

# CME Report

## Family Physician's Guide to Diagnosing Hypoactive Sexual Desire Disorder: First, Communication

### An Evidence-based CME Consensus Recommendation From an Expert Panel



#### Introduction

**C**an asking one simple question improve the well-being of your female patients and leave them feeling more satisfied about being in your practice?

Try, "What sexual concerns do you have?"

But don't be surprised if your patient fails to respond as blithely as the women in "Sex and the City."

*Charlotte: So how are you?*

*Carrie: I'm good. How are you?*

*Charlotte: Great.*

*Carrie: I told Aidan about the affair and he broke up with me.*

*Charlotte: Trey and I never had sex on our honeymoon.*

*Carrie: You win. So. Should we get more coffee or should we get two guns and kill ourselves?*

Talking about sex sounds so easy for them. What about you? What would you need to feel comfortable talking about your sex life? More importantly, what do your patients need to feel comfortable talking with you about their sexual concerns?

Creating an environment in which women are comfortable talking about intimate issues can benefit both patient and provider. With appropriate evaluation and management, it is possible for clinicians to alleviate many sexual problems. The result for women can be a heightened sense of

personal well-being, happiness, and overall life satisfaction.<sup>1</sup> In addition, since many women are gate-keepers for an entire family's health care, there is potential for positive outcomes for a clinical practice as a result of increased patient satisfaction with care.

Recently, the New Jersey Academy of Family Physicians (NJAFP) convened a panel of experts to discuss ways to improve physician-patient communications relating to the diagnosis and treatment of the most prevalent female sexual disorder seen in the primary care setting, hypoactive sexual desire disorder (HSDD). The resulting educational materials are designed to provide family physicians with the knowledge and skills they need to enhance communication with their patients when screening, assessing, and treating this condition.

#### Sex Matters

Sex is perhaps the most fundamental of all human behaviors. It not only is crucial for the ongoing

*(continued on page 3)*



## Objectives

### GOAL

*The goal of this educational program is to provide family physicians and other health care providers with the knowledge and skills they need to confidently assess and effectively address the sexual health concerns of their women patients.*

### SPECIFIC OBJECTIVES

By the end of this program, participants will be able to:

- *Recognize the legitimacy of female sexual dysfunctions as related to overall health*
- *Routinely obtain a sexual history as part of their patients' general history*
- *Exhibit comfort and confidence in initiating a dialogue with female patients about their sexual health concerns*
- *Differentiate between HSDD and other types of female sexual dysfunction*
- *Incorporate questions into their inquiry about sexual health that are likely to improve accurate diagnosis of HSDD*
- *Use available evidence-based guidelines to appropriately diagnose and effectively manage patients with HSDD*
- *Identify local referral and Web-based educational resources for sexual health*
- *Refer women to a sexual health specialist when necessary*

## Expert Panel

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## Physician Accreditation Statements

**Family Physician's Guide to Diagnosing Hypoactive Sexual Desire Disorder: First, Communication** has been reviewed and is acceptable for up to 2.5 Prescribed credit(s) by the American Academy of Family Physicians. AAFP accreditation begins May 1, 2010. Term of approval is for two year(s) from this date, with option for yearly renewal.

AAFP Prescribed credit is accepted by the American Medical Association (AMA) as equivalent to AMA PRA category 1 credit toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as prescribed credit, not as category 1.

## Acknowledgements

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maintenance of the species, but is linked to personal identity, the ability to develop and maintain relationships, and the capacity to forge bonds of physical and emotional intimacy. It is intuitive that sex is linked to health and well-being and this observation is also supported by evidence.

A 2008 review of several large-scale survey studies in multiple countries found a consistent association between sexual activity and sexual satisfaction on the one hand, and overall quality of life on the other. Although the authors were unable to identify specific causal factors for their findings, they noted that, “women with more active and satisfying sexual relationships report consistently higher ratings of emotional and relationship satisfaction. This heightened sense of well-being potentially contributes to improved subjective health and other positive outcomes.”<sup>1</sup> Conversely, researchers have also identified a significant relationship between sexual dysfunction and a lower quality of life.<sup>2,3</sup>

During the past decade, the topic of men’s sexual problems, particularly erectile dysfunction, moved from being taboo to becoming mainstream discussion. The commercial availability of medical treatments for erectile dysfunction fueled information and education campaigns that brought conversations about male sexual dysfunction into the open—from the office water cooler to the clinical exam room.

However, women’s sexual problems remain far more closeted. Despite “women’s liberation” and the “sexual revolution,” social and cultural taboos still hinder the discussion, diagnosis, and treatment of women’s sexual dysfunction. Most women report they are too embarrassed to even broach the topic with their doctors.<sup>4</sup> Physicians are reluctant to bring it up for a variety of reasons.<sup>5</sup> The result is that treatable conditions go undiagnosed and patients suffer in silence.

