

HOSPITAL PHYSICIAN®

OBSTETRICS AND GYNECOLOGY BOARD REVIEW MANUAL

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The *Hospital Physician Obstetrics and Gynecology Board Review Manual* is a peer-reviewed study guide for residents and practicing physicians preparing for board examinations in obstetrics and gynecology. Each manual reviews a topic essential to the current practice of obstetrics and gynecology.

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Female Sexual Dysfunction

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Table of Contents

Introduction	2
Female Sexual Response	2
Screening and Evaluation for Sexual Dysfunction...	4
Sexual Dysfunction Disorders	6
Conclusion	11
References	11

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Female Sexual Dysfunction

Sheryl A. Kingsberg, PhD, and Rebecca Flyckt, MD

INTRODUCTION

Sexual dysfunction refers to persistent or recurrent disturbance of the normal sexual response cycle or pain associated with sexual activity. According to data from the National Health and Social Life Survey, a study of sexual behavior in the United States, sexual dysfunction is more prevalent in women (43%) than in men (31%).¹ Yet, research in the area of assessment and treatment of sexual dysfunction has largely targeted men.

One of the most important reasons why sexual dysfunction in women has not been more extensively researched is the difficulty in measuring appropriate endpoints. Until recently, there were few sensitive, specific, and validated outcome measures for assessing female sexual desire and arousal. In contrast, assessment of male arousal (ie, erections) is relatively straightforward. Further, there is considerable overlap among the female sexual dysfunction disorders, making diagnosis and treatment approaches more difficult.

Evidence suggests that healthy sexual functioning is an important contributor to a woman's sense of well-being and quality of life. Yet, women are hesitant to initiate discussions with their clinicians about sexual matters. In 2001, U.S. Surgeon General David Satcher put out a *Call to Action* to promote sexual health as one component of the goals of Healthy People 2010.² Dr. Satcher's report described the role of health professionals as well as individuals and the community in promoting sexual health and called for better education and competence of physicians in this arena.

Patient hesitancy to discuss sexual concerns suggests that clinicians should routinely initiate discussions about sexual function during clinical visits. When assessment of sexual function is a priority and clinicians are comfortable discussing and managing these concerns, even time-constrained visits can allow a few moments to inquire about sexual function and to develop a diagnostic and therapeutic approach. This manual provides an overview of female sexual function and presents a framework for assessment, diagnosis, and management of sexual dysfunction in women.

FEMALE SEXUAL RESPONSE

EXPLANATORY MODELS

Current models for understanding the female sexual response reflect the complicated and multifactorial nature of female sexuality. Basson's³ model acknowledges the importance of emotional intimacy, psychological factors, and sexual stimuli and posits that in women arousal often precedes desire (**Figure**). This description updates the traditional linear models of Masters and Johnson⁴ as well as Kaplan,⁵ in which desire precedes arousal. Levine⁶ suggests that desire has 3 distinct but interrelated components—drive (spontaneous biologically driven sexual interest), cognitive factors (expectations, beliefs, and values about sex), and motivation (emotional and interpersonal factors)—further emphasizing the complexity of the female sexual response.

PHYSIOLOGY

Physiologic arousal in women is the result of an intricate neurobiologic mechanism that is not fully understood. The cycle of arousal is initiated by genital vasocongestion. Consequently, the vulva swells exposing the introitus, the vagina lengthens and dilates, the outer third of the vagina tightens, the clitoris increases in length and diameter, and the uterus rises above the levator plate.⁷ Stimulation of pelvic nerves induces smooth muscle relaxation and decreases resistance within the arteries, leading to increased blood flow to the clitoris. The corpora cavernosa of the clitoris become engorged, and the clitoris becomes progressively more prominent. In addition, vaginal lubrication occurs due to increased pressure in the capillaries of the genital vasculature and transudation of fluid through the subepithelium of the vaginal walls.

Although the exact actions of neurotransmitters underlying clitoral and genital arterial smooth muscle relaxation have not been defined, it is likely that nitric oxide (NO), vasoactive intestinal peptide (VIP), and possibly acetylcholine (ACh) play key roles in this stage of arousal.⁸ Most of our understanding of these neurotransmitters is derived from what is already known about