The management of Sexual Dysfunction – Treatment and referral guidelines for the GP

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A. Introduction

Many primary care physicians feel ill-equipped to deal with the sexual concerns of their patients. There are numerous reasons for this, amongst them a lack of adequate pre-graduate training in sexual health in medical schools, time constraints in private practice and in the public sector and various intra- and inter-personal factors.

Maurice[1] lists seven reasons why questions about sexual functioning are not asked in health settings (Table 1)

TABLE 1

WHY QUESTIONS ARE NOT ASKED

1. Unclear what to do with the answers
   * Uncertainty about the next question
   * Unfamiliarity with treatment approaches
2. Fear of offending patient
3. Lack of obvious justification
4. Generational obstacles
5. Fear of sexual misconduct charge
6. Sometimes perceived irrelevant
7. Unfamiliarity with some sexual practices

B. Importance of taking a sexual history

In recent years, it has become most important to include a sexual history in the family practice setting for the following reasons:

1. *Sexually Transmitted Infections (STI's) including HIV/AIDS.*

The primary care physician or general practitioner (GP) has a unique opportunity, but also a responsibility, to be involved in AIDS/STI prevention through the provision of patient information and education.

2. *Sexual dysfunction(SD) may be a symptom of an underlying disease.*

Patients suffering from depression or diabetes, for example, often initially present with sexual dysfunction. It is presently believed that erectile dysfunction (ED) equals endothelial dysfunction and can therefore be a warning sign of a possible impending cardiac event.

3. *Treatment side-effects may cause SD.*

It is well known that certain drugs can have a negative effect on sexual functioning. Also surgery may result in sexual dysfunction, in a physical or a psychological way.

4. *Past experiences may explain present problems*

A history of previous childhood sexual abuse or assault can explain complaints of a lack of desire or vaginismus.

5. *Sexual functioning is potentially lifelong.*

Younger GP's, especially, may feel uneasy about asking older patients about their sexual functioning, or even presume that these patients cannot or should not be sexually active anymore. The population of the world is growing older day by day and older people still have the capacity and need to be sexually functional.

6. *Sexual dysfunction and difficulties are common.*

The prevalence of ED in the Massachusetts Male Aging Study (MMAS), for example, was 52% amongst men between the ages of 40 and 70 years.[2]

7. *There is an association between sexual functioning, health and happiness*

Sexual activity and good health are related. There is also a correlation between sexual activity and happiness especially in people who only have one sexual partner, who have sex at least two or three times per week and in women who always or usually experience an orgasm in partnered sex.[3]

8. *Why should doctors not be asking questions about sexual function?*

There is no justification for the omission of a sexual history, provided that it is appropriate in that situation. Routine history-taking on sexual function should be part of any general consultation, just like bowel and bladder function.

9. *It may be a sign of negligence if ignored*

Not discussing sexual matters with a patient can become an ethical issue when the *prima facie* moral principles of beneficence (do good) and non-maleficence (do no harm) are not upheld. On the other hand, discussing this issue inappropriately and without the necessary sensitivity can also be seen as unprofessional conduct.

Maurice suggests 4 screening questions regarding a patients sexual functioning:[1]

1. Can I ask you a few questions about sexual matters?
2. Have you been sexually active with a partner in the past six months?
3. With women? Men? Both?
4. Do you or your partner have any sexual concerns?

TABLE 2

SEXUAL DIFFICULTIES

- Inconvenient time chosen by partner
- Inability to relax
- Attraction to person(s) other than mate
- Disinterest
- Attraction to person(s) of the same sex
- Different sexual practices or habits
- "Turned off"
- Too little foreplay before intercourse
- Too little "tenderness" after intercourse

C. Sexual difficulties versus dysfunctions

Experiencing sexual difficulty (Table 2)[1] does not equal having a

sexual dysfunction. Overall sexual dissatisfaction is related more to sexual difficulties than to sexual dysfunction. Sexual dysfunction is predominantly a physiological problem, whereas sexual difficulties are more psychosocial or relational in nature.