Beyond embarrassment, many patients—both male and female—are hesitant to bring up their sexual concerns because of misconceptions about the clinician’s response. For example, one survey of adults found that 76% were very or somewhat concerned that there would be no medical treatment for their sexual problems, and 71% were concerned that the physician would dismiss their problem, saying it was in their head.<sup>6</sup>

As one of the few medical specialties that requires training in a biopsychosocial model of disease, family physicians are inclined to look beyond a patient’s mere physical complaints. Because family physicians have first-line and long-term contact with patients,

they are ideally suited to address women’s sexual concerns, including sexual dysfunction.<sup>7</sup>

## Definitions and Classification

In recent years, the topic of female sexual dysfunction has stimulated a spirited dialog as to just what constitutes “normal” or “healthy” function versus “dysfunction” and “disorder.”<sup>8-11</sup> Of clinical significance for family physicians and other primary care providers is a potential shift from viewing female sexual response based on a traditional linear model (desire, arousal, orgasm) to an alternative cyclic model (described later in this topic). This change is linked to three key iterations of definitions for HSDD.

The first and most traditional definition is found in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. The current version (DSM-IV-TR) describes four main categories of female sexual dysfunction (**Table 1**) which all include personal or relationship distress as additional required criterion for a diagnosis of sexual dysfunction.<sup>12</sup> Conceptually, the definitions are based on a linear model of human sexual response (desire, arousal, orgasm) as depicted by Masters and Johnson, and Kaplan and Lief.<sup>13</sup>

**Table 1: DSM-IV-TR Classification of Female Sexual Dysfunction**

<b>SEXUAL DESIRE DISORDERS</b>	
Hypoactive Sexual Desire Disorder	Absence or deficiency of sexual interest and/or desire
Sexual Aversion Disorder	Aversion to and avoidance of genital contact with a sexual partner
<b>SEXUAL AROUSAL DISORDERS</b>	
Female Sexual Arousal Disorder	Inability to attain or maintain adequate lubrication-swelling response of sexual excitement
<b>ORGASM DISORDERS</b>	
Female Orgasmic Disorder	Delay in or absence of orgasm after a normal sexual excitement phase
<b>SEXUAL PAIN DISORDERS</b>	
Dyspareunia	Recurrent or persistent genital pain associated with sexual intercourse
Vaginismus	Involuntary contraction of the perineal muscles, preventing vaginal penetration

**SOURCE:** American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., text revision. Washington, DC: American Psychiatric Association, 2000.



carefully in view of a controversial suggestion that the pharmaceutical industry has created a new “disease” of female sexual dysfunction.”<sup>16</sup>

Key differences in the evolving definition of HSDD are summarized in **Table 2** on page 5.

With the definition of female sexual dysfunction—particularly hypoactive sexual desire disorder—in flux, the judgment of the clinician along with that of the patient becomes paramount. Consideration should be given not only to evolving diagnostic criteria, but also to context. A patient’s concerns about diminished or absent sexual desire must be considered within the normal variability linked to life cycle, culture, relationships, and co-morbid medical conditions.

Having a thorough understanding of the Basson model and risk factors associated with HSDD (described in the next topic) can help family physicians educate and counsel their female patients who have distress related to low sexual desire.<sup>17</sup>

## Prevalence and Predictors

### HOW COMMON IS HSDD?

A statistic that is often cited is that 43% of women report sexual problems.<sup>18</sup> In recent years, concerns have been raised about the methodology underlying this figure, its interpretation, and its on-going use.<sup>8</sup>

The 43% figure, widely (and somewhat erroneously) referred to as the rate of female sexual dysfunction, was derived from analysis of a 1992 survey. Women were asked if they had experienced any of seven sexual problems, for two months or more, during the previous year. Any “yes” answer was characterized as having sexual dysfunction.

However, the survey did not address whether distress was associated with the sexual problem<sup>17</sup>. Subsequent research indicates that a significant portion of those reporting sexual problems are not distressed by them,<sup>16</sup> hence many respondents would not meet current or proposed definitions for having sexual “dysfunction.”

In a 2008 publication, West and colleagues<sup>19</sup> sought to identify the “true” prevalence of female sexual dysfunction using rigorous methods and criteria. They used the Profile of Female Sexual Function (PFSF) desire domain to determine low sexual desire and the Profile of Female Sexual Function and the Personal Distress Scale (PDS) to define HSDD. Prevalence rates for female sexual disorders were significantly lower than those published using alternative instruments and methodologies (*see Table 2 below*). The researchers compared the prevalence of low sexual desire (with no reported distress) to that of HSDD (including the criteria of distress) and found:<sup>19</sup>

- For low sexual desire (without distress), the overall prevalence was 36.2%
- For HSDD (with distress) the overall prevalence rate was 8.3%

**Table 2: Changing Definitions of HSDD**

<b>DSM-IV-TR. American Psychiatric Association, 2000</b>	Persistent or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. Definition includes clinician’s judgment of factors that may affect patient’s sexual functioning such as age and life context.
<b>Revised definition from AFUD/AUAF International Consensus Committee, 2003</b>	Absent or diminished feelings of sexual interest or desire, absent sexual thoughts or fantasies and a lack of responsive desire. Motivation to become sexually aroused is scarce or absent. Lack of interest is beyond a normative lessening with life cycle and relationship duration.
<b>Revisions for upcoming DSM-V suggested by Segraves et al, 2007</b>	Persistent lack of desire for sexual activity and/or lack of responsive desire. This is beyond normative lessening with relationship duration or aging.

**SOURCE:** Basson R. Women’s sexual function and dysfunction: current uncertainties, future directions. *Int J Impot Res.* 2008;20:466-478, citing:

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed., text rev. Washington, DC: American Psychiatric Association; 2000:493-538.
- Basson R, Leiblum S, Brotto L, et al. Definitions of women’s sexual dysfunctions reconsidered: advocating expansion and révision. *J Psychosom Obstet Gynaecol.* 2003;24 :221-229.
- Segraves M, Balon R, Clayton A. Proposal for changes in diagnostic criteria for sexual dysfunctions. *J Sex Med.* 2007;4:567-580.

