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EDITORIAL

Women's right to a better sexual life

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It is a great honour and pleasure to be the invited editor of this issue of *Urodinamica*, dedicated to Female Sexual Dysfunctions (FSD). The right of women to get a better sexual life is increasingly recognized. However, this goal cannot be achieved without a thorough understanding of their sexuality in physiologic and pathologic conditions (1-6), in different contexts and cultures (7, 8), with different religious and ethic backgrounds. Classification's changes reflect both the effort of perfectly describing women's experiences and complaints and yet the limits of the current understanding of FSD (9, 10). The latest classification of FSD is summarized in Table 1 (10).

Fortunately, after decades of marginal interest, the topic of female sexual function and dysfunction is currently receiving dedicated research and clinical attention. Health care providers are indeed increasingly required to address FSD in an effective way.

However, concise, updated, and authoritative books or journals dedicated to the clinical approach to FSD are rare (11). Many focus on a single aspect (12, 13). Excellent books are available but their volume often discourages the busy clinician (14). This volume of *Urodinamica* is therefore timely. I am honoured to present here the contributions of some of the most brilliant experts of the world in the area of FSD. They have kindly agreed to focus on the clinical approach of each aspect considered, to ease the reader in his/her perception of the clinical relevance of data and expertise they are reporting and discussing.

A few points, that the readers will find discussed in greater detail in the individual chapters, will be highlighted here. Women's sexuality is *multifactorial*, rooted in biological, psychosexual and context-related factors (1-8), either correlated to couple dynamics but also family and sociocultural issues. It is *multisystemic:* in men and women, a physiologic response requires the integrity of

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Table 1 - Classification of female sexual disorders.

Women's sexual interest / desire disorder
There are absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies and a lack of responsive desire. Motivations (here defined as reasons/incentives), for attempting to become sexually aroused are scarce or absent. The lack of interest is considered to be beyond a normative lessening with life cycle and relationship duration.

Sexual Aversion Disorder
Extreme anxiety and/or disgust at the anticipation of/or attempt to have any sexual activity.

Subjective Sexual Arousal Disorder
Absence of or markedly diminished cognitive sexual arousal and sexual pleasure from any type of sexual stimulation. Vaginal lubrication or other signs of physical response still occur.

Genital Sexual Arousal Disorder
Complaints of absent or impaired genital sexual arousal. Self-report may include minimal vulval swelling or vaginal lubrication from any type of sexual stimulation and reduced sexual sensations from caressing genitalia. Subjective sexual excitement still occurs from non genital sexual stimuli.

Combined Genital and Subjective Arousal Disorder
Absence of or markedly diminished subjective sexual excitement and awareness of sexual pleasure from any type of sexual stimulation as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication).

Persistent Sexual Arousal Disorder
Spontaneous, intrusive and unwanted genital arousal (e.g. tingling, throbbing, pulsating) in the absence of sexual interest and desire. Any awareness of subjective arousal is typically but not invariably unpleasant. The arousal is unrelieved by one or more orgasms and the feelings of arousal persist for hours or days.

Women's Orgasmic Disorder
Despite the self-report of high sexual arousal/excitement, there is either lack of orgasm, markedly diminished intensity of orgasmic sensations or marked delay of orgasm from any kind of stimulation.

Dyspareunia
Persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse.

Vaginismus
The persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger, and/or any object, despite the woman's expressed wish to do so. There is often (phobic) avoidance and anticipation/fear of pain. Structural or other physical abnormalities must be ruled out/addressed.

Modified from (10).

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the hormonal, vascular, nervous, muscular, connective and immunitary system: a fact too often overlooked in women, until recently (1-5). Three major dimensions: *Female Sexual Identity*, *Sexual Function* and *Sexual Relationship* interact to give to women's sexual health its full meaning or its problematic profile (6, 11). Women's sexuality is *discontinuous* throughout the life cycle and is dependent on personal, current contextual and relationship variables as well as historical factors (9, 10).

FSD is *age related*, *progressive* and *highly prevalent*, affecting up to 20% to 43% of women in the fertile age (14), and 46% of the elderly ones, still sexually active in the late postmenopause (15). Prevalence figures vary greatly among studies, due to methodological biases. Unbiased prevalence estimates from population samples have been rare, and incidence estimates have been non-existent.

