

# Incorporating Sexual Medicine into Clinical Practice

Hilda Hutcherson, MD

Sexuality is important to our overall health and sense of well-being. Sexual problems may affect a woman's self esteem, happiness, relationship with her partner and quality of life. Increasing age adversely affects sexual functioning, and there may be further decline in sexual functioning with the menopausal transition. Although sexual difficulties with aging are common, the more pertinent issue is whether these sexual problems are causing personal distress.<sup>1</sup>

Incorporating sexual medicine into clinical practice can enhance the health and well-being of the older woman. A thorough assessment of sexual concerns should include physical, hormonal, psychological and relationship issues. Sexual problem identification and evaluation should be a routine component of medical care.

While sexual problems are common, Laumann et al<sup>2</sup> reported that only 10% to 20% of women with sexual dysfunction sought medical consultation for their problems. Many midlife women are reluctant to initiate a conversation about sex or sexual problems, and may not volunteer such information to their doctors. Many believe that their sexual function is too personal and private to discuss.<sup>3</sup> In a poll of 500 adults, ages 25 years and older,<sup>4</sup> 71% said that they thought their

doctor would dismiss their sexual concerns. Sixty-eight percent were afraid that discussing sex would embarrass their physicians.

Physicians also may not initiate the discussion due to feelings of embarrassment, a belief that sexual health is not important, or the assumption that sexual problems after menopause are normal.<sup>5</sup> Other barriers include physicians' fears that they may not possess adequate knowledge about sexual problems, concerns about "opening a can of

worms," inadequate compensation from insurance companies, and the time constraints of the typical medical practice. Physicians are also less likely to raise sexual issues with older patients.<sup>6</sup>

Ninety percent of adults surveyed in the National Health and Social Life Survey believed that sexual difficulties caused problems such as depression, emotional distress and relationship problems, making sexual disorders an important health concern.<sup>2</sup> It is, therefore, important for healthcare professionals who provide medical care to perimenopausal and postmenopausal women to initiate discussions of sexual function.<sup>7</sup> Even physicians who do not plan to pursue a complete evaluation and treatment of sexual problems can validate the importance of sexual health and empower their patients to take the necessary steps to get appropriate care.<sup>3</sup>

## Female Sexual Dysfunction: Epidemiology and Definition

Sexual problems are common, affecting approximately 43% of women.<sup>2,8</sup> The incidence of sexual dysfunction increases with both aging and the menopausal transition. In a prospective study of 438 Australian participants (ages 45 to 55

years) in the Melbourne Women's Midlife Health Project,<sup>9</sup> 42% reported sexual dysfunction in the early menopausal transition. Eight years after menopause, the incidence of sexual problems increased to 88%.

Many of the physical, psychological, and relationship changes that are common during menopause have the potential to impair sexual functioning.<sup>1</sup> The most common sexual complaints of postmenopausal women include loss of desire, impaired arousal and orgasm, decreased frequency of sexual activity, decreased feeling for the woman's partner, partner performance problems, lack of a partner, increased vaginal dryness and sexual pain.<sup>1,5,9</sup>

Researchers have discovered that women may not follow the traditional linear sexual response cycle of Masters, Johnson and Kaplan. This linear model underlies the traditional definition of sexual dysfunction organized by the American Psychiatric Association and published in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Women don't necessarily begin sexual encounters with spontaneous desire, and arousal may actually precede desire. In addition, subjective arousal is an important component of women's sexual functioning. With this in mind, an International Definitions Committee organized by the American Urological Association Foundation recently proposed fundamental changes to the existing definitions of female sexual dysfunction.<sup>10,11</sup>

- *Sexual interest/desire disorder*: Absence or diminished feelings of

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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 the normative lessening with lifecycle and relationship duration.<sup>10,11</sup>

- *Subjective sexual arousal disorder*: Absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation. Vaginal lubrication or other signs of physical response still occur.<sup>10,11</sup>
- *Genital sexual arousal disorder*: 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 in response to non-genital stimuli.<sup>10,11</sup>
- *Combined genital and subjective*

*arousal disorder*: Absence of or markedly diminished feelings of sexual arousal (sexual excitement and sexual pleasure) from any type of sexual stimulation, as well as complaints of absent or impaired genital sexual arousal (vulval swelling, lubrication).<sup>10,11</sup>

- *Persistent sexual arousal disorder*: Spontaneous, intrusive and unwanted genital arousal (e.g., tingling, throbbing) 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.<sup>10,11</sup>
- *Orgasmic disorder*: Lack of orgasm, markedly diminished intensity of orgasmic sensations, or marked delay of orgasm from any kind of stimulation despite the self-report of sufficient sexual arousal/excitement.<sup>10,11</sup>
- *Vaginismus*: A woman's persistent or recurrent difficulties in allowing vaginal entry of a penis, a finger, and/or any object despite her expressed wish to do so. There is often (phobic) avoidance and anticipation/fear/experience of pain, along with variable involuntary pelvic muscle contraction. Structural or other physical abnormalities must be ruled out/addressed.<sup>10,11</sup>
- *Dyspareunia*: Persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse.<sup>10,11</sup>

**Initial Assessment: Taking a History**  
Women's sexual response is complex, and most sexual problems are multi-factorial. The evaluation of

midlife women must include physical, hormonal, psychological, social and relationship issues.