Results from the PRESIDE (Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking) study published in 2008 by Shifren and colleagues showed that 44% of adult women (mean age 49 years) report having some type of sexual problem, however only 22% report related distress.<sup>20</sup> This large, cross-sectional survey found that sexual problems increased with age, however, distress peaked in the middle years (See Table 3). Figures for HSDD were similar; the prevalence of low desire with distress peaked in the middle aged group.

**Table 3: Age and Sexual Problems<sup>20</sup>**

	Respondants reporting sexual problems	Respondants reporting sexual problems with distress	Respondants reporting low desire with distress
18 to 44 year olds	27%	11%	11%
45 to 64 year olds	45%	15%	15%
65+	80%	9%	9%

While specific prevalence figures vary based on definition criteria and study methodology, it is worth noting that research consistently finds that reduced sexual desire is the most common female sexual complaint, and that only a subset of women are bothered by this.

The take-away message for clinicians is that low sexual desire in women is relatively common, but intervention is not always needed. Sometimes, all the patient needs is reassurance. The clinician should determine if low sexual desire is causing the patient distress before undertaking a more thorough assessment or proposing treatment.

***Low sexual desire in women is relatively common, but intervention is not always needed. Talk with the patient and determine if low sexual desire is causing distress before taking more in-depth steps. Sometimes, all the patient needs is reassurance.***

## RISK FACTORS ASSOCIATED WITH HSDD

The 2008 publication by West and colleagues holds additional data of interest to physicians. The researchers noted that the highest rates of distress about low sexual desire were reported by recently surgically menopausal women. The authors noted that this may indicate difficulty adjusting to the sudden hormonal changes that follow such surgery.<sup>19</sup> This high rate of distress suggests that family physicians should be extra vigilant in asking about sexual concerns when treating women who have recently undergone bilateral oophorectomy.

Two studies by Hayes and colleagues provide additional insights. In a 2007 study of the relationship between HSDD and aging,<sup>21</sup> researchers found that the proportion of women reporting low sexual desire increased with age, but the proportion of women reporting distress about their low desire decreased with age, resulting in a relatively constant prevalence for HSDD over time.<sup>21</sup>

In a separate but related 2008 study, Hayes and colleagues<sup>22</sup> examined risk factors associated with female sexual dysfunction. They found that relationship factors were more important than age or menopause status.<sup>22</sup> Low sexual desire was reported more often in women in stable, long-term (20-29 years) relationships.<sup>22</sup> In addition, they found that sexual distress was positively associated with depression, and was inversely associated with better communication of sexual needs.<sup>22</sup>

A woman's medical history can also influence her chance of having HSDD. Evidence finds that certain organic diseases and physical conditions are associated with HSDD including breast cancer, pregnancy, diabetes, depression, urinary incontinence, autoimmune disorders, and multiple sclerosis.<sup>23</sup>

Of course, if the full etiology of HSDD were known, identification of risk factors might be easier. Unfortunately, the causes and contributing factors appear complex and highly interrelated, for example, an arousal problem of neurological or vascular origin may lead to low desire. Therefore, researchers are continuing to explore:

- *Hormonal issues (natural and surgical menopause, premature ovarian failure, contraceptive use, etc.)*
- *Neurological issues (central or peripheral nervous system disorders such as those caused by diabetes, levels of neurotransmitters in the brain, etc.)*
- *Vascular problems (such as diminished blood flow to the genitals, hormonal influences on vaginal moisture/dryness, dyspareunia, etc.)*

- Psychological factors (such as stress, relationship problems, mood disorders, prior sexual abuse, lack of self esteem, etc.)
- Medication side effects (antipsychotics, barbiturates, tricyclic antidepressants, selective serotonin-reuptake inhibitors (SSRIs), antihypertensives, oral contraceptives, and anticonvulsants that are known to lower libido) The use of estrogen-containing oral contraceptives may also be associated with low sexual desire in some patients, perhaps due to their effect on increasing Sex Hormone Binding Globulin (SHBG), subsequently reducing free testosterone.

## MEDICATIONS AND SEXUAL SIDE EFFECTS

It is common knowledge that many prescription medications are associated with sexual side effects. Some of the major categories and classes are listed in *Table 4*.

## Overcoming Barriers

Despite male sexual dysfunction becoming a “water cooler” topic, when it comes to meaningful talk about women’s sexual problems, discomfort remains the norm for patients and providers alike. One survey of women receiving routine gynecological care found that 70% reported feeling too embarrassed to raise the topic of sexual concerns.<sup>4</sup> Physician gender (i.e., being less comfortable talking to a male physician) was noted as a potential barrier, but this gender concern was not strong.

So why did women feel awkward raising the topic?