FSD may occur along a continuum from *dissatisfaction* (with potential integrity of the physiologic response but emotional/affective frustration) to *dysfunction* (with or without pathological modifications), to severe *pathology*, biologically rooted (9, 10). However, sexu-

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al dissatisfaction, disinterest and even dysfunction may be appropriate for an "antisexual" context (for example, a partner affected by Male Sexual Disorders or abusive) and they should not be labeled per se as "diseases" or dysfunctions worth of medical treatment (16). FSD may occur with or without significant personal (and interpersonal) distress (15, 16). Sexual problems reported by women are not discrete and often co-occur: co-morbidity is one of the leading characteristics of female sexual dysfunctions (9, 10).

Co-morbidity between FSD and medical conditions – urological, gynecological proctological, dismetabolic, cardiovascular and nervous diseases, to mention a few – is as well beginning to be recognized. For example, latent classes of sexual dysfunctions by risk factors in women indicate that urinary tract symptoms have a RR= 4.02 (2.75-5.89) of being associated with arousal disorders and a RR=7.61 (4.06-14.26) of being associated with sexual pain disorders, according to the epidemiological survey of Laumann et al. (14), credited to be the best survey produced up to now. Endocrine, infectious, muscular, vascular, nervous (particularly pain associated) and psychosexual factors contributing to the shared pathophysiology between FSD and associated medical conditions deserve therefore to be thoroughly investigated. The attention dedicated to co-morbidity – both between FSD and between FSD and medical conditions – in this issue reflects the clinical relevance of this association, especially in the uroginecological domain. The clinical approach to single dysfunctions has been enriched with other papers focusing on aspects of clinical relevance for the clinician. The increasing awareness of pelvic floor disorders as key factors both in sexual pain disorders and urinary tract symptoms, the life span perspective in urological symptoms and associated FSD, new histological evidence on the extension of corpora cavernosa around the urethra, the role of neuropathic pain and neurogenic inflammation, will be discussed in detail as well. Age and menopause will be considered as leading factors causing FSD. The role of endocrine factors, testosterone first, in modulating sexual drive, central and peripheral arousal will be addressed in a dedicated chapter. Depression and the role of psychoactive drugs on FSD is the subject of another paper. Controversial issues, such as "hypersexuality" in women, and "new" syndromes, like the Persistent Sexual Arousal Disorders (PSAS) will be briefly described as well. Psychosexual issues, like the outcome of sexual abuse, have been considered. Many other topics related to FSD, for sake of concision, have been only briefly mentioned. Considering the main interest of the readers of *Urodinamica*, the focus of the issue has a priviledged medical perspective. However, as repeatedly stressed in the last consensus conferences on FSD, for a more accurate definition of the sexual symptoms, the physician should as well briefly investigate the so called "descriptors" of the disorders. They include: A) *contextual factors*, which appear to be most salient to qualify the disorder: 1) negative upbringing/losses/trauma (physical, sexual, emotional), past interpersonal relationships, cultural/religious restrictions, 2) current interpersonal difficulties, 3) partner sexual dysfunction, inadequate stimulation and unsatisfactory sexual and emotional contexts, 4) medical conditions, inclusive of psychiatric, medications, substance abuse, 5) the disorder being generalised or situational; B) *time-related factors*, i.e. the disorder being lifelong or acquired; C) *the distress scale*, that can indicate a mild, moderate, or severe impact on the personal life. The use of validated measurement of the distress may be preferable. Sexual distress should be distinguished from non-sexual distress and from depression. The degree of reported distress may have implications for the woman's motivation for therapy and for prognosis.

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Indeed *sociocultural factors* may further modulate the perception, expression and complaining modality – i.e. the "wording" – of a sexual disorder. The meaning of sexual intimacy is to be understood, as it is indeed a strong modulator of the sexual response and of the quality of satisfaction the woman experiences, besides the simple adequacy of the sexual response (4, 8-11, 17, 18). Quality of feelings for partner and partner's health and sexual problems may further contribute to FSD (4, 8, 9, 19).

To address the complexity of FSD requires a balanced clinical perspective between biological and psychosexual/relational factors. Apart from addressing the FSD complaint in a competent way when the issue is openly raised by the patient, a physician, who is prepared to listen, can contribute to improving the quality of (sexual) life of his/her patients, by routinely asking them, during the clinical history taking: "How's your sex life"? thus offering an overture to current or future disclosure.

The wish is that this issue will significantly contribute to increase both the physician's confidence in asking and listening to FSDs complaint and his/her "clinical impact factor", i.e. his/her ability to appropriately diagnose and effectively treat FSD in an increasing number of women – and couples – who seek for help in a difficult moment of their sexual life.

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