*Broaching the topic.* Many women are unlikely to volunteer information about sexual problems. One study showed that while only 14% of women spontaneously reported sexual dysfunction, 58% did so when sexual function questions were included in a questionnaire.<sup>12</sup> Physicians should make inquiry about sexual health and satisfaction a part of routine medical history taking. A thorough evaluation can be time-consuming, which may be difficult in the typical office practice. To facilitate an initial identification of a sexual problem, physicians may elect to include a few specific questions about sexual functioning as part of a general medical intake questionnaire. The Brief Sexual Symptom Checklist,<sup>13</sup> developed by an international committee, may assist physicians in identifying whether a sexual problem exists, assessing the type and duration of a sexual problem, and determining the willingness of the patient to discuss the problem with the physician (Figure). Once a problem is identified, the physician may decide to refer the patient to a specialist, or schedule a follow-up appointment for a more thorough evaluation.

*Medical history.* A complete and comprehensive medical history is the foundation of any evaluation of sexual functioning. The history should include medical, sexual, psychosocial and relationship issues.<sup>7,8,12</sup>

Many age-related medical problems can impair sexual functioning. Diabetes, cardiovascular disease, hypertension, hyperlipidemia, per-

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ipheral vascular disease, neurologic disease and endocrine problems are all risk factors for female sexual dysfunction.<sup>13</sup> Medications, such as antihypertensives, antidepressants, oral contraceptives, progestins, phenothiazines, narcotics, aromatase inhibitors, androgen antagonists and antihistamines, may adversely affect sexual functioning. Surgical procedures, illicit drugs, smoking and alcohol consumption

may also place women at high risk for sexual disorders.

*Psychosocial history.* An effective psychosocial history should include questions designed to reveal information about any history of psychiatric disorders (anxiety, depression, psychosis), relationship issues, or physical, emotional or sexual abuse.

*Sexual history.* A sexual history should assess the woman's current and past sexual relationships, sexual orientation, sexual functioning and history of sexually transmitted infections. When obtaining a sexual history, care must be taken to consider social, ethnic and cultural sensitivities of the patient. Privacy and confidentiality must be assured, and questions should be presented in a matter-of-fact, non-judgmental manner. For instance, instead of making assumptions about a patient's sexuality, a question about pain during intercourse

Please answer the following questions about your overall sexual function in the past 3 months or more.

1. Are you satisfied with your sexual function? Yes    No  
If no, please continue.
2. How long have you been dissatisfied with your sexual function?  
\_\_\_\_\_
- 3A. The problem(s) with your sexual function is: (mark one or more)
  - 1) Problems with little or no interest in sex
  - 2) Problems with decreased genital sensation (feeling)
  - 3) Problems with decreased vaginal lubrication (dryness)
  - 4) Problems reaching orgasm
  - 5) Problems with pain during sex
  - 6) Other: \_\_\_\_\_
- 3B. Which problem is most bothersome (circle 1, 2, 3, 4, 5 or 6)
4. Would you like to talk about it with your doctor? Yes    No

**Figure. Brief sexual symptom checklist: women's version**

could be preceded with a question such as, “Are you sexually active with men, women, or both?” When possible, including the partner may add valuable information about the presenting problem.

The assessment of sexual problems is time consuming. Validated questionnaires, though created for use in research protocols rather than clinical practice, may increase physician efficiency. Questionnaires also may make it easier for some women to answer sensitive questions. One commonly used questionnaire is the Female Sexual Function Index.<sup>14</sup> Despite their usefulness, questionnaires should never be used as a substitute for a thorough sexual history.

### Physical Assessment

The physical exam is an essential component of the workup of sexual dysfunction. The exam should include a general screening for medical problems that might contribute to sexual problems, such as cardiovascular, neurologic, endocrine and, when indicated, genitourinary problems.<sup>13</sup>

Not only does the physical exam help to detect pathology that might contribute to sexual problems, it also provides an opportunity to educate the patient about normal anatomy and sexual functioning. Negative genital self-image, in particular, may negatively affect sexual desire.<sup>12</sup> Sometimes, simply assuring a patient that her anatomy is normal helps to boost her sexual self-esteem and improve her sexual functioning.

