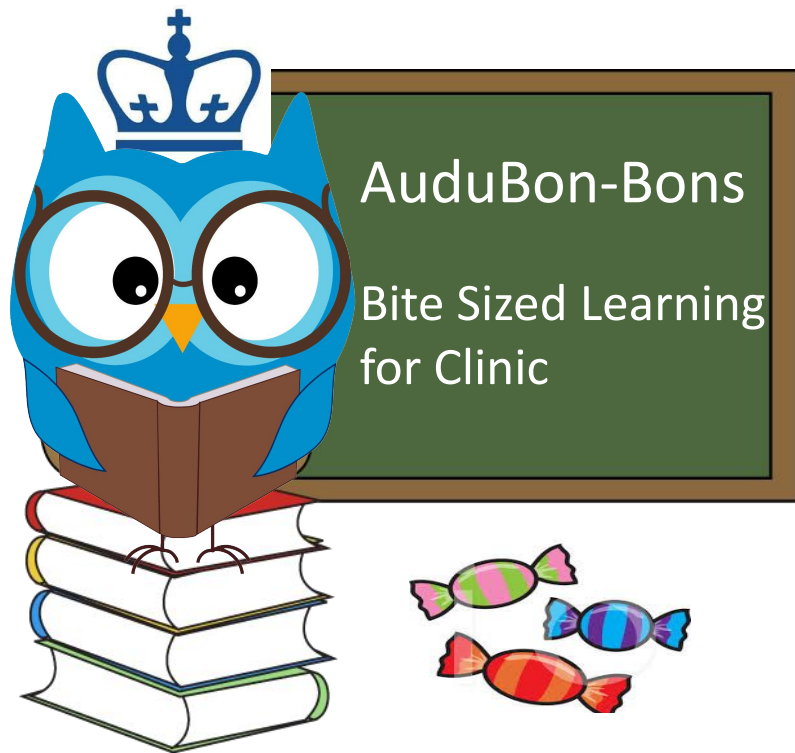


# FEMALE SEXUAL DYSFUNCTION

Week 10

Prepared by: **Holli Jakalow, MD**

Reading Assignment:  
*ACOG Practice Bulletin #213*  
Female Sexual Dysfunction



# LEARNING OBJECTIVES



- To understand the female sexual response
- To be able to diagnose the different types of female sexual dysfunction
- To be able to perform the initial evaluation of possible female sexual dysfunction



# CASE VIGNETTE

- Ms. Pine, a 51 y.o. G3P2012 woman presents because she has felt decreased sexual desire.



# FOCUSED HISTORY

What elements of the patient's history are most relevant?

- **PMH:** HTN
- **PSH:** D&C for 1TM VTOP
- **POBH:** G3P2012: SVD x2; 1TM VTOP x1
- **PGYNH:** Achieved menopause at age 50. Denies PMB. Denies history of STIs or abnormal paps. Up to date on pap. Sexually active with mutually monogamous male partner. Denies history of fibroids or cysts.
- **MEDS:** Lisinopril
- **All:** Sulfa – hives
- **FH:** Mother with HTN, Father with HLD, HTN, DM
- **SH:** Denies tob, drug, etoh use. Denies IPV. Works as an elementary school teacher. Accepts blood products