The answer may lie in the findings of a separate study that found 68% of patients were afraid their physician would be embarrassed to talk about sexual issues.<sup>6</sup> Perhaps mirroring this concern, a survey of 2000 health care professionals found embarrassment among the leading obstacles to initiating discussions of sexual health along with time constraints and limited knowledge of female sexual dysfunction.<sup>24</sup>

***Studies have shown that patients were afraid that their physician would be embarrassed to talk about sexual issues. How do you make your patient feel comfortable enough to engage in conversations about sexual concerns?***

**Table 4: Medications Known to Cause Sexual Side Effects**

<b>Antidepressants, mood stabilizers</b>	Selective serotonin reuptake inhibitors (SSRIs) Serotonin-norepinephrine reuptake inhibitors (SNRIs) Tricyclic antidepressants Monoamine oxidase inhibitors (MAOIs) Antipsychotics Benzodiazepines Antiepileptics
<b>Antihypertensives</b>	Beta-blockers Alpha-blockers Diuretics
<b>Cardiovascular agents</b>	Lipid-lowering agents Digoxin
<b>Gastrointestinal agents</b>	Histamine 2-receptor blockers
<b>Hormonal</b>	Oral contraceptives Estrogens, progestins, antiandrogens, GnRH agonists Narcotics Amphetamines Anticonvulsants Steroids

**SOURCE:** Kingsberg S, Althof SE. Evaluation and treatment of female sexual disorders. *Int Urogynecol J Pelvic Floor Dysfunct.* <javascript:AL\_get(this, 'jour', 'Int Urogynecol J Pelvic Floor Dysfunct. ');> 2009;20(suppl 1):S33-S43, citing:  
 • Clayton A. Sexual function and dysfunction in women. *Psych Clin North Am.* 2003;26:673-682.  
 • Berman J, Berman L, Goldstein I. Female sexual dysfunction: incidence pathophysiology, evaluation and treatment options. *Urology.* 1999;54:385-391.  
 • Pauls R, Kleeman S, Karram M. Female sexual dysfunction: principles of diagnosis and therapy. *Obstet Gynecol Surv.* 2005;60:196-205.

These barriers can be overcome with training and the use of simple, effective strategies.

## OVERCOMING EMBARRASSMENT

Evidence indicates that the vast majority of women (78.1% in one study<sup>4</sup>) are unlikely to initiate a discussion about sexual concerns with their doctor. Therefore, it depends on the physician to “open the door” for this discussion. What can ease the way?

Researchers have identified several factors that women say makes it easier for them to talk with physicians about their sexual concerns.<sup>25</sup> Of greatest importance was that the physician was kind and understanding, showed concern, was professional, and appeared comfortable with the topic. Somewhat less important was having seen the physician before and feeling that the doctor knew them. The most

essential ingredient, however, for making this discussion happen is *that the physician brings up the topic*.

A woman is more likely to be forthcoming about her sexual concerns if the physician raises the topic after first establishing rapport and putting her at ease. Some tips for helping patients be more comfortable talking about sexual issues are listed below.

## Practice Tips for More Comfortable Conversations about Sex

- **Don't make them naked and nervous.** Sitting in nothing more than an exam gown can make any woman feel vulnerable. Arranging for your patient to be clothed when you ask about sexual issues can help to reduce anxiety and embarrassment.
- **Make it clear you have time to talk.** If the patient is sitting, you should also be sitting. Give the patient time to talk. Don't interrupt. Listen. Try to look like you're not thinking about all the patients in the waiting room. If time is tight, suggest scheduling an additional visit to focus on the issue.
- **Be supportive and knowledgeable.** Explain that concerns about sexual desire are common and let your patient know that this matter can be addressed. Make sure you are familiar with the current understanding of sexual function and dysfunction in both women and men.
- **Use appropriate language.** A teen-ager and her grandmother may both be sexually active, but use different terms to describe their sex life. Adjust your language to match the tone and style of your patient. However, even if the patient uses sexual slang, you should not. Street terms detract from professionalism and often come with value judgments attached. When using medical terminology, make sure the patient understands their meaning.
- **Be culturally aware.** Race, religion, ethnicity, and sexual orientation can affect a woman's comfort level in discussing sexual issues. Acknowledging the importance of cultural factors can help a woman feel you understand and respect her values, which can make it easier for her to speak freely.
- **Ask questions in a matter-of-fact, but sensitive manner.** When making inquiries for a sexual history avoid language that assumes sexual orientation. Link questions to the patient's medical history or current health problem/concern. Avoid moral/religious judgments of patient behavior. When possible, generalize and normalize sexual behaviors.
- **Practice, practice, practice.** Evidence shows that participating in communications training increases clinician comfort when using explicit sexual terminology.<sup>26</sup> When you show you are comfortable in discussing sexual issues, your patient will feel more comfortable.

**SOURCE:** Consensus recommendations of Expert Panel.<sup>27</sup>

## OVERCOMING CULTURAL BARRIERS

Culture can significantly influence a woman's thoughts, feelings, and behaviors related to sexual

issues.<sup>16</sup> With recent census data showing that more than one-third of the U.S. population is composed of Hispanics/Latinos, African-Americans, Asians, Pacific islanders, and American Indian/Alaskan Natives,<sup>28</sup> it is vital for all health care professionals to be culturally aware and informed.

Data from the Study of Women's Health Across the Nation (SWAN), a multiethnic observational study of women during the menopause transition, demonstrated numerous racial/ethnic differences. For example, compared with white women, Chinese and Japanese women reported less importance for sex, desire, masturbation, and arousal, and African American women reported greater importance and frequency for sex, but less arousal, emotional satisfaction, and physical pleasure than did white women.<sup>16</sup>

A study of Latino women who immigrated to the U.S. from Mexico or Central America found that background cultural influences continued to exert significant effects on sexual functioning even after the women were living in a new cultural environment.<sup>29</sup> Limited English language skills and the central role of male family members can sometimes hamper open doctor-patient communication.<sup>30</sup> For example, if a newborn's father serves as the family interpreter, the mother may be hesitant to bring up post-partum sexual concerns.