*Pelvic exam.* A pelvic exam adds little, if any, information when evaluating the woman whose sole

**N**ot only does the physical exam help to detect pathology that might contribute to sexual problems, it also provides an opportunity to educate the patient about normal anatomy and sexual functioning.

complaint is loss of desire or sexual interest. It is important to be aware that some women with desire problems, or inability to stay focused on sexual stimulation, have histories of abusive sexual experiences. Genital examination in these women may cause major anxiety. Complete explanations of the exam (when such an exam is indicated) and permission to proceed should be obtained prior to the exam.

The pelvic exam should include an evaluation of the vulva. Skin lesions, infections, lichen sclerosus and other vulvar dystrophies should be noted. The exam should assess signs of estrogen deficiency, such as dryness, thinning of tissue, pale color, thinning pubic hair and loss of vaginal rugae. Vaginal pH should be measured. A pH above 5 is consistent with vaginal atrophy

in an otherwise healthy vagina.<sup>7</sup> Genital pain mapping, to localize the focus of pain, is indicated in women complaining of sexual pain. A moistened cotton-tipped applicator is used to gently touch the vulva, vestibule, hymenal ring, and Bartholin's and Skene's glands. The pelvic floor should be evaluated for strength and the presence of involuntary contractions. Monomanual and bimanual exams are used to assess pelvic masses, infections, endometriosis, fibroids, adhesions and cervical motion tenderness. The speculum exam evaluates the vagina and cervix for signs of infection and dryness.

### Laboratory Evaluation

Few laboratory tests are required for evaluation of female sexual dysfunction, as the cause of sexual dysfunction is often obvious after the comprehensive history and physical exam. The most commonly recommended tests include those that evaluate general health, such as a complete blood count, blood chemistries, fasting glucose, and cholesterol and lipid levels. Follicle-stimulating hormone, luteinizing hormone, and estradiol levels may be added to the testing if a woman's menopausal status is unclear. Some practitioners recommend measurement of total, free and bioavailable testosterone, dehydroepiandrosterone sulfate, androstenedione, and sex hormone-binding globulin in women with desire disorders, while others disagree. It should be noted that the significance of measured serum androgen levels in women is controversial. No single androgen level has been found to be predictive of

low female sexual function.<sup>15</sup> The position statement of The North American Menopause Society further states that laboratory testing of testosterone levels should be used only to monitor for supra-physiologic levels before and during therapy, not to diagnose testosterone insufficiency.<sup>16</sup>

Other tests should be based on the practitioner's suspicions after the medical history and physical exam. These may include measurement of thyroid-stimulating hormone and prolactin.

*Specialized tests.* Some practitioners of sexual medicine have found specialized diagnostic tests such as vaginal photoplethysmography, thermal and vibratory sensory analysis,<sup>17</sup> and duplex doppler ultrasonography<sup>18</sup> useful in the comprehensive evaluation of sexual problems. These tests, while essential in sexual functioning research, have little value in clinical practice. The expense, time requirements, size and complexity of the equipment, technical skills requirement, and lack of clinical evidence supporting the value of these tests make them impractical in the typical medical practice. In addition, for most patients, these tests do not add significantly to the therapeutic decision-making process.<sup>13</sup>

### Billing Issues

Assessment and evaluation of sexual problems can be time consuming, and insurance reimbursement may be problematic. Although female sexual dysfunction is considered an important health issue, office visits and specialized tests for the evaluation of sexual dysfunction

## Physician and patient should work together to devise a mutually acceptable management plan.

are not reimbursed by some insurance companies. Sexual pain disorders can be billed by using the International Classification of Diseases, Ninth Revision (ICD-9) code that corresponds to the specific organic problem, such as endometriosis or fibroids, which is causing the pain (Table). It may be more difficult to find a reimbursable diagnosis for disorders of desire, arousal and orgasm, for which a specific physical etiology may not be known. Often, patients are totally responsible for all fees associated with the evaluation of sexual disorders.

### Treatment

After a comprehensive evaluation, patients should have a follow-up visit to review findings and receive an explanation of their specific problem and available treatment options. Physician and patient should work together to devise a mutually acceptable management plan. A comprehensive review of the treatment of sexual dysfunction is beyond the scope of this article, but the following tips might be helpful for the physician who is contemplating incorporating sexual medicine into his or her practice.

