**Sex**

1. **In patients, specifically pregnant women, adolescents, and perimenopausal women:**
	1. **Inquire about sexuality (e.g. normal sexuality, safe sex, contraception, sexual orientation, and sexual dysfunction)**

Sexual history: age of first intercourse, perceived gender of self, gender of partners, current relationship status, current sexual activity, pain or bleeding with intercourse, type of sexual activity, satisfaction (desire, arousal, orgasm), assault/abuse, contraception methods and use thereof, review safer sex practices

* 1. **Counsel the patient on sexuality (e.g. normal sexuality, safe sex, contraception, sexual orientation, sexual dysfunction)**

Useful website: sexualityandu.ca (has lots of resources for pts and professionals).

1. **Screen high-risk patients (e.g. post-MI, diabetics, pts with chronic disease) for sexual dysfunction, and screen other pts when appropriate (e.g. during the periodic health exam)**

High risk populations:

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| Medications | Antihypertensives (thiazide, ACEI, CCB, spironolactone), anticonvulsants, opioids, benzos, H2 receptor blockers (ranitidine), antineoplastics, antipsychotics, antidepressants, anticholinergics, anti-emetics (haldol, maxeran, prochlorperazine, dimenhydrinate), chemotherapy, ketoconazole |
| Cancer | Surgical disfigurement, alopecia, weight changes, hormonal changes, fatigues, depression/anxiety, fungating wounds, fistulas, alteration in physical perceptions, brain metastases, RT, effect of sx medications |
| Neuro | MS, CVA, spinal cord injury |
| Endocrine | Hypo/hyperthyroidism, diabetes, menopause, andropause, hypogonadism, hyperprolactinemia |
| Vascular | HTN, CAD, PVD |
| Urology/Gyne | Anatomic abnormality, menopause, vestibulitis, STI |
| Psychiatric | Depression, anxiety, PTSD, psychosis, sexual orientation issues, developmental issues |
| Psychosocial | ETOH, smoking, mood altering drugs, marijuana, LSD, cocaineRelationship changes, new couple, infertility, miscarriage, post-partum, parenthood, teen, empty nest, loss of spouse, affairs, different sexual expectationsSocial stressors (job, money, work, etc..) |

1. **In pts presenting with sexual dysfunction, identify features that suggest organic and non-organic causes**

**SD Common in both men and women**

Types of sexual dysfunction:

* + - Desire phase: hypo/hyperactive sexual desire, sexual aversion disorder
		- Arousal phase: female sexual arousal disorder, vaginismus, dyspareunia, decreased lubrication, ED
		- Orgasm phase: female orgasmic disorder, premature ejaculation, delayed ejaculation

 APA criteria for diagnosing the major female sexual disorders

 •Hypoactive sexual desire disorder — deficient (or absent) sexual fantasies and

 desire for sexual activity

 •Female sexual arousal disorder — inability to attain, or to maintain until completion

 of the sexual activity, an adequate lubrication-swelling response of sexual

 excitement

 •Female orgasmic disorder — delay in, or absence of, orgasm following a normal

 sexual excitement phase

 •Dyspareunia — genital pain that is associated with sexual intercourse

 •Vaginismus — involuntary contraction of the perineal muscles surrounding the outer

 third of the vagina when vaginal penetration with penis, finger, tampon, or speculum

 is attempted

Approach to organic, versus non-organic sexual dysfunction:

* Sexual history, INCLUDING PARTNER HISTORY
* Discontinue/switch possibly offending medications
* Physical exam (emphasis on endocrine, vascular, and uro/gyne)
* Psychiatric disorder screen (e.g. MDD, anxiety, PTSD, psychotic D/O)
* **Nocturnal penile tumescence testing**
* **Duplex Doppler imaging**
* Blood work: free testosterone, total testosterone, prolactin, TSH, CBC
* Transvaginal ultrasound, cervical swabs for chlamydia and gonorrhea.

**(Routine measurement of serum testosterone to detect hypogonadism in ED continues to be debated, however UpToDate suggests measuring testosterone levels in men to detect hypogonadism). Testosterone, FSH,LH level measurements not recommended in women with sexual dysfunction.**

Features that suggest a non-organic cause:

* Abrupt onset
* No history of trauma
* No new meds
* Ongoing nocturnal erections
1. **In pts who have sexual dysfunction with an identifiable cause, manage the dysfunction appropriately**

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| Cause | Treatment |
| Post-menopause | Estrogen creams equivalent to Replens for vaginal drynessSee below for details |
| Surgically-induced menopause | Testosterone |
| Vaginismus | Vaginal dilators, counseling, PT, awareness, |
| Female Anorgasmia | Primary: books, counselingSecondary: change meds, sildenafil, vibrators if increase stimulation needsLow libido: if from relationship, treat reason |
| Female Dyspareunia(treat the cause) | ***Vulvar:*** skin conditions, vulvitis, vulvar vestibulitis, poorly repaired episiotomy***Vaginal:*** lubrication, imperforate hymen, infections, vaginismus***Pelvic:*** endometriosis, pelvic varicosities, ovary in cul-de-sac, tumor, adhesions, UTI, interstitial cystitis, constipation, proctitis |
| Male decrease libido | History, possibly counseling |
| Erectile dysfunction | Sildenafil (NO NITRATES), yohimibine or trazodone for psychological to increase libido, intraurethral alprostadil (MUSE), intracavernosal injections (Caverject), vacuum assisted erection device, penile prosthesis |
| Ejaculatory disorder | Couple sex therapy, SSRI |

**Constructive psychological and lifestyle change—balanced healthy diet, increasing physical exercise, decreasing alcohol and tobacco use—positively impact sexual health by enhancing well-being, self-worth, and body image and increasing overall stamina.**

**•For postmenopausal women with hypoactive sexual desire disorder in whom non-pharmacologic therapy has been unsuccessful, we suggest a trial of testosterone (Grade 2B). • For premenopausal women with sexual dysfunction, recommendation is against androgen therapy (Grade 1B).**

1. **In pts with identified sexual dysfunction, inquire about partner relationship issues.**

As above.

1. **Barriers to effective diagnosis:**

 Difficult or embarrassing to discuss.

 Persisting cultural and religious taboos about sex, self-blame about negative

 sexual experiences or sexual dissatisfaction—even when related to pain—can

 lead women to refrain from discussing

 Attribute to the normal effects of aging.

 May opt to discontinue sexual intercourse altogether.

1. **Treatment of Vaginal atrophy**

Nonhormonal treatments (useful for mild symptoms) - OTC vaginal moisturizing agents - do not reverse atrophic vaginal changes.

Increasing sexual activity play an important role in improving vaginal function. (“use it or lose it phenomenon”)

Vaginal Estrogen Therapy (VET) - Most effective treatment for moderate to severe symptoms of VA, provided there are no CI’s (eg. estrogen-dependent tumors). Cream, tablet, or ring form

Low dose VET- solely for VA symptoms (≤50 mcg estradiol or ≤0.3 mg conjugated estrogens/≤0.5 g cream. A preparation containing only 10 micrograms of estradiol (Vagifem) is effective).

VET more effective than Systemic estrogen therapy for VA

Progestin not necessary to protect against endometrial hyperplasia or cancer in women treated for VA with the low dose ring/cream or tablet

**References:**

UpToDate

OBG Management (Nov. 2010)