While no clinician can be expected to understand all the nuances of every cultural milieu that they may encounter in primary health care, it is important for family physicians to be acquainted with the significant cultural influences, beliefs and communication preferences of the patients commonly encountered in their practice.

## OVERCOMING TIME CONSTRAINTS

Time constraints (and related insurance reimbursement issues) are ubiquitous in clinical practice today. However, the amount of time needed to address a patient's sexual concerns may be less than many clinicians anticipate. A single query plus one or two follow-up questions are often all that is needed to determine if a patient has a sexual problem that is causing distress. Several efficient models for screening and assessing patient's sexual concerns are described later in this document.

In family medicine, it is rare for a patient's sexual concerns to be the primary focus of an appointment. As such, sexual issues are likely to emerge late in the allotted appointment time. When a sexual problem is identified, it is useful to "triage" the issue and decide if it:

- Can be addressed during the current appointment
- Could be better addressed during a separate follow-up appointment
- Appears to be beyond the scope of the family physician and might be better managed by referral to a specialist

When another appointment or referral is needed to further address the concern, remember the evidence that indicates patients expect their doctor to dismiss their sexual concerns and believe that treatments are lacking.<sup>6</sup> To help the woman feel she is not being “put off” or “pushed out,” it is important to acknowledge the importance of sexual concerns in her life, to legitimize their concerns, and to be clear that sexual problems are common and treatable, and then recommend the appropriate follow up.

***When more time is needed to properly assess sexual dysfunction, the clinician should first acknowledge the importance of sexual concerns in the patient’s life, then reinforce that sexual problems are common and treatable, and finally recommend a follow-up appointment or referral.***

## Screening for HSDD

### WHEN TO SCREEN

Screening for HSDD and other sexual concerns can be part of a routine health maintenance exam, a scheduled chronic illness appointment, a follow-up after surgery, a medical procedure or a recent major illness, or a consultation related to major life-cycle events (puberty, postpartum, menopause).

Screening for sexual problems need not be time-consuming; sometimes, one question is all that is needed.

***“What sexual concerns would you like to discuss?”***

If the patient says none, make sure to leave the door open for future concerns.

***“If you have questions about sexual issues in the future, please know you can always ask me.”***

If the woman indicates that she does have questions or concerns, a few, focused follow-up questions can often clarify the issue.

***“Are you having difficulty with desire, arousal, orgasm, or pain during intercourse?”***

## Practice Recommendation #1

Adult women should have a health maintenance exam (HME) that includes risk evaluation and counseling for sexual health, sexual abuse, and preconception counseling for women of reproductive age [B], and prevention of sexually transmitted infections [B] at intervals listed below in accordance with risk status [D]:

- Ages 18 to 49 Years – one HME every 1 to 5 years
- Ages 50 to 64 years – one HME every 1 to 3 years
- Age 65+ years – one HME at least every 2 years

### Source:

#### Adults aged 18-49

Michigan Quality Improvement Consortium. Adult preventive services (ages 18-49). Southfield (MI): Michigan Quality Improvement Consortium.

#### Adults aged 50 and older

Michigan Quality Improvement Consortium. Adult preventive services (ages 50-65+). Southfield (MI): Michigan Quality Improvement Consortium; 2008 Sep. 1 p.

### Website:

#### Adults aged 18-49

[http://www.guideline.gov/summary/summary.aspx?ss=15&doc\\_id=13164&nbr=6727](http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=13164&nbr=6727)

#### Adults aged 50 and older

[http://www.guideline.gov/summary/summary.aspx?ss=15&doc\\_id=13165&nbr=6728](http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=13165&nbr=6728)

### Strength of Evidence:

- Recommendations followed by [B] – controlled trials, no randomization.
- Recommendations followed by [D] – opinion of the expert panel of the Michigan Quality Improvement Consortium.

***“Have you noticed anything that seems to make it better or worse (such as a romantic vacation or a different partner)?”***

***“How long have you been bothered by this problem?”***

## MODELS FOR SCREENING, ASSESSMENT, AND MANAGEMENT

There are efficient, effective tools available to assist with screening, assessing, and managing patients for HSDD.

### **Decreased Sexual Desire Screener**

A brief, validated screening tool specific to identify generalized acquired HSDD in pre-, peri-, and postmenopausal women has recently become available.<sup>31</sup> The Decreased Sexual Desire Screener (DSDS) was developed specifically for use by practicing clinicians with little or no experience in diagnosing HSDD.

## Table 5: Decreased Sexual Desire Screener

Dear Patient,

Please answer each of the following questions:

1. In the past was your level of sexual desire or interest good and satisfying to you?

Yes  No

2. Has there been a decrease in your level of sexual desire or interest?

Yes  No

3. Are you bothered by your decreased level of sexual desire or interest?

Yes  No

4. Would you like your level of sexual desire or interest to increase?

Yes  No

5. Please check all the factors that you feel may be contributing to your current decrease in sexual desire or interest:

A: An operation, depression, injuries, or other medical condition

B: Medication, drugs or alcohol you are currently taking

C: Pregnancy, recent childbirth, menopausal symptoms

D: Other sexual issues you may be having (pain, decreased arousal or orgasm)

E: Your partner's sexual problems

F: Dissatisfaction with your relationship or partner

G: Stress or fatigue

When complete, please give this form back to your clinician.

