



SEXUAL DYSFUNCTION



How to ask about, and manage, the undertreated problem of sexual dysfunction

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Dr. Levy reports no financial relationships relevant to this article.

Sexual dysfunction is common among women, with an overall incidence of about 40%—even higher in some populations.^{1,2} All the more surprising, then, that only a minority of women raise the topic with their physician. In one well-regarded study, for example, only 22% of older women reported having discussed sex with their physician after the age of 50.³

One reason for the lack of communication may be a sense of discomfort around sexuality, among physicians as well as patients.

Other reasons may include limited time on the part of physicians, and a lack of clarity about how to evaluate sexual function in women.

How, then, to assess a woman's sexual function? In this Update, I address this question, and offer numerous others you can discuss with your patients without adding a significant time burden to your day. A sidebar on page 27 focuses on a few strategies for tackling sexual function in an efficient and timely manner.

Linear model of female sexual function is not clinically useful

The classical linear model that proposes that women progress from sexual excitement to plateau, orgasm, and resolution is not that helpful when we are trying to determine the cause of our patient's sexual problem and choose a course of treatment. More revealing is the biopsychosocial model, which considers physical, psychological, relational, and situational variables in exploring sexual function. If a physician focuses the history on these four aspects of sexual function, she generally can discover the source of any problem.

According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, female sexual dysfunction typically falls into one or more categories:

- **desire disorders** – hypoactive sexual desire disorder (HSDD) and sexual aversion disorder
- **problems with arousal** – female sexual arousal disorder
- **pain disorders** – dyspareunia and vaginismus
- **orgasmic disorders** – female orgasmic disorder.⁴

If we superimpose this framework over the biopsychosocial model, diagnosis and management can be elucidated further. For example, we might see a 57-year-old patient who complains during her annual exam about decreased libido. We ask about menopausal symptoms and general health and screen for depression and intimate partner

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Dr. Levy describes the many variables that may influence sexual desire, at obgmanagement.com

How to find time to address sexual function

In an ObGyn practice already pressed for time, adding a new domain of concern to the mix can be a challenge. (This is assuming you do not already ask patients routinely about sexual function.) It may not be as challenging as you think, however. One way to start is to add a few basic questions about sexual function to the intake form. This approach serves two purposes:

- It validates sexual function as an important part of health
- It allows the patient to identify any problems without having to raise the subject herself.

The second purpose is especially important because many patients are reluctant to broach the topic of sex.

After reviewing the intake form, you can take a more detailed history, addressing the concerns gently and matter of factly, to determine the scope of the problem, its duration, and any steps the patient has already taken to remedy it. The physical exam then can be more appropriately focused.

Straightforward areas of dysfunction, such as perimenopausal vaginal dryness, usually can be addressed in the same visit. More extensive problems may merit a separate office visit.

violence. On questioning, we discover that her partner was diagnosed with prostate cancer 2 years earlier and is able to achieve an erection on occasion with the use of medication, but there is fear, for both of them, that the erection will not last. This development has changed their sexual behaviors in ways that are not satisfying for either of them.

Clearly, addressing this fairly common scenario as “female sexual dysfunction” will overlook the main issues. This couple needs help communicating their love and support for each other and some direction to help them learn new ways to express themselves sexually that can be satisfying for both. It is important to remain sensitive to the patient’s

(and partner’s) social and medical history, age, and physiological status.

Keep in mind, however, that it is common to see overlapping disorders in a patient with sexual dysfunction. For example, a lack of desire can lead to diminished arousal and anorgasmia. For this reason, when one disorder is diagnosed, ask the patient to describe any other problems she may have. Also inquire about the chronology of multiple sexual disorders in order to determine which problem came first.

One last caveat: When you are evaluating a patient’s sexual function, don’t assume that she has a male partner—or any partner at all.



Overlapping disorders are common in a patient who has sexual dysfunction

Don’t overlook psychosocial variables when assessing desire disorders

Prevalence of low sexual desire ranges from 26.7% among premenopausal women to 52.4% among naturally menopausal women—no small problem.⁵

The Female Sexual Function Index (FSFI), a multidimensional self-reporting tool used widely in research, describes sexual

