"**Sexual health** **is a state *of physical, emotional, mental and social well-being*** in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence"

www.who.int/reproductivehealth/gender/sexualhealth.html

Female Sexual Dysfunction: Screening, Diagnosis and Treatment

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Goals and Objectives

- Discuss issues surrounding screening for female sexual dysfunction
- Identify the most prevalent types of female sexual dysfunction
- Discuss diagnostic considerations for female sexual dysfunction and when to begin treatment
- Discuss treatment strategies for female sexual dysfunction

Prevalence of Sexual Dysfunctions

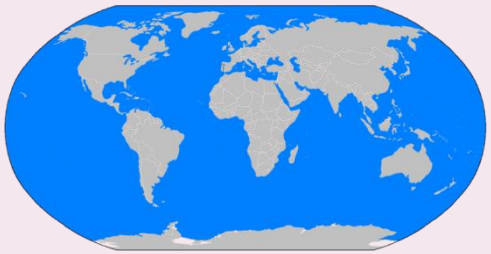
Men N > 90,000	Women N ~ 10,000
▪ Any SD 31% ▪ Low desire 5% - 15% ▪ Anorgasmic 8% ▪ Rapid ejaculation 14% - 30% ▪ Erectile disorder(ED) 18% - 52% ▪ 36% moderate or complete ED ▪ ↑ with age - - 25% of men < 59 yo - 61% of men > 70	▪ Any SD 32% ▪ Low desire 17% - 55% > in surgical menopause ▪ Arousal problems 14% - 35% ▪ Orgasm issues 25% -39% ▪ Pain 2% - 26%

- Sexual problems can be life long or acquired
  - Generalized or situational

- DeRogatis & Burnet. J of Sexual Medicine 2008:5:289-300
- McVary, NEJM 2007:357:2472.
- Shifren, Monz, Russo, et al. Obstet Gynecol 2008:112:970

Impact of Sexual Problems

- Global Study of Sexual Attitudes Behaviors
  - Survey of 27,000+, 40-80 y/o



80% of men, 60% of women rated sexual function as a **"moderately to extremely"** important

- Not all pts meet formal diagnostic criteria but the impact of sexual problems is ↑
- Treatment helpful even if a formal dx is not made

Lauman, et al . Int J Impot Res 17: 2005;39-57

Correlates of Sexual Problems

- **Age**
  - Occurrence of problems ↑ with age
  - Distress ↓ with age
- **Health comorbidities**
  - DM, CVD, HTN, prostate / gyn problems, cancer, obesity, tobacco, alcohol, recreational drug use
- **Medications**
  - Psychotropics, antihypertensives, anticonvulsants..
    - ~ 25% of ED cases are medication related
- **Psychosocial factors**
  - Depr, anx, relationship issues, stress, sexual trauma

- Bacon, Mittleman, Kawachi, et al. Ann Intern Med, 2003:139-161
- Lindau, Schumm, Laumann, et al. NEJM 2007(357)762.

Emotional Factors and Sexuality

- **Depression**
  - Impacts all aspects of sexual response
    - desire, arousal and orgasm
- **Anxiety**
  - Common in SD - performance anxiety, fear of inadequacy, spectatoring
    - all impede psychophysiological arousal
- **Anger**
  - Impedes communication and intimacy

Besharat M, 2001

Depression and Sexual Dysfunction

- Sexual dysfunction is both:
  - A symptom of depression
  - An adverse effect of many antidepressants & other psychotropics
- Treatment-emergent sexual dysfunction
  - A major cause of noncompliance and drug discontinuation
  - It is a substantial risk factor for relapse or recurrence of a depressive episode
  - Important to assess sexual function in patients with depression before selecting the most appropriate antidepressant medication

Kennedy & Rizvi. J of Clin Psychopharm, 29(2), 2009

Importance of Screening for SD

Underdiagnosed and Undertreated

- Obstacles for patients
  - Don't ask, don't tell..
  - Patients not likely to bring it up unless asked
- Obstacles for physicians
  - Lack of training
  - Lack of confidence
  - Lack of knowledge regarding treatment options
  - Inadequate time to obtain a sexual history
  - Underestimation of the prevalence of sexual dysfunction

When and How Do you Screen?

- When should we screen for Sexual Dysfunction?
- How do we screen for Sexual Dysfunction?

Easy Screening Questions

- Are you sexually active?
- Any pain during sexual activity?
- Are you able to achieve an orgasm?
- Any decreased desire or libido that is troubling for you and your partner?
- Everyone should be screened for domestic violence and sexual abuse during annual visits.