**SOURCE:** Clayton AH, Goldfischer MI, et al. (2009). "Validation of the Decreased Sexual Desire Screener (DSDS): A Brief Diagnostic Instrument for Generalized Acquired Female Hypoactive Sexual Desire Disorder (HSDD)." *J Sex Med.* Mar; 6 (3): 730-8.

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## Table 5 Verification

Clinician:

Verify with the patient each of the answers she has given.

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision, characterizes Hypoactive Sexual Desire Disorder (HSDD) as a deficiency or absence of sexual fantasies and desire for sexual activity, which causes marked distress or interpersonal difficulty, and which is not better accounted for by a medical, substance-related, psychiatric, or other sexual condition. HSDD can be either generalized (not limited to certain types of stimulation, situations, or partners) or situational, and can be either acquired (develops only after a period of normal functioning) or lifelong.

If the patient answers “NO” to any of the questions 1 through 4, then she does not qualify for the diagnosis of generalized acquired HSDD.

If the patient answers “YES” to all of the questions 1 through 4, and your review confirms “NO” answers to all of the factors in question 5, then she does qualify for the diagnosis of generalized acquired HSDD.

If the patient answers “YES” to all of the questions 1 through 4 and “YES” to any of the factors in question 5, then decide if the answers to question 5 indicate a primary diagnosis other than generalized acquired HSDD. Co-morbid conditions such as arousal or orgasmic disorder do not rule out a concurrent diagnosis of HSDD.

Based on the above, does the patient have generalized acquired Hypoactive Sexual Desire Disorder?

Yes  No

**SOURCE:** Clayton AH, Goldfischer MI, et al. (2009). “Validation of the Decreased Sexual Desire Screener (DSDS): A Brief Diagnostic Instrument for Generalized Acquired Female Hypoactive Sexual Desire Disorder (HSDD).” *J Sex Med.* Mar; 6 (3): 730-8.

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The ALLOW model is an algorithm for screening and assessing sexual complaints that addresses the varied skills and interests of clinicians managing sexual problems. Family physicians may find this model particularly useful since some may find dealing with HSDD rewarding while others may prefer to work with a referral.

## Table 6: ALLOW Model

<b>Ask</b> ↓	Ask the patient about sexual function and activity. (Some ways of doing this are identified in the first step of the PLISSIT model below.)
<b>Legitimize</b> ↓	Legitimize the patient’s problems. Acknowledge that sexual dysfunction is a common clinical issue and that it is treatable. This prevents the patient from feeling that her complaint is being trivialized or dismissed, which can prevent her from seeking additional help in the future.
<b>Limitations</b> ↓	Identify limitations. Honestly evaluate your own knowledge, skills, and interest in working with patients who have FSD. If you feel uncertain about your ability to intervene successfully or if the problem requires specific subspecialty intervention, give the patient a referral to an appropriate specialist.
<b>Open Up</b> ↓	If you feel comfortable to further explore the problem, open up discussion with the patient. Get a sense of what she is looking for in the way of intervention and treatment, including her interest in a potential referral to a specialist who treats sexual issues.
<b>Work Together</b>	Work together with the patient to develop reasonable goals and a mutually agreeable management plan.

**SOURCE:** Sadovsky R and Nusbaum M. “Sexual health inquiry and support is a primary care priority.” *J Sex Med.* 2006;3(3): 3-11.

The PLISSIT model is a management-focused algorithm that is built on the concept that patients have varying degrees of need for intervention. It assumes that most patients want less, rather than more, and that very few need or want intensive sexual therapy. With PLISSIT, there are four steps to bring about a comfortable, productive dialogue.

- **P** - Permission giving
- **LI** - Limited Information
- **SS** - Specific Suggestions
- **IT** - Intensive Therapy

## ALLOW and PLISSIT

Two models, ALLOW (*Table 6*) and PLISSIT (*Table 7*), can be useful tools for assessing and managing patients with HSDD. Both models are aimed at health care professionals who are not trained as sexual therapists.

**Table 7: P.L.I.S.S.I.T. Model**

<b>Permission giving</b>	Get the patient's permission to discuss sexual issues (e.g., "I usually ask all my patients if they have any sexual issues they want to discuss; is that okay with you?"). Give the patient permission to express her concerns. The query can be generic ("Do you have any sexual issues you're concerned about?") or specific to an illness or condition ("Some women say that after [having a baby/menopause] they notice changes in sexual desire. Have you been bothered by anything like that?")
<b>Limited Information</b>	Clarify misinformation, dispel myths, and provide factual information (especially about the range of what is "normal" in sexual activity) but in a limited manner, focused on the issue of concern.
<b>Specific Suggestions</b>	Provide specific suggestions directly related to the patient's particular problem (e.g., if having problems with vaginal lubrication, explain the differences between vaginal moisturizers and lubricants, and suggest experimenting with each type).
<b>Intensive Treatment</b>	For patients with more complex issues who might benefit from intensive or individualized therapy, consider referral to a sexual health specialist.
<b>SOURCE:</b> Based on Annon JS. The behavioral treatment of sexual problems. Honolulu: Enabling Systems, 1974-1975.	

