Behavioral modification and nonpharmacologic therapies should be a first step. Patient and partner counseling may improve communication and relationship strains. Lifestyle changes involving known risk factors can be an important part of the treatment process. Emphasis on maximizing physical health and avoiding lifestyles (e.g., smoking, alcohol abuse) and medications likely to produce FSD is important (Table 397-3). The use of topical lubricants may address complaints of dyspareunia and dryness. Contributing medications such as antidepressants may need to be altered, including the use of medications with less impact on sexual function, dose reduction, medication switching, or drug holidays.

HORMONAL THERAPY

In postmenopausal women, estrogen replacement therapy may be helpful in treating vaginal atrophy, decreasing coital pain, and improving clitoral sensitivity **(Chap. 395)**. Menopause and its transition represent significant risk factors for the development of vulvovaginal atrophy–related sexual dysfunction. Available vaginal estrogen preparations include conjugated equine estrogens, estradiol vaginal cream, a sustained-release intravaginal estradiol ring, or a low-dose estradiol tablet. Vaginal estrogen preparations with the lowest systemic absorption rate may be preferred in women with history of breast cancer and severe vaginal atrophy. Vaginal lubricants and moisturizers applied on a regular basis have an efficacy comparable to that of local estrogen therapy and should be offered to women wishing to avoid the use of vaginal estrogens. If a hormonal supplement is chosen, then estrogen replacement in the form of local cream is the preferred method as it avoids systemic side effects. Androgen levels in women decline substantially before menopause. However, low levels of testosterone or DHEA are not effective predictors of a positive therapeutic outcome with androgen therapy. The widespread use of exogenous androgens is not supported by the literature except in select circumstances (premature ovarian failure or menopausal states) and in secondary arousal disorders.

Atrophic vaginitis is very common in postmenopausal women and is most commonly treated with estrogen-based treatments.