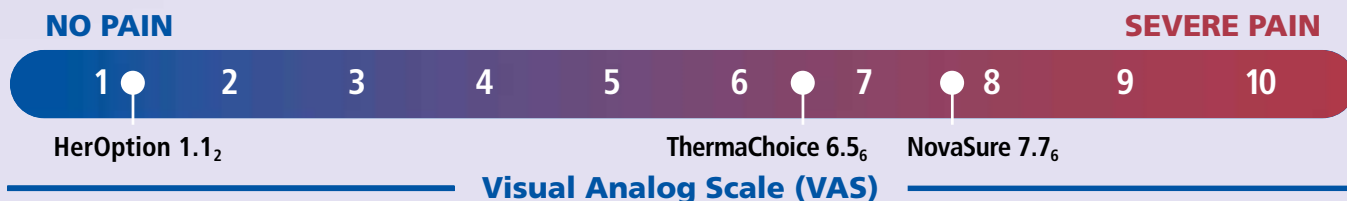
desire as “a feeling that includes wanting to have a sexual experience, feeling receptive to a partner’s sexual initiation, and thinking or fantasizing about having sex.”⁶ The FSFI attempts to discern whether a desire disorder is present by asking about the patient’s feelings **over the preceding 4 weeks.**

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UPDATE

sexual dysfunction

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Sexual aversion disorder is a psychiatric illness that requires management by a qualified mental health professional

Among the questions it poses are:

- How often have you felt sexual desire?
- How would you rate your level of sexual desire or interest?

These questions may be useful as a starting point when a patient complains of low desire.

Low desire may have multiple causes

Desire disorders may be associated with depression, but they also may arise from experiences and attitudes that occurred during childhood. For example, women who had a strict religious upbringing or were exposed to negative parental attitudes toward sex may suffer lifelong psychological effects. Other deep-seated sources of impaired desire include childhood physical, sexual, and emotional abuse.

These influences may not be readily apparent if the woman is in a new relationship, when powerful hormonal determinants of attraction—driven by phenylethylamine—hold sway. Once the relationship matures, however, and the “lust” begins to recede and a more comfortable, stable relationship emerges—these psychological barriers to physical enjoyment may come to the fore.

Referral is indicated for SAD

Sexual aversion disorder (SAD) is

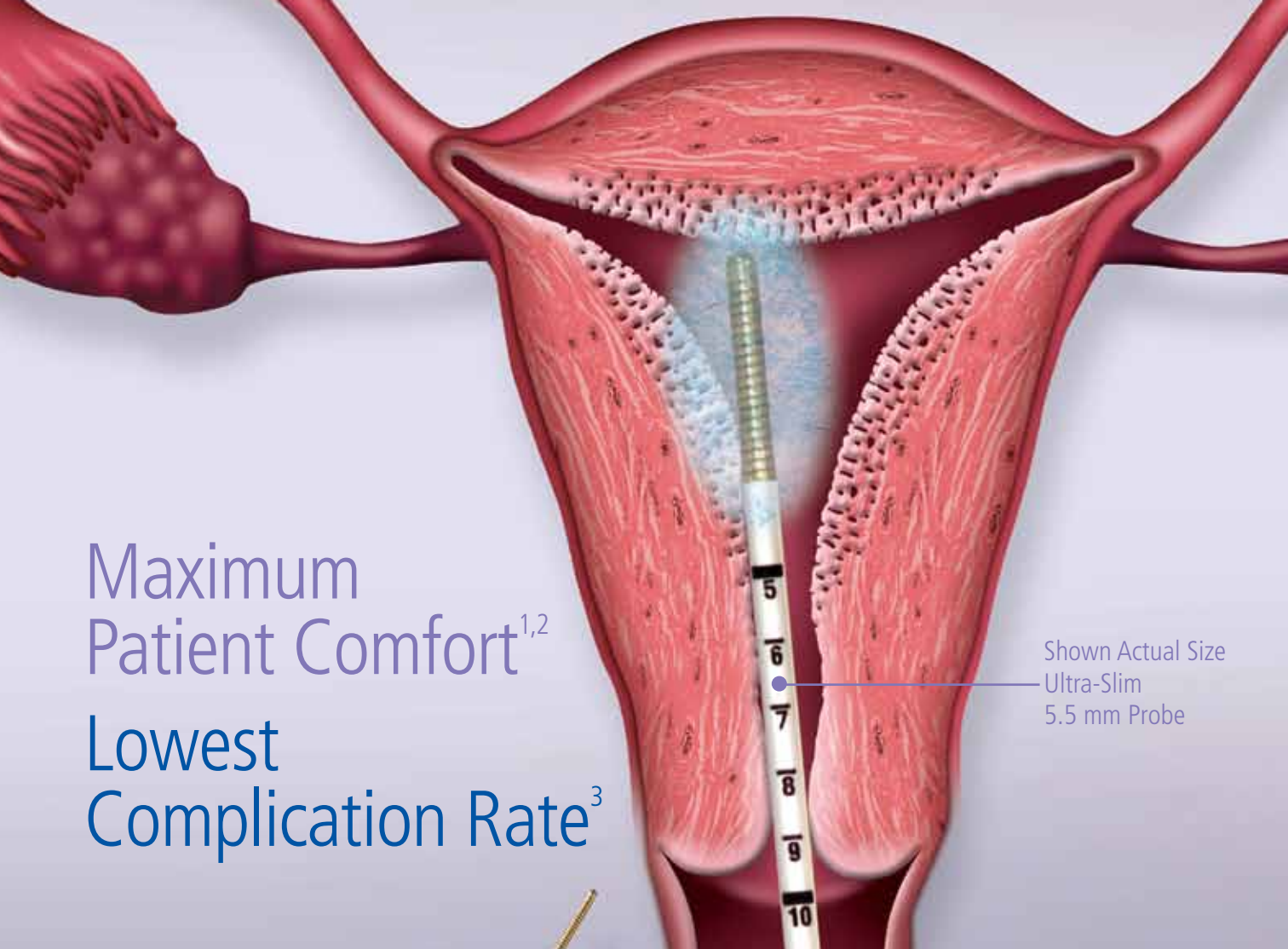
characterized by “persistent or recurrent extreme aversion to and avoidance of all (or almost all) genital sexual contact with a sexual partner,” according to *DSM-IV*.² Unlike HSDD, which reflects a lack of interest in sex, SAD may involve physiologic aversion responses such as nausea, revulsion, and shortness of breath.³