The diagnosis of a sexual dysfunction, as described in the DSM IV,[5] is based on the sexual response cycle described by Masters and Johnson (Excitement, Plateau, Orgasm and Resolution) and Kaplan (Desire, Excitement and Orgasm) rather than on an individual's subjective experiences. One criticism levelled at this approach is the assumption that there is an inevitable progression from one phase to the other. This is, for instance, not true for females, who can experience orgasms without any pre-existing desire, or experience physiological arousal without any subjective arousal.

D. What to determine in the assessment of sexual dysfunctions

The following topics can structure the generalist's approach to sexual dysfunctions if the patient has had any concerns.

1. Pattern of sexual functioning (see table 3)[1]
2. Sexual practices
3. Affectionate behaviour
4. Relationship with partner
5. Sexual development history
6. Medical history
7. Physical and laboratory examinations

TABLE 3

PATTERN OF A SEXUAL DYSFUNCTION: WHAT TO ASK.

1. DURATION of difficulty: lifelong or acquired
2. CIRCUMSTANCES in which difficulty appears: generalised or situational
3. DESCRIPTION of difficulty
4. PATIENT'S SEXUAL RESPONSE CYCLE
   - Males: desire, erection, ejaculation/orgasm
   - Females: desire, vaginal lubrication, orgasm, absence of coital pain
5. PARTNER'S SEX RESPONSE CYCLE (see no. 4)
6. PATIENT AND PARTNER'S REACTION to presence of difficulty
7. MOTIVATION FOR TREATMENT (when difficulty is not the chief complaint)

E. Male sexual dysfunction

The main sexual dysfunctions in men are: low sexual desire, pre-mature ejaculation and erectile dysfunction (ED)

Low sexual desire

There are numerous causes of a low sexual desire in males, and it is seldom only a hormonal or physical problem that is responsible for the low desire. Relational and psychological factors also play a major role, especially in females with a low desire.

Table 4 gives a summary of possible causes of low desire in both males and females. These "D" and "A" words are mostly self-explanatory.[5]

TABLE 4

CAUSES OF LOW SEXUAL DESIRE

Disease	Alcohol
Drugs	Androgen
Depression	Anxiety
Deliberate control	Anger
Dissociation	Avoidance
Divorce	Age
Distraction	Affair
Disagreement	Abuse
Domination	Abortion
Denial	Aversion
Dysfunction	Anticipation
Differences	Attitude

In men with proven hypogonadism (low testosterone) resulting in low desire, androgen replacement therapy is indicated. This is available as tablets, injections, implants, skin patches and gels, and is best prescribed by an endocrinologist.

Premature ejaculation (PE)

This condition creates a lot of personal distress for both males and their partners. Management of this condition with the use of selective serotonin uptake inhibitors (SSRI's) is well known. This should be done in conjunction with sex therapy and relationship therapy.[6]

The four-level PLISSIT model, as described by Annon, is very useful in dealing with a variety of sexual dysfunctions. The acronym stands for: P = Permission, LI = Limited Information, SS = Specific Suggestions and IT = Intensive Therapy.[7]

Often patients need to be "given permission" to experience sexual dysfunctions or difficulties and to talk about them. The GP may give the patient with PE information about normal ejaculatory latency time, and can also dispel unrealistic expectations. Specific suggestions can include using the "stop-start" or "squeeze technique". Only a small number of males with PE will need intensive therapy or referral to a specialist. They are usually the males with lifelong PE.

Erectile Dysfunction (ED)

ED was always thought to be a predominantly psychogenic condition. Today we know it is usually organic in nature and a sign of endothelial dysfunction. Risk factors associated with ED are hypertension, diabetes and hypercholesterolemia.

The management of patients complaining of ED should include taking a proper history and per-forming a good general and uro-genital examination. If there are no other systemic diseases present that warrant further special investigations, the minimum blood tests for an ED sufferer would be blood glucose, lipids and testosterone determinations.

Most patients with ED can be treated by their GP. Only a limited number of patients with complicated aetiologies need to be referred to specialists. The first in line in the treatment of ED are the oral phosphodiesterase type 5 (PDE5) inhibitors (Sildenafil, Tadalafil and Vardenafil). These oral agents are reliable, effective and safe, provided they are not taken with organic nitrates (absolute contra-indication) and there is adequate sexual stimu-lation after taking one of the drugs.

