



Review

Aetiology, diagnostic algorithms and prognosis of female sexual dysfunction

Alessandra Graziottin^{a,*}, Audrey Serafini^b, S. Palacios^c^a Centre of Gynecology and Medical Sexology, H. San Raffaele Resnati, Milan, Italy^b Department of Obstetrics and Gynecology, H. San Raffaele Resnati, Milan, Italy^c Palacios Institute of Woman's Health, Madrid, Spain

ARTICLE INFO

Article history:

Keywords:

Female sexual dysfunction
 Hypoactive sexual desire disorder
 Arousal disorder
 Orgasmic disorder
 Sexual pain disorder
 Dyspareunia
 Vaginismus

ABSTRACT

Objective: The aim of this paper is to describe the aetiology, diagnosis and prognosis of female sexual dysfunction (FSD), so as to increase the physician's competence in the management of women with these problems.

Method: A literature review of the most relevant publications was undertaken evaluating each sexual dysfunction.

Results: The aetiology of FSD is multifactorial. The most important causes include biological, psychosexual and contextual factors. When assessing FSD, the clinical history should assess if: (a) the disorder is generalized or situational; (b) the disorder is lifelong or acquired after months or years of satisfying sexual intercourse; (c) the level of distress is mild, moderate, or severe in terms of the impact of FSD on personal life; and (d) the leading aetiologies. To diagnose a sexual dysfunction, it is crucial to ask specifically about sexual function and avoid a collusion of silence that is all too common. A structured clinical history, selected investigations and physical examination are fundamental to diagnosis.

Conclusions: A structured multidisciplinary, integrative approach is fundamental to the evaluation and management of FSD.

© 2009 Elsevier Ireland Ltd. All rights reserved.

Contents

1. Introduction	128
2. Components of female sexuality	129
3. Aetiology of FSD	129
3.1. Hypoactive sexual desire disorder	129
3.2. Arousal disorder	129
3.3. Orgasmic disorders	129
3.4. Sexual pain disorders	129
4. Diagnostic approach	130
4.1. Hypoactive sexual desire disorder	130
4.2. Arousal disorder	130
4.3. Orgasmic disorders	130
4.4. Sexual pain disorders	130
5. Prognosis	132
6. Conclusion	133
Conflict of interest	133
Acknowledgments	133
References	133

1. Introduction

Gynaecologists are increasingly required to address women's sexual disorders. However most of them feel uneasy to open the Pandora's box of female sexual disorder (FSD) [1], with two major concerns: (a) lack of specific training and (b) fear of "wasting their

* Corresponding author at: Via Enrico Panzacchi 6, 20123 Milano, Italy.

Tel.: +39 02 72002177; fax: +39 02 876758.

E-mail addresses: a.graziottin@studiograziottin.it, segreteria@studiograziottin.it (A. Graziottin).

time” with lengthy histories and the complicated dynamics of the clinical examination.

The goal of this paper is to distil the experience of the FSD European team group on the aetiology, diagnosis and prognosis of FSD and so increase the physician’s competence in this complex area.

2. Components of female sexuality

Three major dimensions (female sexual identity, sexual function and sexual relationship) interact in women’s sexual health [2–4]. Women’s sexuality is discontinuous throughout the life cycle and is dependent on biological (reproductive events) as well as personal, current contextual and relationship variables. Gynaecologists are the physicians who will have the most knowledge about: (a) the impact of different reproductive endocrine changes on women’s well-being, mood, and physiology of the sexual response throughout life and (b) the contextual-related factors, rooted in family life and work that may contribute to impair the sexual response. Interactions between FSD and concurrent medical conditions and treatments (drug, surgery, chemo-radiotherapy) must also be taken into account.

3. Aetiology of FSD

The aetiology is multifactorial and includes biological, psychosexual and contextual factors.

- **Biological factors:** The main factors include ovarian steroid deficiency, pelvic floor disorders, cardiovascular problems, neurological conditions (particularly pain related), metabolic disorders (diabetes) and affective disorders (depression and anxiety). Medical conditions may affect sexuality either directly or indirectly through their treatments [5,6]. For example gynaecological cancer may be treated with surgery, radio- and chemotherapy, all of which can impact on sexuality. Loss of ovarian steroids at the menopause is a major contributor to FSD [7].
- **Psychosexual factors:** These embrace emotional, affective, and psychological factors such as childhood problems, bereavement [8], body image issues [9], sexual aversion disorder [10], eating disorders and relationship issues. The last may involve unfaithfulness by the partner with the consequent disruption in the relationship. Unfortunately, psychosexual factors are usually neglected in the medical setting. Their recognition should make the gynaecologist refer the woman to a suitable colleague.
- **Contextual factors:** This involves past and current significant relationships [11], current interpersonal difficulties and the partner’s general health and sexual function. Diagnosing partner-related issues, and specifically male sexual disorders (MSD), that may contribute to FSD, should lead the gynaecologist to refer the partner to the appropriate colleague.