SAD is a psychiatric illness that requires management by a qualified mental health professional, preferably a sex therapist. (For information on how to find a qualified therapist, consult the American Association of Sexuality Educators, Counselors, and Therapists at www.aasect.org.)

No FDA-approved drug for HSDD

HSDD is characterized by “a deficiency or absence of sexual fantasies and desire for sexual activity,” according to *DSM-IV*.⁴ It may be treated by an experienced psychotherapist without additional training in sexual therapy.

Regrettably, attempts to treat HSDD with pharmacologic agents have been modestly successful at best, and we lack FDA-approved medications. Some trials demonstrated a slight improvement in desire among surgically menopausal women on estrogen therapy when a supraphysiologic dose of testosterone was given. Off-label use of a compounded testosterone or a lower



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1, 2, 3, 4, 5 For reference details see <http://www.coopersurgical.com/Documents/HerOptionBrochure.pdf>
6 Clark et al; Bipolar Radiofrequency Compared with Thermal Balloon Endometrial Ablation in the Office; Obstetrics & Gynecology; Jan 2011

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dose of a male testosterone product may be useful.

Avoid laboratory assays for testosterone—serum or salivary—in the diagnosis of HSDD. However, if a commercial testosterone product is given, testing may

be useful to prevent excessive levels of testosterone and associated (and sometimes irreversible) physiologic changes, such as male-pattern hair loss and deepening of the voice.

Failure to lubricate is the hallmark of female sexual arousal disorder

The *DSM-IV* defines female sexual arousal disorder as persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate physiologic response (lubrication, swelling) of sexual excitement.⁴ It is analogous to erectile dysfunction in men. In women, however, it may be difficult to distinguish this condition from primary desire disorder, particularly in cases in which a pattern of poor arousal, dryness, and dyspareunia has developed. The hallmark of female sexual arousal disorder is a failure to lubricate.

A few simple questions

Among the questions you might ask the patient:

- Do you feel interested in sexual activity?
- Do you have a problem lubricating well?
- Do you use a lubricant for sexual activity? If so, does it work to make sexual intercourse comfortable?

Other variables to consider

Arousal occurs secondary to genital vasodilation and tissue engorgement. It may be disturbed by any physiologic condition that reduces blood flow, such as smoking, hypertension, diabetes, and hypoenestrogenism.

Decreased sensation sometimes may contribute to arousal disorder. For example, when the vagina and external genitalia experience decreased sensation, the cause may be physiologic, neurologic, or supratentorial.

Unlike men, women experience very little direct feedback regarding arousal. A disconnect between the sensory afferent input and higher-level awareness is not unusual. A thorough physical and neurologic exam may be necessary to assess the sensory nerves, integrity of the skin (signs of any inflammation), and blood flow to the genitalia.

