

Medical and sexual comorbidities: when the integrative approach is key

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Abstract

Sexual function requires the integrity of the main systems of the body: hormonal, nervous, vascular, muscular, metabolic, immunitary. When one or more of these systems are dysfunctional, comorbidity with sexual problems increases with the severity of the primary disease: this is a solid concept in male sexual dysfunctions, specifically when erectile deficit emerges as the alerting symptoms of depression, cardiovascular diseases, low testosterone, or neurological problems. This is much less evident in women, where until recently the emphasis on psychosexual and relational issues has shadowed the importance of biological factors. On the other hand, when sexuality is dysfunctional, consequences may affect the medical domain. Medical and sexual comorbidities are therefore emerging as the new frontier of diagnosis and treatment of sexual dysfunctions in both genders.

The presentation will focus on women's sexuality and medical comorbidities, a most neglected issue, with a few critical examples of how comorbidities should be diagnosed and addressed:

a) depression and loss of desire: common neurobiological pathways (serotonergic and dopaminergic) and overlapping sensitivity to sexual hormones (estrogens and testosterone) are the biological factors contributing to this frequent comorbidity;

b) urogynecologic and sexual comorbidity: embryologic affinity, anatomic contiguity, hormonal sensitivity, vulnerability to reproductive, coitus-related and iatrogenic and/or traumatic events (Graziottin, 2006), contribute to the frequent and yet neglected co-morbidity between Urinary Incontinence (UI), Lower Urinary Tract Symptoms (LUTS) and Female Sexual Dysfunctions (FSD), specifically genital arousal disorders (Giraldi & Graziottin, 2006), dyspareunia (Graziottin & Rovei, 2007) and orgasmic difficulties. Latent classes analysis 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 its most frequently reported associated symptom: vaginal dryness) and a RR=7.61 (4.06-14.26) of being associated with sexual pain disorders (Laumann et Al., 1999);

b) gastrointestinal diseases and sexual comorbidity: Irritable bowel syndrome (IBS) is characterized by the up-regulations of mast cells, critical directors of the inflammatory response (Barbara et Al, 2007). IBS is associated with recurrent cystitis, vulvar vestibulitis/vulvodynia, endometriosis, chronic pelvic pain and dyspareunia, which recognize the same mast cells' up-regulation (Bachmann et Al, 2006; Graziottin & Rovei, 2007). Obstructive constipation, caused by the hyperactive pelvic floor and inverted perineal command, is associated with dyspareunia, primary vaginismus and recurrent post-coital cystitis (Graziottin, 2007). Recognizing and addressing the common pathophysiologic background may significantly reduce the impact of the disease/dysfunction on women's health and QoL and of sexual life.

The presentation will discuss sexual and medical comorbidities in the lifespan perspective, with special focus on predisposing, precipitating and maintaining factors: biological, psychosexual and context-related. It will stress the importance of an integrative approach for a comprehensive diagnosis and a well tailored etiologically oriented treatment (Graziottin & Rovei, 2007).

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