How do you break the ice with patients to ask about their sexual health?

A patient may skip talking about sexual function out of embarrassment, and a clinician out of concern for the patient's feelings. We may be overlooking women in need of treatment when we have the tools we need to assess and treat patients' sexual dysfunction.

Cheryl B. Iglesia, MD

CASE Patient may benefit from treatment for dyspareunia

A 54-year-old woman has been in your care for more than 15 years. Three years ago, at her well-woman examination, she was not yet having symptoms of menopause. Now, during her current examination, she reports hot flashes, which she says are not bothersome. In passing, she also says, "I don't want to take hormone therapy," but then is not overly conversational or responsive to your questions. She does mention having had 3 urinary tract infections over the past 8 months. On physical examination, you note mildly atrophied vaginal tissue.

Your patient does not bring up any sexual concerns, and so far you have not directly asked about sexual health. However, the time remaining in this visit is limited, and your patient, whose daughter is sitting in the waiting area, seems anxious to finish and leave. Still, you want to broach the subject of your patient's sexual health. What are your best options?

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We learned a lot about women's perceptions regarding their sexual health in the 2008 Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking study (PRESIDE). Approximately 43% of 31,581 questionnaire respondents reported dysfunction in sexual desire, arousal, or orgasm.[1] Results also showed that 11.5% of the respondents with any of these types of female sexual dysfunction (FSD) were distressed about it. For clinicians, knowing who these women are is key in recognizing and treating FSD.

Important to the opening case, in PRESIDE, Shifren and colleagues found that women in their midlife years (aged 45 to 64) had the highest rate of any distressing sexual problem: 14.8%. Younger women (aged 18 to 44 years) had a rate of 10.8%; older women (aged 65 years or older) had a rate of 8.9%.[1]

The most prevalent FSD was hypoactive sexual desire disorder,[1] which in 2013 was renamed sexual interest and arousal disorder in the *Diagnostic and Statistical Manual of*

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Sexual health is an important aspect of overall health, and patients benefit from this acknowledgment

Mental Disorders, Fifth Edition.[2] As with any distressing FSD, reports of being distressed about low sexual desire were highest for midlife women (12.3%) relative to younger (8.9%) and older (7.4%) women.[1]

Unfortunately, decreased desire can have a ripple effect that goes well beyond a patient's sexual health. A less-than-satisfying sex life can have a significant negative impact on self-image, possibly leading to depression or overall mood instability, which in turn can put undue strain on personal relationships.[1,3] A patient's entire quality of life can be affected negatively.

With so much at stake, it is important for physicians to take a more active role in addressing the sexual health of their patients. Emphasizing wellness can help reduce the stigma of sexual dysfunction, break the silence, and open up patient–physician communication.[4] There is also much to be gained by helping patients realize that having positive and respectful relationships is protective for health, including sexual health.[4] Likewise, patients benefit from acknowledging that sexual health is an element of overall health and contributes to it.[4]

Toward these ends, more discussion with patients is needed. According to a 2008 national study, although 63% of US ObGyns surveyed indicated that they routinely asked their patients about sexual activity, only 40% asked about sexual problems, and only 29% asked patients if their sex lives were satisfying.[5]

Without communication, information is missed, and clinicians easily can overlook their patients' sexual dysfunction and need for intervention. For midlife women, who are disproportionately affected by dysfunction relative to younger and older women, and for whom the rate of menopausal symptoms increases over the transition years, the results of going undiagnosed and untreated can be especially troubling. As reported in one study, for example, the rate of bothersome vulvovaginal atrophy, which can be a source of sexual dysfunction, increased from less than 5% at premenopause to almost 50% at 3 years postmenopause.[6] What is standing in our way, however, and how can we overcome the hurdles to an open-door approach and meaningful conversation?

