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Sexual dysfunctions in women
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Sexual dysfunctions in women

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Background

Female sexual dysfunction (FSD) is a multidimensional problem combining biological, psychological and interpersonal elements of multiple aetiology. Types of FSD include hypoactive sexual desire disorder (HSDD), sexual arousal disorder, orgasmic disorders and sexual pain disorders (dyspareunia and vaginismus). The prevalence of this disorders is high: 29% of European women aged 18-70 complain of hypoactive sexual desire disorder, 22% of arousal disorder, 19% of orgasmic disorder and 14% of sexual pain disorder. Up to 27% of women aged 40–80 years in Europe experience a lack of sexual interest; in the US, this number is considerably larger.

Objective

The aim of the presentation is to review and update:

1. the etiology of FSD, with focus on HSDD, vaginal dryness, dyspareunia and postcoital cystitis;
2. the therapeutic options – both pharmacological and non-pharmacological – available for FSD, with a special focus on giving practical recommendations to those physicians interested in the management of women with sexual complaints.

Method

Literature review and Author's clinical experience.

Results

1. Lifestyle intervention

Depression is the psychiatric disorder more frequently associated to HSDD. Obesity with metabolic syndrome, diabetes and CVD dramatically affect sexual function in women. Solid data indicate that diet, weight loss and regular exercise may significantly reduce CVD risk and improve FSD in women. Specifically, daily exercise can reduce inflammation, common denominator of depression and many diseases associated with aging, and specifically contribute to improve the sexual response in women.

2. Pharmacological therapy

For successful treatment of FSD, hormonal treatment may be considered. Their role is higher for menopause-associated FSD. After the menopause, interventional options include hormonal therapies such as estrogens, topical or systemic, combined estrogen and testosterone, testosterone alone (as in the Aphrodite study), tibolone and dehydroepiandrosterone. As solid data indicate that male sexual dysfunction (MSD) (erectile deficit and premature ejaculation) may induce FSD in the partner (HSDD, arousal disorders and orgasmic disorders) appropriate diagnosis and pharmacologic treatment of MSD is important as well.

3. Physiotherapy

This cost-effective intervention can contribute to improve the hypotonic pelvic floor, typical of women with multiple vaginal deliveries and/or operative vaginal deliveries, with the associated sexual symptoms of reduced vaginal sensitivity, incontinence during thrusting (when stress incontinence is comorbid), orgasmic difficulties; and the hyperactive/hypertonic pelvic floor, associated with sexual pain disorders (dyspareunia, vaginismus, post-coital cystitis and LUTS, lower urinary tract symptoms and coital anorgasmia);

4. Psychosocial therapy

Psychosocial interventions include basic counseling, psychosexual intervention, either individual or couple, and is combined with biomedical interventions to provide an optimal outcome.

Conclusions

Dealing with sexual issues in clinical practice is becoming increasingly important as FSDs can have an enormous impact on a patient's and couple's quality of life. Therapeutic interventions useful in the clinical practice will be presented.