

**INTRODUCTION:**

Sexual dysfunction is very common in the UK.

A recent large UK population study (NATSAL); of 15,000 men and women; between the ages of 16 and 74 showed that 42% of men and 51% of women have complaints of sexual problems. These were associated with physical, and psychiatric problems as well as having had an STI and a history of non-volitional sex.

In 10% of men and women, these problems were felt to cause distress and were thus significant clinical problems.

This study further showed that the following specific sexual dysfunctions were reported in both women and men-decreased interest in sex, lack of sexual enjoyment, pain at sex, no excitement at sex, difficulty orgasming, orgasming more rapidly than wanted to, as well as erectile dysfunction in men and dryness at sex in women.[1]

**ASSOCIATIONS WITH OTHER CONDITIONS:**

Dunn et al. in a large cross-sectional study; showed that sexual problems are associated with self-reported physical problems in men, and with psychological and social problems in women.[2]

Only 20% of women presenting with sexual problems; come forward to seek help – some women, presented themselves inappropriately at gynaecology outpatients.[3]

Erectile dysfunction is common, and may be a predictor of cardiovascular disease, either alone; or in conjunction with diabetes in around 65-70% of men. Erectile dysfunction in older men is often a predictor of cardiovascular disease,[1] because of the underlying vascular occlusive pathology. Sexual dysfunction in men, is associated with loss of self-esteem, and with depression, particularly, when the
onset of erectile dysfunction is slow, or initially intermittent, and is associated with increasing age. It may be the first indication of cardiovascular damage.

Most men presenting to their GP with erectile dysfunction, will be considered for active drug therapy. Pharmacological treatment for erectile dysfunction is not always successful; and about 40% of men do not renew their prescription. [4] [5] [6] [7] [8] [9].

Depression and other psychiatric illnesses; are independent risk factors for cardiovascular disease in men with erectile dysfunction. Depression and anxiety are also very common problems, often associated with somatic complaints and with underlying sexual dysfunction as a causative factor. A reduction in the burden of depression can be achieved by finding and treating the underlying causes. [10] [11] [12].

Vaginismus and other causes of vulval pain, affect up to 12% of women [13], and HIV in men and women is a not an uncommon background cause of sexual dysfunction [14] [15].

**APPROACHES TO THE MANAGEMENT OF SEXUAL DYSFUNCTION:**

International consensus strongly agrees; that the management of sexual dysfunction should be by the biopsychosocial approach of sexual medicine, which should include: Doctors, nurses, psychologists, sex therapists and physiotherapists [16]. This model, has been shown to be effective and cost effective [17] [18], and works well in a sexual health clinic [19].

The biopsychosocial models used in sexual medicine; are evidence based where possible and if not, consensus opinion is taken by experts from a wide range of specialties [20].

Although most patients with sexual dysfunction will go to primary care as a first call [3], GPs may not be equipped or have the time or resources to handle more complex cases of sexual dysfunction [21].

**AIMS OF A LOCAL SEXUAL DYSFUNCTION SERVICE:**

1. Improve the level of expertise in sexual medicine in general practice, the main gateway to other services, to improve diagnosis, offer treatment, and reduce inappropriate referral.

2. Improve the level of expertise in sexual medicine in other services where patients commonly present with sexual dysfunction e.g. gynaecology, urology, oncology, cardiology, GUM/HIV and contraceptive services.

3. Improve the recognition of psychosexual/sexual dysfunction as a cause or result of other physical or mental illnesses to reduce the burden of these conditions on the Health Service.

4. Ensure equitable access to local specialist sexual dysfunction and psychosexual and services.

5. Recognise that sexual abuse (including FGM) and more recent trauma may result in sexual dysfunction and that specialist psychological treatment for this may be required.

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References:


18. Goldmeier D et al. How to recognise sexual addiction in the sexual health clinic setting STI 2011;87:370-1