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?
_____

3a. men/women specific questions…

3b. Which problem is most bothersome (circle) 1 2 3 4 5 6 7

4. Would you like to talk about it with your doctor?
□ Yes □ No

Brief Sexual Symptom Checklist: 3a

For Men (BSSC-M)

3a. The problems with your sexual function is: (mark one or more)

1 Problems with little or no interest in sex

2 Problems with erection

3 Problems ejaculating too early during sexual activity

4 Problems taking too long, or not being able to ejaculate or have orgasm

5 Problems with pain during sex

6 Problems with penile curvature during erection

7 Other :

For Women (BSSC-W)

3a. The problems with your sexual function is: (mark one or more)

1 Problems with little or no interest in sex

2 Problems with decreased genital sensation (feeling)

3 Problems with decreased vaginal lubrication (dryness)

4 Problems reaching orgasm

5 Problems with pain during sex

6 Other : .....

Integrative Treatment Models

- **PLISSIT** Model (Annon, 1976)
  - **P**ermission – for the pt to discuss the issue
  - **L**imited **I**nformation – education about the psychophysiology of sexual arousal and normal sexual functioning
  - **S**pecific **S**uggestions – e.g., communication skills, relaxation skills, sensate focus
  - **I**ntensive **T**herapy - refer for additional treatment as needed

- **Brief Sexual Counseling** (Schover & Jensen, 1988)
  - Sex education
  - Restructure maladaptive beliefs about sexuality
  - Help the pt stay sexually active (e.g., sensate focus, identify mutually satisfying sexual experiences)
  - Address conflict resolution and communication skills

