**

NEW ORLEANS — Postmenopausal women are more than twice as likely to experience sexual dysfunction as are younger women, and their risk also is doubled if they have low levels of dehydroepiandrosterone (DHEA), according to new data from the Penn Ovarian Aging Study.

"Higher levels of DHEA appear to be protective in this population," said Dr. Clarisa R. Gracia, who presented the findings at the annual meeting of the American Society for Reproductive Medicine. "This raises the question about whether supplementation is an option—although there is no evidence to support this at this time," she commented at a press conference during the meeting.

The Penn Ovarian Aging Study, which included more than 400 healthy women aged 35-47 years, aimed to examine the natural progression of ovarian function during the transition to menopause.

Women were followed for 3 years with questionnaires, including the Female Sexual Function Index, and annual measurement of reproductive hormones including follicle-stimulating hormone, luteinizing hormone, sex hormone-binding globulin, total testosterone, and DHEA.

This analysis of the study included 311 women-102 with sexual dysfunction and 209 without. Women with sexual dysfunction were twice as likely to have DHEA levels in the lowest quartile, with an average measurement of 66.5 mcg/dL compared with an average measurement of 81.1 mcg/dL in those without sexual dysfunction. No significant associations were noted between the other measured hormones and sexual dysfunction, according to Dr. Gracia of the University of Pennsylvania in Philadelphia.

Multivariate analysis revealed that high DHEA levels were protective against sexual dysfunction, while factors associated with sexual dysfunction included absence of a sexual partner (OR 11.2), high anxiety (OR 3.8), and children under age of 18 living at home (OR 1.6), she said.

-Kate Johnson

Reference: 1. Data on file. Duramed Pharmaceuticals Inc, Pomona, NY.