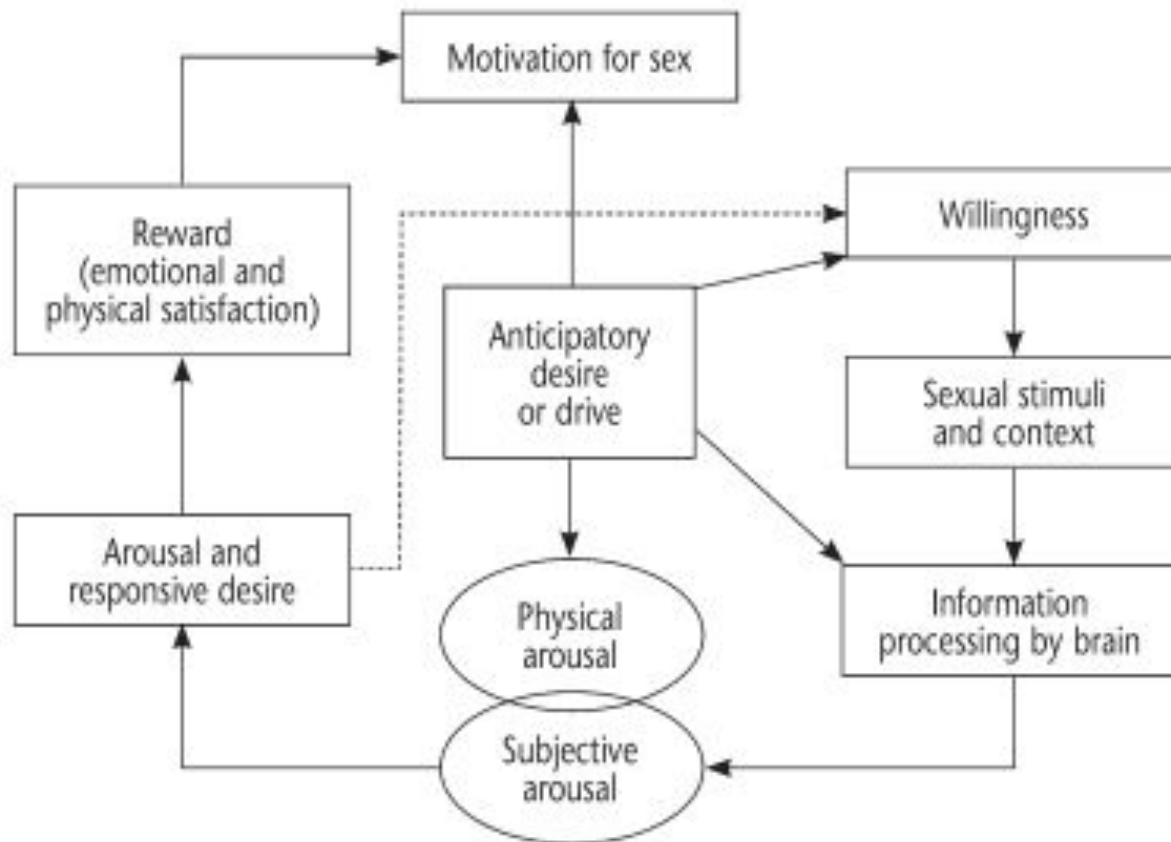
# PERTINENT PHYSICAL EXAM FINDINGS

**What elements of the patient's physical exam are most relevant?**

- **General:** Well appearing woman, VSS
- **CV:** RRR
- **Resp:** CTAB
- **Abd:** Soft, ND, NT, no rebound or guarding
- **Vulva:** Normal external female genitalia. No lesions.
- **Vagina:** Mildly atrophic mucosa
- **Cervix:** Multiparous cervix. No lesions. No bleeding. No CMT
- **Uterus:** NT. Anteverted. No masses
- **Adnexae:** NT. No masses palpable



# FEMALE SEXUAL RESPONSE



**Figure 1.** Female sexual response. The circular sexual response cycle shows overlapping phases of variable order. Reasons or motivations for sex are numerous, and sexual desire or drive may or may not be present at the outset but reached after the brain has processed sexual signals as sexual arousal, which conflates with sexual desire. The latter creates an urge for increased arousal, allowing acceptance of increasingly intense sexual stimulation. (Basson R. Sexuality and sexual disorders. Clin Update Womens Health Care 2014;XIII(2);1-108. Available at: <https://www.clinicalupdates.org/viewissue.cfm?issue=cuwhc-v13n2>. Retrieved February 22, 2019.)



# FEMALE SEXUAL DYSFUNCTION

## What is the prevalence of female sexual dysfunction?

- 43% of American women report experiencing sexual problems
  - 12 consider it to be so bothersome that it leads to personal distress
  - Increases through middle age with peak of 15% among women aged 45-64 years

## What are some of the common etiologies and risk factors?

### Box 1. Common Etiologies and Risk Factors for Female Sexual Dysfunction

Anxiety disorder  
Diabetes  
Depression  
Female genital mutilation  
Genitourinary syndrome of menopause  
History of sexual abuse  
Hypertension  
Hysterectomy  
Intimate partner violence  
Medications (psychotropic medications [selective serotonin reuptake inhibitors], antihypertensives, histamine blockers, hormonal medications)  
Negative sexual attitudes  
Neurologic disease  
Personality traits of perfectionism and self-dislike  
Postpartum period

- Breastfeeding
- Obstetric trauma

Premature ovarian failure  
Psychologic sequelae of gynecologic cancer and breast cancer  
Relationship discord  
Stress—emotional or environmental  
Stress urinary incontinence  
Substance use disorder