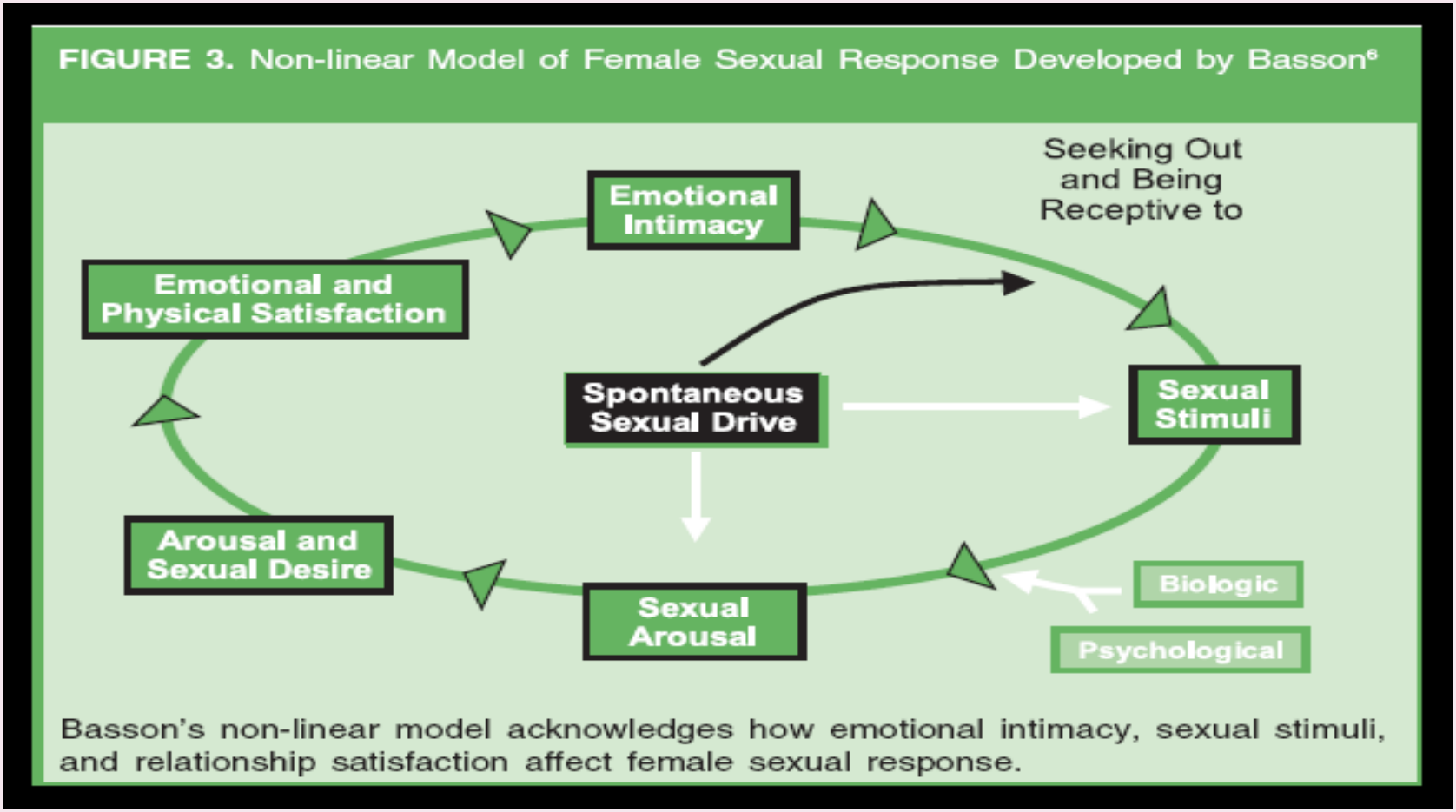
Female Sexual Interest/Arousal Disorder

- At least 3 of the following:
  - Reduced (or absent) interest in sexual activity
  - Reduced sexual/erotic thoughts or fantasies
  - Reduced initiation of sexual activity, unreceptive to a partner's attempts
  - Reduced sexual excitement or pleasure
  - Reduced sexual interest/arousal in response to sexual cues (e.g., written, verbal, visual)
  - Reduced genital or nongenital sensations
- Freq associated with:
  - Orgasm problems, painful sex, couple-level discrepancies in desire, unrealistic expectations, lack of information about sexuality

Brotto LA, Petkau JA, Labrie F, Basson R:
Predictors of sexual desire disorder in women.
J Sex Med 8(3):742–753, 2011

"I really think you should see a specialist about your lack of libido Sharon."

Basson's Non-linear Model



Treatment

- Biopsychosocial and Educational Approach
  - Focus on the Cause of the Disorder
  - Cognitive-Behavioral Techniques and/or Traditional Sex Therapy.
    - Communication exercises
    - Body image exercises
    - Sensate focus exercises
  - Mindfulness-based treatment
    - Encouraging results
    - Need larger studies
- Pharmacological treatment

Check Medications

- Medications commonly associated with SD
  - Antihypertensives
  - Histamine blockers
  - Oral Contraceptive pills
  - Psychotropic medications
    - SSRIs are most commonly linked to sexual dysfunction
    - Estimated incidence of SSRI-induced sexual dysfunction ranges from approximately 15 to 80 percent
    - Interest/Arousal and Orgasmic disorder are the most common issues

Serretti A, Chiesa A. J Clin Psychopharmacol. 2009 Jun;29(3):259-66.
Baldwin DS, Foong T. Br J Psychiatry. 2013 Jun;202:396-7.

Meds cont..

- Decreasing the dosage may help alleviate some issues
- Switching to another antidepressant may alleviate symptoms, but other antidepressant classes also have been associated with sexual dysfunction.
- A structured treatment interruption may be helpful in some patients, but is not always an option in some other patients.

Flibanserin and Bremelanotide

Flibanserin (Addyi)

- 5-HT1a serotonin receptor agonist, 5-HT_{2A} receptor antagonist and a dopamine D4 receptor partial agonist.
- Non-Hormonal
- Increases dopamine/noradrenalin and reduces Serotonin
- Hypoactive sexual desire disorder (HSDD) in premenopausal women
- Dose 100mg qhs
- Side effects: fatigue (morning), hypotension
- Take daily and no alcohol use on this medication (if drinking should skip the dose.

Bremelanotide (Vyleesi)

- melanocortin receptor agonist that activates several receptor types, most notably MC1R and MC4R in the central nervous system
- Hypoactive sexual desire disorder (HSDD) in premenopausal women
- Injection given 1 hour prior to sexual activity

***There are currently no FDA-approved formulations for postmenopausal women with low libido.

Bremelanotide

- Melanocortin receptor agonist
- Contraindicated: heart disease or uncontrolled htn
- Begins to work approx. 45 min and can last up to 8 hours
  - Should not use more than once in 24 hours
  - Should not use more than 8 times in a month
- Side Effects (rare):
  - transient increase in blood pressure and decrease in heart rate
  - focal hyperpigmentation (face, gums, breast)
  - nausea