Patient education should be considered an essential component of management strategy. Discussions about sex, sexuality and sexual functioning can be quite time-consuming. Nurses, nurse practitioners, physician assistants and other physician extenders may be useful in providing needed education to the patient and her partner. Pamphlets and other patient

**Table.**  
**Examples of ICD-9 Codes Commonly Used for Female Sexual Dysfunction**

Type of Dysfunction	ICD-9 Code
Hypoactive sexual desire disorder	302.71*
Female sexual arousal disorder	302.72*
Female orgasmic disorder	302.73*
Decreased libido	799.81
Vulvodynia	625.0
Dyspareunia	625.9

\*These ICD-9 codes appear under "mental disorders" and may not be reimbursed by some insurance companies.

education material may be provided to the patient for supplemental at-home reading. Sometimes, simply validating the patient's concerns, providing her with education about sexual anatomy and physiology, and dispelling sexual myths is sufficient to alleviate her sexual problem. Patient education pamphlets detailing sexual anatomy, sexuality and sexual problems can be purchased from the American College of Obstetricians and Gynecologists ([www.ACOG.com](http://www.ACOG.com)). A new textbook by Goldstein, Meston, Davis and Traish, *Women's Sexual Function and Dysfunction: Study, Diagnosis and Treatment*, is a good reference for physicians interested in increasing their sexual knowledge.

Sexual problems in menopausal women are often easily treated with simple interventions. The most common complaints are decreased sexual desire and painful sex caused by vaginal dryness. Sexual pain caused by vaginal dryness can sometimes be alleviated simply by the use of water-based lubricants during sex. Lubricants that contain silicone tend to coat the vagina better and last longer. Lubricants can be purchased over-the-counter or ordered online. Women who have a significant amount of dryness and atrophy may not find relief with lubricants alone, and systemic or local estrogen may be necessary. For women without other menopausal symptoms, local estrogen may be preferable. Estrogen tablets (Vagifem), estrogen creams or an estrogen-containing vaginal ring (Estring) may be used for local therapy. When massaged into the vaginal tissue daily, an amount of

**I**deally, the initial evaluation by the physician may be combined with an evaluation by a psychosexual specialist during the same visit.

estrogen cream as small as a bean (a helpful reference for patients) may be enough to increase vaginal moisture.

Desire disorders are commonly multi-factorial and the most difficult to treat. Testosterone therapy, when combined with systemic estrogen, has been shown to be effective in some surgically menopausal women.<sup>19</sup> However, testosterone has not been approved for use in women, and long-term safety data are not available. Desire may not be essential to initiate sexual response in women, and often the environment and stimuli are more important in arousing a woman who is initially sexually neutral. Providing this information to patients may go a long way in their therapy. Women with psychological or relationship issues should be referred to the appropriate mental health provider.

The frequency and intensity of orgasm may decrease after menopause. Topical testosterone (not approved for use in women) and/or a suction device approved

by the FDA for treatment of female sexual dysfunction (the EROS CTD; NuGyn, Inc) have been used with some success by sexual medicine practitioners.<sup>20</sup> Zestra, a botanical oil,<sup>21</sup> and vibrators<sup>22</sup> may also be useful in women with vaginal dryness and diminished orgasmic response.

When indicated, referrals to specialists should be provided. Women who have depression, anxiety, long-standing sexual problems or relationship problems should be referred to a sex and marital therapist, psychiatrist, psychologist or clinical social worker. Ideally, the initial evaluation by the physician may be combined with an evaluation by a psychosexual specialist during the same visit. This team approach prevents the "it's not in my head" feeling that leads some patients to refuse the assessment that is often essential to comprehensive evaluation and treatment of patients with sexual dysfunction.<sup>20</sup> Integrating sex therapy into the medical practice will improve effectiveness in treating sexual disorders. To find a sex therapist, consult the American Association of Sex Educators (AASECT). You can search by location for a referral online at [www.aasect.org](http://www.aasect.org). Names, addresses, brief biographies, and areas of specialization of therapists are provided.

### Summary and Conclusions

Sexual dysfunction is an important public health concern. Sexual problems can cause serious emotional stress for patients, their partners and their relationships. Women's sexual response is

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complex, and the evaluation should include physical, hormonal, psychological, social and relationship issues. A comprehensive medical and sexual history and physical exam are essential for the workup of female sexual dysfunction. Few laboratory tests are required for the evaluation. Evaluation of sexual problems is time-consuming and may require multiple office visits. As most of the ICD-9 codes for female sexual dysfunction are included under the heading "mental disorders", reimbursement from insurance companies may be problematic.

Most sexual problems in menopausal women are amenable to treatment by primary care physicians, and assessment of sexual function should be a routine part of the care of the older woman. ■

Hilda Hutcherson, MD, is Assistant Clinical Professor, Obstetrics and Gynecology, Columbia University College of Physicians and Surgeons, New York, NY.

*Dr. Hutcherson reports that the Web site of Zestra Laboratories, Inc. has included a link to her book ("Pleasure: A Woman's Guide to Getting the Sex You Want, Need, and Deserve") on Amazon.com.*

*This article includes discussion of off-label drug use.*

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