3.1. Hypoactive sexual desire disorder

Loss of desire or hypoactive sexual desire disorder (HSDD) is multifactorial. It includes biological, psychosexual and contextual-related factors [12]. Aging is the main factor affecting sexual desire in women [13] and the menopause has a further worsening effect. Surgical menopause has a specific adverse effect due to the loss of ovarian oestrogens and androgens. The ovaries contribute more than 50% of androgens during reproductive life. A cross-sectional survey of 2467 European women aged 20–70 years, which included 1356 women who were surgically menopausal, found that a greater proportion of surgically menopausal women had low sexual desire compared with premenopausal or naturally menopausal women (odds ratio [OR] = 1.4; 95% confidence interval [CI] = 1.1, 1.9; $P = 0.02$).

Surgically menopausal women were more likely to have HSDD than premenopausal or naturally menopausal women (OR = 2.1; 95% CI = 1.4, 3.4; $P = 0.001$). Sexual desire scores and sexual arousal, orgasm, and sexual pleasure were highly correlated ($P < 0.001$), demonstrating that low sexual desire is frequently associated with decreased functioning in other aspects of the sexual response. Women with low sexual desire were less likely to engage in sexual activity and more likely to be dissatisfied with their sex life and partner relationship than women with normal desire ($P < 0.001$) [14]. Premature iatrogenic menopause is the most frequent cause of a biologically determined generalized loss of desire; the younger the woman, the higher the distress this loss may cause [3,14].

Other conditions leading to HSDD include psychiatric disorders, such as depression, as well as general medical conditions. Chronic disease interferes with sexual function in several ways, of which induced fatigue is an important element [15]. HSDD is also associated with the use of some medications, such as selective serotonin reuptake inhibitors (SSRIs), hormone antagonists, anti-hypertensives and chemotherapy drugs. Misuse of alcohol and recreational drugs (opiates) must not be forgotten. Psychological causes, relationship and intrapersonal issues, or socio-cultural causes (poverty/low income, distressing or difficult working conditions or sexual norms) may be involved. These causes are not mutually exclusive and may interact with each other.

3.2. Arousal disorder

The leading biological cause of arousal disorders is the loss of sex steroids, primarily oestrogen, as found in hypothalamic amenorrhea, postpartum amenorrhea during lactation and the menopause.

Hormonal contraception can also cause genital arousal disorder as well vaginal dryness [16]. A postal survey of 356 Australian women aged 20–70 years found that low genital arousal was more likely among women who were perimenopausal (OR 4.4, 95% CI 1.2–15.7), postmenopausal (5.3, 1.6–17.7), or depressed (2.5, 1.1–5.3), and was less likely in women taking hormone therapy (0.2, 0.04–0.7), more educated (0.5, 0.3–0.96), in their 30s (0.2, 0.1–0.7) or 40s (0.2, 0.1–0.7), or placed greater importance on sex (0.2, 0.05–0.5) [17].

Pelvic floor disorders also contribute to arousal disorders. Increased activity of the pelvic floor musculature may cause tenderness at the introitus and thus dyspareunia. Pain is the strongest inhibitor of genital arousal. Thus genital arousal disorders, and the consequent vaginal dryness, often co-exist with dyspareunia [18]. Conversely a lax pelvic floor (after traumatic or instrumental childbirth) may contribute to genital arousal disorder because it reduces pleasurable sensations for both partners [19]. Also, diabetes and vascular factors [20] smoking, lower urinary tract symptoms (LUTS), pelvic surgery, neurological disease, drug therapy, psychological and socio-cultural causes may be involved.

3.3. Orgasmic disorders

The causes may be biological (such as aging and pelvic floor disorders), iatrogenic (medication with SSRI and other antidepressants), psychological or socio-cultural.

3.4. Sexual pain disorders

Dyspareunia is a common symptom of a variety of coital pain-causing disorders (Box 1).

The most frequent cause is biological. Pain perception can be worsened by psychological or contextual factors [21]. Psychological and socio-cultural causes include intrapersonal issues, inadequate foreplay, inexperience, different sexual norms, lack of sexual skills and in certain countries genital mutilation.

Download English Version:

<https://daneshyari.com/en/article/1918101>

Download Persian Version:

<https://daneshyari.com/article/1918101>

[Daneshyari.com](https://daneshyari.com)