Obstacles to taking a sexual history

Initiating a sexual history can be like opening Pandora's box. How do clinicians deal with the problems that come out? Some clinicians worry about embarrassing a patient with the first few questions about sexual health. Male gynecologists may feel awkward asking a patient about sex—particularly an older, midlife patient. The problem with not starting the conversation is that the midlife patient is often the one in the most distress, and the one most in need of treatment. Only by having the sexual health discussion can clinicians identify any issues and begin to address them.

Icebreakers to jump-start the conversation

Asking open-ended questions works best. Here are some options for starting a conversation with a midlife patient:

1. say, "Many women around menopause

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FIGURE 1 Brief sexual symptom checklist

1. Are you satisfied with your sexual function?
   ☐ Yes ☐ No If No, please continue.
2. How long have you been dissatisfied with your sexual function? _____
3. The problem(s) with your sexual function is: (mark one or more)
   a. Problems with little or no interest in sex
   b. Problems with decreased genital sensation (feeling)
   c. Problems with decreased vaginal lubrication (dryness)
   d. Problems reaching orgasm
   e. Problems with pain during sex
   f. Other: _____
4. Which problem (in question 3) is most bothersome?
   (circle) a b c d e f
5. Would you like to talk about it with your health care provider?
   ☐ Yes ☐ No

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Adding a sexual symptom checklist to your intake form can help bridge the sexual health communication gap that has persisted between physicians and patients

develop sexual problems. Have you noticed any changes?"

2. say, "It is part of my routine to ask about sexual health. Tell me if you have any concerns."
3. add a brief sexual symptom checklist (**FIGURE 1**) to the patient history or intake form. The checklist shown here starts by asking if the patient is satisfied, yes or no, with her sexual function. If yes, the satisfied patient (and the clinician) can proceed to the next section on the form. If no, the dissatisfied patient can answer additional questions about problems related to sexual desire, arousal, orgasm, and dyspareunia.

Such tools as checklists are often needed to bridge the wide communication gap between patients and physicians. Of the 255 women who reported experiencing dyspareunia in the Revealing Vaginal Effects at Midlife (REVEAL) study, almost half (44%) indicated that they had not spoken with their health care clinician about it.[7] Another 44% had spoken about the problem but on their own initiative. In only 10% of cases had a physician started the conversation.

Clinicians can and should do better. Many of us have known our patients for years—given them their annual examinations, delivered their babies, performed their surgeries, become familiar with their bodies and intimate medical histories. We are uniquely qualified to start conversations on sexual health. A clinician who examines tissues and sees a decrease in vaginal caliber and pallor must say something. In some cases, the vagina is dry, but the patient has not been having lubrication problems. In other cases, a more serious condition might be involved. The important thing is to open up a conversation and talk about treatments.

CASE Continued

As today's office visit wraps up and your patient begins moving for the door, you say, "Your hot flashes aren't bothering you, but some women start experiencing certain sexual problems around this time in life. Have you noticed any issues?"

"Well, I have been having more burning during intercourse," your patient responds.

On hearing this, you say, "That's very important, Mrs. X, and I am glad you told me about it. I would like to discuss your concern a bit more, so let's make another appointment to do just that."

At the next visit, as part of the discussion, you give your patient a 15-minute sexual status examination.

Sexual status examination

Performing this examination helps clinicians see patterns in both sexual behavior and sexual health, which in turn can make it easier to recognize any dysfunction that might subsequently develop. The key to this process is establishing trust with the patient and having her feel comfortable with the discussion.

The patient remains fully clothed during this 15-minute session, which takes place with guarantees of nonjudgmental listening, confidentiality, privacy, and no interruptions. With the topic of sex being so personal,

FIGURE 2 Differential diagnosis: psychiatric illnesses and general health factors that may affect sexual function

- Mood disorders[10]
  - —Major depression
  - —Bipolar illness
- Anxiety disorders[11,12]
- Psychotic illness[13]
- Hypertension[14]
- Neurologic disorders[15]
- Endocrine disorders[16]
  - —Diabetes, thyroid disorders, hyperprolactinemia[16]
- Urologic problems[17]
- Sexually transmitted infections[18]
- Gynecologic problems
  - —Illness, postpartum[19]
- Other chronic
  - —Rheumatoid arthritis[20]
  - —Psoriasis[21]
  - —Breast cancer[22]

it should be emphasized that she is simply giving the clinician information, as she does on other health-related matters.