## Assessing Sexual Dysfunction

### WHEN TO ASSESS

The Expert Panel recommends clinicians consider undertaking a more thorough assessment of sexual function/dysfunction:

- *When initial screening for female sexual dysfunction (FSD) indicates a woman has a concern related to sexual function/dysfunction*
- *During follow-up after surgery, a medical procedure, or recent major illness*
- *When monitoring a patient with chronic illness associated with sexual dysfunction*
- *During consultation around major life-cycle events (puberty, postpartum, menopause)*
- *When meeting a new patient for the first time*

### HOW TO ASSESS

The Expert Panel recommends that a thorough clinical assessment of sexual function/dysfunction include:

- **Patient's sexual history** – to identify the nature and characteristics of the woman's sexual complaint and assess etiology and contributing factors. A thorough sexual history should include medical, reproductive, surgical, psychiatric, social, and sexual information. When asking about medications that the patient uses, it is important to explain that this includes all prescription drugs, over-the-counter (OTC) medications, and complementary and alternative (CAM) products. Key questions for assessing sexual dysfunction are listed in Table 8.
- **A focused physical exam** (when relevant and appropriate to the practice setting) – to determine the health and condition of genitalia especially if vaginal atrophy or other pelvic organ pathology is suspected. In some cases, consider a physical examination for possible contributing neurologic or vascular problems.
- **Lab work/other tests** – the Expert Panel notes that there is no evidence that hormone levels correlate with HSDD, so lab tests are generally not needed; however if a physical ailment appears to be a possible contributing factor, then appropriate testing for optimal medical management is warranted.

The questions in Table 8 provide an essential framework for assessing sexual dysfunction, but the Expert Panel recommends against using it as a checklist. Rather, to get a full picture, clinicians are encouraged to elicit the patient's story. Listen for clues and cues in their speech and follow up with open-ended questions. For example:

#### **Patient Statement:**

I don't know what happened. I just don't feel like I used to. When David and I do have sex...it's... well... I don't know—sometimes I feel like part of me died. Maybe I'm grieving for my lost libido.

#### **Clinician Responses:**

What doesn't feel like it used to?  
Tell me about when you and David have sex.  
Tell me about David.  
Tell me about feeling like part of you died.  
Tell me about feeling like you are grieving.  
Tell me more. (Three very powerful words!)

---

***How do you listen for the clues and cues your patient might be giving you about her sexual concerns? Do you have a strong foundation in communication skills?***

---

## Table 8: Essential Questions for Assessing Sexual Dysfunction

### Patient's perception of problem

How would you describe the problem?

Do you feel you're having difficulty with desire, arousal, orgasm, or some combination?

### Onset: Lifelong vs. Acquired

How long has the problem been bothering you?

Was the onset sudden or gradual?

### Context: Generalized vs. Situational

Is the problem specific to one situation or partner or does it occur all the time?

Are there things that make it better or worse (stress, vacation, different partner)?

### Etiology: Medical, Psychological, Both

Can you think of anything that may have triggered your problem – health issues, life events, medication changes?

Does your partner have any sexual problems?

Do you have any physical problem such as pain (either chronic pain from a medical problem or acute pain during sex)?

**SOURCE:** Kingsberg S. "Taking a sexual history." *Obstet Gynecol North Am.* 2000;33(4): 535-547.

## PATIENT EDUCATION AND COUNSELING

Decades have passed since the ground-breaking 1973 publication of "Our Bodies, Ourselves,"<sup>32</sup> which introduced countless women to their own sexual anatomy. However, the truth remains that even today many women lack a full understanding of female sexual anatomy and physiology. Since appropriate terminology is needed for any discussion of sexual problems, a good place to start any treatment of FSD is to ensure that the woman is familiar with terms for female genitalia and key aspects of sexual response.

For some women, misconceptions about the role of sexual desire can contribute to distress. A woman may believe that craving for sex—as stereotypically portrayed in the popular media—is the norm ("I don't crave sex. There must be something "wrong" with me."). A woman's distress may be heightened by misguided advice found in many health resources that continue to present outdated linear models of women's sexual response (first desire, then arousal, ending with orgasm).

The family physician may allay some or all of a patient's concerns by explaining:

- *Normal fluctuations in sexual desire (associated with aging, stress, illness, medications, relationship duration, etc.)*
- *The concept that female sexual desire is often a response to sexual engagement (rather than a driving force for initiating sexual contact)*
- *Different feelings for "desire," which can include wanting emotional intimacy with a partner through sexual activity rather than craving intercourse itself*

## DISCUSSING CONTRIBUTING FACTORS

Nearly everything that a woman experiences in her life can influence her desire for sex — aging, illness, stress, medications, drugs and alcohol, depression, changing relationships, newborns — the list goes on. Talking with the patient about the range of factors that can influence libido may help sort out medical and medication issues that the clinician can address, as well as emotional or psychological issues that the woman may wish to discuss with the physician or with others (from a partner or trusted friend to a professional counselor or sex therapy specialist).