Referral to a therapist also may be necessary so that other barriers to intimacy and sexuality can be determined.

Pain during sex can trigger desire and arousal disorders

Pain during sexual activity can lead to disorders of desire as well as arousal. When a patient reports pain during sex, pay careful attention to her medical history and perform a detailed physical examination. Patience is vital. Successful treatment of pain disorders

requires commitment from the patient and her partner as well as the medical team.

Consider asking the following questions:

- **Over the past 4 weeks**, how often have you experienced discomfort or pain *during* vaginal penetration?



Successful treatment of pain disorders requires commitment from the patient and her partner as well as the medical team

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- How often have you experienced discomfort or pain *following* vaginal penetration?
- How would you rate your degree of discomfort or pain during or following vaginal penetration?⁶

Consider pain as a cause when any patient reports low libido, as pain is a potent suppressor of desire. A meticulous clinical history is required to determine the cause. For example, it is important to uncover whether the pain is of recent onset or of long duration, or whether it is related to childbirth, lactation, or menopausal changes.

Pain upon penetration could be caused by chemical, infectious, or atrophic vulvovaginitis. Dryness and pain upon penetration are often caused by:

- contact dermatitis
- irritation from soaps or scrubbing
- daily use of panty liners
- use of so-called feminine hygiene products
- regular use of swimming pools or hot tubs that contain chemicals.

Another cause of pain to consider is vulvar dystrophy. When lichen sclerosis or hypertrophic dystrophy goes untreated, the result may be fibrosis, lack of elasticity, painful fissures, and loss of normal architecture. These changes usually occur in postmenopausal women, so it is important that treatment address both the fibrosis and the hypoestrogenic atrophy.

If treated early, vulvar vestibulitis may not require surgery

Vulvar vestibulitis is poorly understood. It tends to occur most often in premenopausal women, frequently as a result of vulvar infection or during the postpartum period.

Vulvar vestibulitis involves point tenderness—sometimes experienced as a burning, searing sensation—around the introitus, specifically, the vestibular glands. When this condition is suspected, examine the vulva and vestibule with a moistened cotton swab to assess whether the classic distribution of pain is present. The necks of the vestibular glands may appear inflamed and erythematous.

If the condition is treated early enough with topical steroids and, in some cases,

hydroxyzine, surgery may be avoided, provided the patient also avoids topical irritants. In many women, however, vestibulectomy is required to eliminate symptoms.

Vulvodynia may be associated with other pain syndromes

This disorder is a more generalized pain syndrome that involves the entire vulvar region. Like vulvar vestibulitis, it can cause painful penetration. It is also associated with other pain syndromes, including interstitial cystitis and endometriosis. Sensitization to pain at a central level may lead to hyperesthesia and allodynia. Also consider pudendal neuropathy, especially if the patient is a regular bicycle rider.

Treatment usually consists of off-label use of neuromodulators, such as gabapentin, tricyclic antidepressants, or duloxetine. The use of topical local anesthetic creams or gels may also permit pain-free sexual activity.

Vaginismus may indicate a history of sexual abuse

When the perineal muscles surrounding the outer third of the vagina contract involuntarily upon contact with a penis, speculum, or other item, vaginismus may be present. This disorder can be primary or secondary. In primary vaginismus, the patient may be unable to tolerate any vaginal penetration at all, not even a single digit or tampon. When this is the case, the patient may have a history of childhood sexual abuse. Explore her history, including any medical examinations that may have been painful or generated fear and anxiety. Also be aware that women with sexual aversion disorder may present with primary vaginismus.

Secondary vaginismus can occur even after years of satisfying sexual activity when a woman undergoes pelvic reconstructive surgery or develops vulvar dystrophy or vulvovaginal atrophy. Pain or the fear of pain can trigger a powerful reflex spasm of the levator ani musculature. Also keep in mind that secondary vaginismus may not be reproducible during the pelvic examination.

Treatment of both primary and secondary vaginismus includes physical therapy

FAST TRACK

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Sexual dysfunction tends to increase with age

As menopause approaches, so do a number of interrelated issues that may affect a woman's sexual function. Here are five of them:

Body image may deteriorate, leading to feelings of unattractiveness that can lower interest in sexual activity.