Establish her sexual status. Begin by asking the patient to describe her most recent or typical sexual encounter, including details such as day, time, location, type of activity, thoughts and feelings, and responses.

Potential issues can become apparent immediately. A patient may not have had a sexual encounter recently, or ever. Another may want sex, or more sex, but sees obstacles or lack of opportunity. Each of these is an issue to be explored, if the patient allows.

A patient can be sexually active in a number of ways, as the definition varies among population groups (race and age) and individuals. Sex is not only intercourse or oral sex—it is also kissing, touching, and hugging. Some people have an expansive view of what it is to be sexually active. When the patient mentions an encounter, ask what day, what time, where (at home, in a hotel room, at the office), and what type of activity (foreplay, oral sex, manual stimulation, intercourse, and position). Following up, ask what the patient was thinking or feeling about the encounter. For example, were there distracting thoughts or feelings of guilt? How did the patient and her partner respond during the encounter?

Assess for sexual dysfunction. After assessing the patient's sexual status, turn to dysfunction. Arousal, pain, orgasm, and satisfaction are 4 areas of interest. Did the patient have difficulty becoming aroused? Was there a problem with lubrication? Did she have an orgasm? Was sex painful? How did she feel in terms of overall satisfaction?

In general, patients are comfortable speaking about sexual function and health. Having this talk can help identify a pattern, which can be discussed further during another visit. Such a follow-up would not take long—a level 3 visit should suffice.

Differential diagnosis. Consider the effects of current medications.[8,9] The psychiatric illnesses and general health factors that may affect sexual function should be considered as well (**FIGURE 2**).[10–22]

When is it important to refer?

There are many reasons to refer a patient to another physician, including:

- a recommended treatment is not working
- abuse is suspected
- the patient shows symptoms of depression, anxiety, or another psychiatric condition
- a chronic, generalized (vs situational) disorder may be involved
- physical pain issues must be addressed
- you simply do not feel comfortable with a particular problem or patient.

Given the range of potential issues associated with sexual function, it is important to be able to provide the patient with expert assistance from a multidisciplinary team of specialists. This team can include psychologists, psychiatrists, counselors, sex educators, and, for pain issues, pelvic floor specialists and pelvic floor physical therapists. These

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During the sexual status examination consider the patient's current medications, psychiatric illnesses, and general health factors

colleagues are thoroughly familiar with the kinds of issues that can arise, and can offer alternative and adjunctive therapies.

Referrals also can be made for the latest nonpharmacologic and FDA-approved pharmacologic treatment options. Specialists tend to be familiar with these options, some of which are available only recently.

It is important to ask patients about sexual function and, if necessary, give them access to the best treatment options.

CASE Resolved

During the sexual status examination, your patient describes her most recent sexual encounter with her husband. She is frustrated with her lack of sexual response and describes a dry, tearing sensation during intercourse. You recommend first-line treatment with vaginal lubricants, preferably iso-osmolar aqueous– or silicone/dimethicone–based lubricants during intercourse. You also can discuss topical estrogen therapy via estradiol cream, conjugated equine estrogen cream, estradiol tablets in the vagina, or the estrogen ring. She is reassured that topical estrogen use will not pose significant risk for cancer, stroke, heart disease, or blood clot and that progesterone treatment is not necessary.

For patients who are particularly concerned about vaginal estrogen use, 2 or 3 times weekly use of a vaginal moisturizer could be an alternative for genitourinary symptoms and dyspareunia.

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Multidisciplinary expertise and latest treatment options can be offered by referral when appropriate to pelvic floor and sexual health experts, sex educators, psychologists, etc

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