Female Orgasmic Disorder

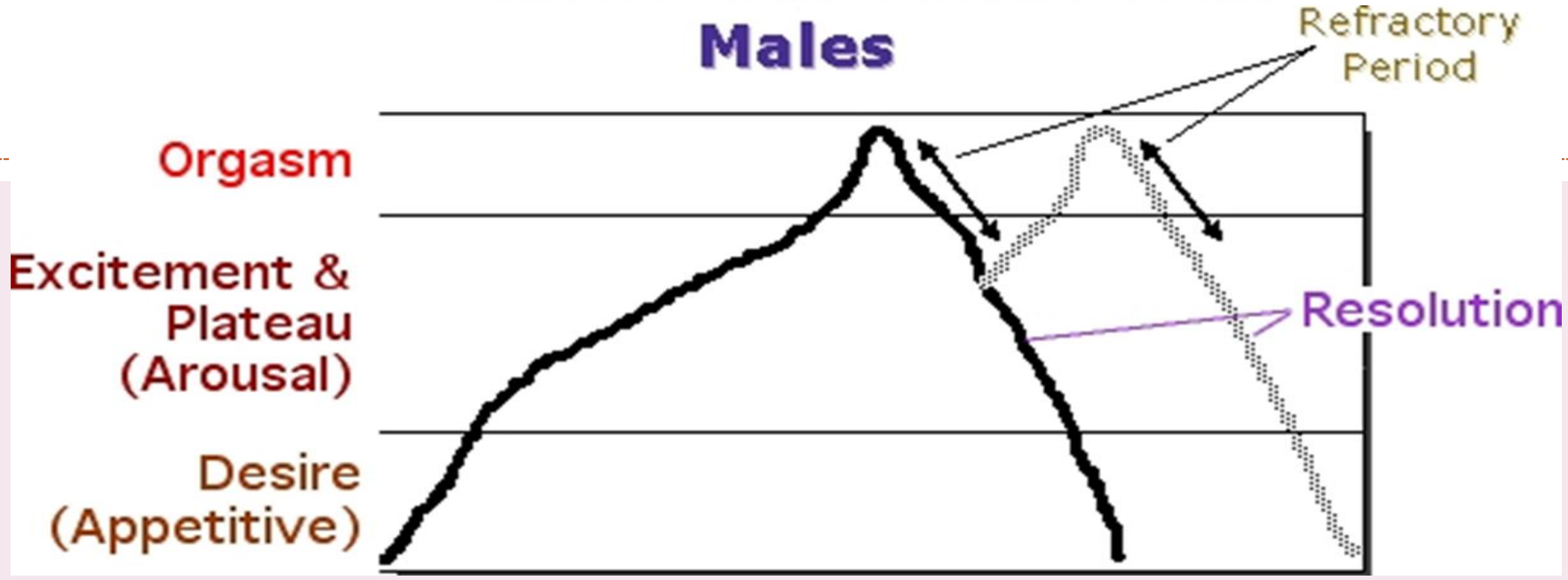
Diagnostic Criteria – for at least 6 months

- Either of the following on 75%–100% during sexual activity:
  - Marked delay in, marked infrequency of, or absence of orgasm.
  - Markedly reduced intensity of orgasmic sensations.
- Causes clinically significant distress
- Not explained by
  - A nonsexual mental disorder
  - A consequence of severe relationship distress (e.g., partner violence)
  - Other significant stressors
  - Not due to the effects of a substance/medication
  - Not due to another medical condition.

