Iatrogenic etiology of Female Sexual Dysfunction: prevention and treatment

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Background
The iatrogenic etiology of Female Sexual Dysfunction (FSD) is a neglected area in the clinical practice.

Aim of the study
To focus on the potential role of iatrogenic factors as predisposing, precipitating or maintaining cofactors of FSD.

Method
Review of the literature, with focus on iatrogenic FSD, desire disorders, arousal disorders, orgasmic disorders, dyspareunia, vaginismus, radiotherapy, chemotherapy, hormonotherapy, cancer treatment, pelvic surgery, colporraphy, vulvar laser treatment, cystoscopy, invasive diagnostic manoeuvres, plus the Author’s clinical experience.

Results
Physicians and health care providers may contribute to sexual disorders, with a:

a) predisposing role, when they do not recognize and diagnose conditions that may prelude to, precipitate in or maintain a Female Sexual Disorder, both in otherwise healthy women or while addressing acute and chronic diseases - diabetes, multiple sclerosis, coronary heart disease (CHD), recurrent cystitis, endocrine disorders and menopause, chronic immunologic diseases such as lupus erthematous or cancer - that may secondarily affect sexuality;

b) precipitating role, through the: 1) inappropriate prescription of medications that may negatively affect women’s and couple’s sexuality; 2) through the negative outcome of surgery, obstetrics and/or of chemotherapy, hormonotherapy or radiotherapy, especially in the pelvic region; 3) through the lack of respect of professional boundaries in the clinician-patient relationship;

c) maintaining role, through the most frequent mistake in the field of FSD: the diagnostic omission, which encompasses occasional or systematic diagnostic neglect, particularly in the area of biological/medical etiology of FSD and/or comorbidity between medical conditions and FSD.

Conclusions
Clinicians should ask about sexuality and potential FSD, and report the information in the medical record, before any medical prescription or surgical intervention, and maintain a proactive diagnosing attention to FSD during and after treatment, without assuming that chronic diseases or advanced age per se excludes the need, the desire or the possibility of a rewarding sexual life.

Further research is needed to quantify the extent of the iatrogenic role in FSD, the role of confounders, the preventive measures that should be encouraged to reduce iatrogenic FSD and the legal implications of a claim of damaged sexuality.

Clinicians should be encouraged to train in sexual medicine and include at least the basics of sexual history taking in their clinical practice, to reduce the iatrogenic contributors of FSD. Referral to a specialist in this area is also important.