# TYPES OF SEXUAL DYSFUNCTION

**Table 1.** *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Criteria for Female Sexual Dysfunction*

Disorder	Definition
Female sexual interest/arousal disorder	<p>A lack of, or significant decrease in, at least three of the following:</p> <ul style="list-style-type: none"> <li>• interest in sexual activity</li> <li>• sexual or erotic thoughts or fantasies</li> <li>• initiation of sexual activity and responsiveness to a partner's initiation</li> <li>• excitement or pleasure during all or almost all sexual activity</li> <li>• interest or arousal in response to internal or external sexual or erotic cues (eg, written, verbal, visual)</li> <li>• genital or nongenital sensations during sexual activity in almost all or all sexual encounters</li> </ul> <p>Symptoms have persisted for a minimum of 6 months and cause clinically significant distress in the individual.<sup>*</sup></p>
Female orgasmic disorder	<p>Marked delay in, marked infrequency of, or absence of orgasm, or markedly reduced intensity of orgasmic sensations, in almost all or all occasions of sexual activity. Symptoms have persisted for a minimum of 6 months and cause clinically significant distress in the individual.<sup>*</sup></p>
Genito–pelvic pain/penetration disorder	<p>The persistent or recurrent presence of one or more of the following symptoms:</p> <ul style="list-style-type: none"> <li>• difficulty having intercourse</li> <li>• marked vulvovaginal or pelvic pain during intercourse or penetration attempts</li> <li>• marked fear or anxiety about vulvovaginal or pelvic pain anticipating, during, or resulting from vaginal penetration</li> <li>• marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration</li> </ul> <p>Symptoms have persisted for a minimum of 6 months and cause clinically significant distress in the individual.<sup>*</sup></p>
Substance/medication-induced sexual dysfunction	<p>A disturbance in sexual function that has a temporal relationship with substance/medication initiation, dose increase, or substance/medication discontinuation and causes clinically significant distress in the individual.<sup>†</sup></p>
Other specified sexual dysfunction and other unspecified sexual dysfunction	<p>Distressing symptoms characteristic of a sexual dysfunction that do not meet the criteria of one of the defined categories. The major distinction between other specified sexual dysfunction and other unspecified sexual dysfunction is whether the clinician specifies the reason that the symptoms described do not meet the criteria for one of the other classes.</p>

<sup>\*</sup>A diagnosis of a sexual dysfunction disorder can be made only if the sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (eg, partner violence) or other significant stressors and is not due to the effects of a substance or medication or another medical condition.

<sup>†</sup>The disturbance is not better explained by an independent sexual dysfunction disorder. Evidence that suggests a nonsubstance/medication-induced sexual disorder includes a history of an independent sexual dysfunction disorder, symptoms that precede the onset of substance or medication use, or symptoms that persist for at least 1 month after cessation of acute withdrawal or severe intoxication.

Data from American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): APA; 2013.





# EVALUATION OF FEMALE SEXUAL DYSFUNCTION

## How should patients be screened?

- **Initiate a clinical discussion of sexual function during routine care visits**
  - Validated self-report checklist
  - *OR* Generalized statement by provider followed by close-ended question followed by open-ended question
    - “Many women experience concerns about sex. Are you experiencing any issues? What is concerning you?”
  - *OR* Broad, open-ended questions during routine history gathering

## What is the initial evaluation?

- Comprehensive history and physical examination
- Laboratory testing if undiagnosed medical etiology is suspected



# DIAGNOSIS OF FEMALE SEXUAL DYSFUNCTION

## How do you confirm the diagnosis?

- Symptoms persist for at least 6 months
  - Except in the case of substance/medication-induced sexual dysfunction
- Symptoms are sufficient to result in significant personal distress
- Symptoms are not better explained by a nonsexual mental health disorder, a medical condition, severe relationship distress, or other significant life stressors, or the effects of a substance of medication (except in the case of substance/medication-induced sexual dysfunction)
- Patients often experience more than one type of female sexual dysfunction

**If a patient's sexual function symptoms do not meet diagnostic criteria do you still evaluate her and offer treatment?**

- **YES!**



# TREATMENT OPTIONS

**What is the preferred treatment for female sexual dysfunction due to genitourinary syndrome of menopause?**

- Low-dose vaginal estrogen therapy

**Is systemic DHEA recommended for treatment of women with sexual interest/arousal disorders?**

- No

**What non-pharmacologic interventions can be used?**

- Psychologic interventions, including sexual skills training, cognitive behavioral therapy (with or without pharmacotherapy), mindfulness-based therapy, and couples therapy

**If a patient's symptoms do not meet diagnostic criteria, could she still benefit from evaluation and treatment?**

- Yes!



# SOCIAL DETERMINANTS OF HEALTH

## Survivors of childhood sexual abuse (CSA)

- Higher risk for sexual dysfunction
- Sexual shame has been noted as a strong influence for sexual dysfunction for this population
- Treatments that aim to reduce sexual shame may improve sexual function for survivors of CSA

Trauma-informed care helps all aspects of your patient's health.

Always screen your patients for both current and past abuse.



# EPIC .PHRASE

## **BBonFSDScreen**

Description: Screening for Female Sexual Dysfunction

The patient was screened for female sexual dysfunction and she screened \*\*\*. She \*\*\* other sexual concerns.



# CODING AND BILLING

- **ICD-10 Code**

- F52.22

- Female sexual arousal disorder

- **CPT Code**

- 99214

- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
      - A detailed history; a detailed examination; medical decision making of moderate complexity.
      - Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
      - Usually, the presenting problem(s) are of moderate to high severity.
      - Typically, 25 minutes are spent face-to-face with the patient and/or family.



# EVIDENCE

Pulverman, C et al. "Sexual dysfunction in women with a history of childhood sexual abuse: The role of sexual shame." Psychol Trauma. 202 Mar;12(3):291-299

Female sexual dysfunction. ACOG Practice Bulletin No. 213. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019; 134e1-18.