Second line treatment would be intra-cavernous injections of Prostaglandin E1 (Alprostadil) and for a few very complicated cases penile prosthesis implantation. Sometimes a simple vacuum pump device with a constriction ring can also be very helpful in attaining and maintaining an erection good enough for successful intercourse.

Figure 1: Penile prosthesis

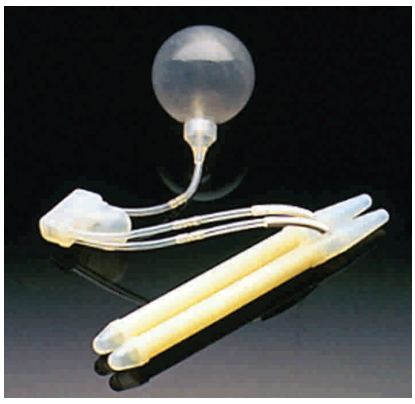

Figure 2: Vacuum pump

Because of its impact on the individual and the relationship, all ED patients and their partners can benefit from sex or relationship therapy.

Female sexual dysfunction[7]

The main sexual dysfunctions in females are interest/desire disorder, arousal disorder, sexual pain disorder and orgasm disorder.

In females there are often a comorbidity of dysfunctions because they have no discreet phases, or an invariant order of phases, in their sexual response. Diagram 1 provides an algorithm to diagnose and classify female sexual dysfunctions.

In females the subjective sexual experience is of paramount importance. They need stimuli in the right context (environment/atmosphere) for proper sexual functioning.

Sexual thoughts are rare and sexual fantasies usually purposeful in females. Their sexual function varies with lifecycle, age and relationship duration. A common reason for females to engage in sexual intimacy is to enhance emotional closeness with their partner.

Multiple aetiologies are involved in female sexual dysfunction and there is interplay between the psychological and biological. Many factors predispose, precipitate and maintain these dysfunctions. Mood states and personality factors are also associated with dysfunction.

If her partner suffers from a sexual dysfunction it can cause a sexual dysfunction in a female and also affect her general sexual wellbeing and quality of life.

Interest/Desire disorder

The causes of low sexual desire in Table 4 can also be applied to females. Depression is a major cause for low female desire and should be diagnosed and treated.

Androgen therapy for desire disorders is not recommended and should especially not be prescribed by a GP. It is still unsure whether the benefit of androgen therapy outweighs the risks. It falls into the realm of specialist treatment, and should not be given as long term treatment, without concomitant oestrogen therapy and to premenopausal females.

Females with low desire can benefit from psychotherapy and sex therapy.

Arousal disorder

Local oestrogen treatment is recommended for females with arousal disorder. PDE5-inhibitors are still under investigation and not registered for treatment of females with arousal disorder.

Sexual pain disorder

Clinically, there is an overlap between vulvar vestibulitis syndrome (VVS) and vaginismu, and also between vaginismus and dys-apareunia.

Females with these conditions can benefit from psychotherapy and relationship therapy. Past sexual abuse needs to be addressed. Focusing on non-penetrative sex might help as well as medical treatment in the form of pain medication. Vaginal inserts or dilators are also sometimes recommended.

Figure 3: Vaginal dilators

Many females with these conditions need more specialised gynaecological evaluation and care.

Orgasmic disorders

When physical factors, like neurological disease and drug side-effects have been ruled out, most females benefit from a PLISSIT approach. The GP can help the patient by counselling her. It may help if she is "given permission" to "let go or lose control", if the mechanism of orgasm is explained to her, or if she is told that many female never climax through vaginal penetration alone. The patient can also be given advice on how to achieve maximal clitoral stimulation.

Conclusion

Patients presenting with sexual dysfunction prefer their doctor to initiate a discussion on such a problem. A well-informed GP will know the importance of taking a thorough sexual history. Today, most sexual dysfunctions can be managed by a sensitive and caring GP. Some individual cases have more complex problems and should be referred to an appropriate specialist for further management.

See CPD Questionnaire p.47

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