Editorial

Female sexual dysfunction: an impression

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Sexual dysfunction in female is a common and often distressing problem that has a negative impact on quality of life as well as medication compliance.[1] Female sexual dysfunction (FSD) is classified as female sexual interest/arousal disorder, female orgasmic disorder, genito-pelvic pain or penetration disorder, other specified and unspecified dysfunction and substance or medication induced dysfunction.[2] About 12% of female in the United States reported distressing sexual health concerns, even though as many as 40% of female reported sexual concerns in general.[3]

The problem is often multi-factorial that addresses biological, psychological, socio-cultural and relational factors.[1] Lower educational level, menopause, depression, presence of sexual dysfunction in their partner and contraceptive use were found to be significantly associated with sexual dysfunction of female.[2] Some chronic illnesses, such as vascular disease, diabetes mellitus, neurologic disease, and malignancy as well as hormonal changes occurring in midlife may directly or indirectly impact sexual function.[4,5] Serotonin-enhancing medications have an inhibitory effect on sexual function. FSD induced by selective serotonin reuptake inhibitor use is common and may include obscurity with sexual desire, arousal and orgasm in female.[5] In additional, many other frequently prescribed medications may negatively affect sexual functioning, including antiestrogens, such as tamoxifen and aromatase inhibitors, and oral estrogens, including combined hormonal contraception.[6]

The preponderance of FSD are connected to several psychological factors.[7] The most common factors impacting female sexual function are depression, anxiety, distraction, negative body image, sexual abuse and emotional neglect. Common contextual or socio-cultural factors that cause or maintain sexual dysfunction include relationship discord, partner sexual dysfunction (e.g., erectile dysfunction), life stage stressors (e.g., transition into retirement, children leaving home), sexual fears or guilt, past sexual trauma as well as cultural or religious messages that inhibit sexuality.[8]

Assessment of FSD is best approached using a bio-psychosocial model and should include a sexual history and physical examination. Laboratory testing is usually not needed to identify causes of sexual dysfunction includes important questions to ask patients during a sexual functioning assessment.[9] FSD are particularly prevalent among women seeking routine gynecological care.[10] The assessment as well as the overall management of FSD is a multi disciplinary (including endocrinology, urology, psychiatry, gynecology and venereology) approach. Most types of FSD can be corrected by treating the underlying physical or psychological problems. Other treatment strategies include medication, mechanical aids, sex therapy, behavioral treatments, psychotherapy and education as well as communication.[11]

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