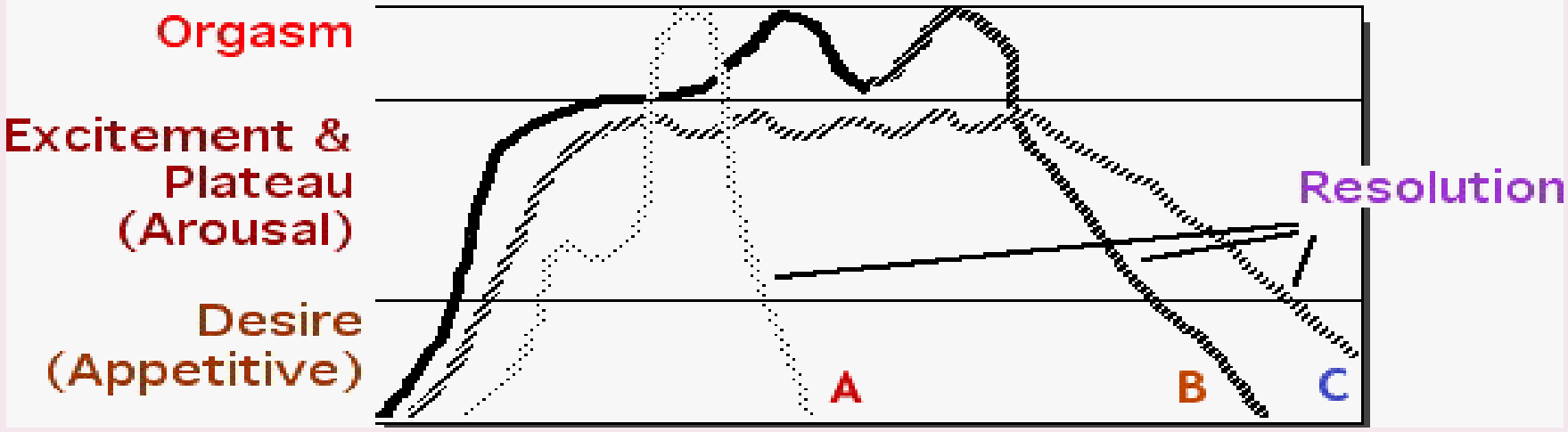
Female Orgasmic Disorder

- Timeline to relating to Orgasmic disorder
  - Ever had an orgasm?
  - Had one with this relationship?
  - Does partner know?
  - Does she engage in self exploration?
- Any comorbid factors (new or old)

Males



Females



Cycle Differences

- 75% of all males→ orgasm is possible within the first 4 minutes after initiation of sexual intercourse

- All women the average time to reach orgasm is between 10 and 20 minutes

Treatment:

- Focus on being comfortable your body and self exploration is encouraged.
- Directed self exploration exercises with clitoral stimulation:
  - encourage patience and persistence with at least three weekly sessions in a good setting
- Transfer of self exercises to "couple"
  - Allow partner to first observe then engage in self exploration exercises. Consider your sexual needs first over your partners.
- Bibliotherapy (see erotic reading list also)
  - The G spot or The science of orgasm
- Lubricants
  - Zestra – stimulating gel (otc)

Genito-Pelvic Pain/Penetration Disorder

- Sxs highly comorbid (need 1 of 4 to dx)
  - Difficulty having intercourse
  - Genito-pelvic pain
  - Fear of pain or vaginal penetration
  - Tension of the pelvic floor muscles

- Behavioral avoidance of sexual situations and of gyn exams is common
  - Avoidance pattern is similar to phobic disorders

Causes of Dyspareunia

- Atrophy
  - Leading cause of dyspareunia due to decreased estrogen
  - Causes:
    - Menopause
    - Premature Ovarian Failure
    - Hypothalamic Amenorrhea (excessive exercise or rapid weight loss)
    - Postpartum/Breastfeeding
    - Low Estrogen Contraceptives
    - Radiation or Chemotherapy (Tamoxifen).

Atrophy

Treatment:

- Hormone-free Lubricants (water-base or silicon):
  - With intercourse
  - Free of Parabens and Glycerin
- Hormone-free Moisturizers
  - Every third night
- Local estrogen or dheas therapy: cream, tablet or vaginal ring.
  - If history of breast cancer – discuss with oncologist prior to use.
- Pelvic floor physical therapy (dilators if necessary)
- Relaxation training.

Vaginismus

- Prevalence rates ranging from 1% to 6%
- Cannot consummate intercourse because vaginal penetration is not possible
  - Involuntary spasm of perineal/levator muscles
  - Vaginal muscle contractions occur as an automatic defense to vaginal penetration
  - For some women it is only limited to vaginal exams, but intercourse is possible and comfortable.
- Diagnosed by eliciting muscle spasm by depressing the levators

Treatments cont..

- Relaxation and desensitization techniques
  - Deep muscle relaxation techniques to use during exercises
  - Using dilators
    - Starting with the smallest one that is comfortable
    - Gradually over time increasing diameter of the dilator as tolerated.
    - Goal is to desensitize a woman to her fear that vaginal penetration will be painful
    - Enable her to gain a sense of control over a sexual encounter or a pelvic examination
- Pelvic floor physical therapy
- Vaginal valium (compounded into a suppository) may be helpful.

Take Home Points

- Roughly 1/3 of patients have Sexual Dysfunction
- It is important to Screen for it Annually
- The Most Common Types of dysfunction are:
  - Hypoactive sexual desire disorder (decreased libido)
  - Anorgasmia
  - Genito-pelvic pain disorder (dyspareunia)
- Treatment will usually start with Behavioral Modifications and Education
- Pelvic Floor Physical Therapy can be very helpful for Dyspareunia.

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Thank You!