Testosterone levels decline throughout a woman's reproductive life, as does estrogen—but the decline in testosterone is much more gradual without any abrupt reduction at menopause. In addition, some common medications, such as oral contraceptives and oral estrogen formulations, increase sex hormone binding globulin, which can reduce dramatically the free testosterone level. Some women are especially sensitive to the effects of these drugs and may report a rapid loss of sexual desire when these agents are given. To sidestep the problem, give transdermal or transvaginal estrogen, when possible.

Comorbidities take a toll on sexual function in many cases. Arthritis, diabetes, cardiovascular disease, and other impairments may hamper sexual satisfaction. In addition, fatigue, insomnia, and depression are common with age.

Medications such as antidepressants (selective serotonin reuptake inhibitors, tricyclics) may inhibit desire and interfere with orgasm.

Partner issues also play a role in diagnosis and treatment of female sexual dysfunction. For example, poor health in the partner can cause or exacerbate sexual problems.

of the pelvic floor using biofeedback. The patient's partner also needs to attend at least one session to learn techniques to prevent levator spasm and disable the reflex.

In the early phase of treatment, it may be helpful for the couple to agree to participate in a pact to avoid penetration during sexual activity. This approach may help reawaken sexual desire and arousal by eliminating the fear of pain.

The nature of the patient's relationship with her partner is a powerful determinant of outcome. For example, intimacy and good communication are more likely to resolve the problem, whereas a difficult relationship may inhibit success. Depending on the scenario, counseling and psychological assessment may be necessary in the treatment of vaginismus, especially when a patient has a history of abuse.

Deep dyspareunia may be linked to pelvic pathology

This pain disorder may be associated with poor arousal or with fixation of the pelvic

organs as a result of endometriosis, adhesions, or posthysterectomy scarring.

In a "normal" scenario, when arousal is unimpeded, the vagina lengthens by about 30%, and the uterus and cervix lift out of the cul-de-sac. This helps explain why not all women who have retroverted uteri or an obliterated cul-de-sac experience deep dyspareunia.

The patient's history is a critical component of diagnosis. Ask her about foreplay, lubrication, and arousal prior to penetration. During the physical examination, be vigilant for point tenderness along the vaginal cuff and painful nodularity along the uterosacral ligaments.

To successfully treat deep dyspareunia, you must address any pelvic pathology as well as arousal problems. If penetration occurs prior to adequate arousal, the vagina remains shorter and the uterus has not yet engorged and lifted out of the cul-de-sac, resulting in "bump" dyspareunia. Surgery can elevate and alter any uterine retroversion that is present, but it is very rarely needed when adequate arousal can be achieved.



Medications such as antidepressants (selective serotonin reuptake inhibitors, tricyclics) may inhibit desire and interfere with orgasm

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Pain with orgasm may arise from uterine pathology

At the time of orgasm, the levator ani musculature and myometrium contract strongly. When adenomyosis or degenerating uterine fibroids are present, pain may occur during or after orgasm. Women who have pelvic floor tension myalgia also may experience pelvic pain and aching after orgasm.

To tease out the cause of orgasm-related pain, perform a careful physical examination. To distinguish uterine pain from pain at

the pelvic floor, perform a single-digit examination of each pelvic floor muscle before touching the cervix and uterus. Compression applied to a tender uterus often triggers a muscle spasm at the pelvic floor, so it is important to evaluate the pelvic floor muscles for tone and discomfort *before* performing a bimanual exam.

Treatment of uterine pathology usually entails medical or surgical intervention, whereas pelvic floor tension myalgia is treated with physical therapy and biofeedback.

Female orgasmic disorder may indicate a need for basic education

When a woman reports a persistent delay in or absence of orgasm after an otherwise satisfying episode of sexual activity and excitement, female orgasmic disorder is the likely cause. It may be primary or secondary.

Primary anorgasmia is often related to sexual inexperience and ignorance. Management may require education, use of a vibrator, and permission to engage in self-exploration—or it may necessitate evaluation and management by a trained sexual therapist. Resources for the patient, including educational materials and video, can be found at www.bettersex.com.

Secondary anorgasmia occurs in women

who have a history of regular orgasm; the cause is generally drug-related. Among the usual culprits are selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants. Anorgasmia can be difficult to treat in these cases because discontinuation of the antidepressant can worsen depression—and depression is often associated with disorders of desire. One option is switching the class of the antidepressant to one less likely to disrupt orgasm, such as bupropion or trazodone. Off-label use of low-dose sildenafil may reverse the effect of SSRIs on orgasmic function, according to recent evidence.⁸ 📌

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Primary anorgasmia is often related to sexual inexperience and ignorance

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