## COMPLEMENTARY AND ALTERNATIVE MEDICINES (CAM)

Many patients with sexual problems attempt to self-medicate with CAM products and herbal remedies. Among the CAM products sometimes marketed with claims for helping HSDD and FSD are ginkgo biloba,

## Treating HSDD

All clinical therapy for HSDD builds on a foundation of communication. From this groundwork, clinicians can build a framework for treatment by:

- *Educating the patient about sexual anatomy, the female sexual response cycle, and female sexual dysfunction*
- *Explaining the complex nature of HSDD while providing reassurance that it is common and treatable*
- *Counseling the patient about successful strategies for addressing HSDD*
- *Offering interventions and treatments for medically-related contributing factors*

yohimbine, L-arginine, damiana leaf, ginseng, and DHEA (dehydroepiandrosterone). In addition, topical creams and herbal oils are marketed to women to help with sexual problems.

Because of the wide use of CAM products, clinicians may find it helpful to be acquainted with them. Like all unregulated herbal remedies and dietary supplements, these products have not been well-studied and evidence for their effectiveness and long-term safety is lacking. Individual studies published on ginkgo biloba and yohimbine reported improvements in FSD from baseline, but the effects were not significantly different from those achieved with placebo.<sup>33</sup>

Patients sometimes fail to disclose use of CAM products because they think “natural” products do not qualify as “medications,” or because they are concerned about clinicians having negative value judgments about their use. To help maintain an open dialogue, family physicians may wish to acknowledge that it is theoretically plausible for biochemically-active CAM products to have positive effects on female sexual desire; but, that it might be equally likely that these untested products could also have undesirable side effects, sexual and otherwise.

#### **ANTIDEPRESSANT USE AND SEXUAL DYSFUNCTION**

Antidepressant-induced sexual dysfunction, particularly decreased libido, can occur in both men and women taking SSRIs or SNRI's (venlafaxine).<sup>34</sup> For women who experience distress about loss of desire while taking antidepressants, the clinician should explain that the condition typically reverses within a short time after discontinuation of medication and returns on reintroduction. The Expert Panel recommends that the clinician and patient discuss options for managing antidepressant sexual side effects such as:

- *Reducing dose*
- *Switching agents*
- *Trying medication “vacations” (e.g., stopping medication for weekends)*
- *Adding bupropion to address sexual side-effects such as diminished libido (effect should be observed within four weeks if present. When discussing this option, patients should be informed that this is an off label intervention with modest evidence of efficacy).*<sup>35</sup>

#### **MENOPAUSE-RELATED SEXUAL SYMPTOMS**

There is evidence that postmenopausal women, especially those in stable, long-term (20-29 years)

relationships, commonly report low sexual desire, often without distress.<sup>21</sup> However some women may be troubled by this when it is the “downstream” effect of vaginal atrophy and related problems with lubrication and discomfort during intercourse. The Expert Panel notes that although both systemic and topical estrogen therapy have been shown to improve vaginal lubrication in postmenopausal women with vaginal atrophy, neither treatment has been shown to consistently increase desire or arousal.<sup>36</sup>

For women with sexual problems related to vaginal atrophy, patient education about the nature and

### **Practice Recommendation #2**

When managing urogenital symptoms in otherwise healthy menopausal and post-menopausal women:

- *Conjugated estrogen cream, an intravaginal sustained-release estradiol ring, or estradiol vaginal tablets are recommended as effective treatment for vaginal atrophy (IA)*
- *Routine progestin cotherapy is not required for endometrial protection in women receiving vaginal estrogen therapy in appropriate dose (IIIC)*
- *Vaginal lubricants may be recommended for subjective symptom improvement of dyspareunia (IIIC)*
- *Health care providers can offer polycarbophil gel (a vaginal moisturizer) as an effective treatment for symptoms of vaginal atrophy, including dryness and dyspareunia (IA)*

**Source:** Urogenital health. In: Menopause and osteoporosis update 2009. *J Obstet Gynaecol Can* 2009 Jan;31(1 Suppl 1):S27-30.

**Website:** [http://www.guideline.gov/summary/summary.aspx?doc\\_id=13612](http://www.guideline.gov/summary/summary.aspx?doc_id=13612)

#### **Strength of Evidence:**

- (IA) I = Quality of evidence: evidence obtained from at least one properly randomized controlled trial. A = Classification of recommendation: There is good evidence to recommend the clinical preventive action.
- (IIIC) III = Quality of evidence assessment: opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees. C = The existing evidence is conflicting and does not allow making a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

timing of the condition may be useful (a patient handout on vaginal atrophy is listed in the “Resources” section of this paper). The patient should understand that while menopausal vasomotor symptoms generally fade over time, problems relating to vaginal atrophy normally progress. The clinician may want to review the range of treatment options and determine the woman’s preferences. Recommended treatments include vaginal lubricants for use during sexual activity, OTC vaginal moisturizers, and topical estrogen products.

Some women may have apprehensions regarding estrogen therapy because they lack information about the differences between systemic and topical treatments. Clinicians may find it helpful to explain these differences and review the various methods for delivering topical estrogen preparations so that women can make informed choices.

### TALKING ABOUT TESTOSTERONE

Currently, there are no pharmacologic treatments for HSDD approved for use in the United States. However the Expert Panel recognizes that some physicians use, and some patients may inquire about, off-label use of testosterone for the treatment of HSDD. While it is beyond the scope of this curriculum to provide a detailed risk/benefit analysis of testosterone supplementation, its routes of administration and its dosing, a brief review of key points may help to inform doctor-patient communications.

First, if women ask about or expect to get a lab test to measure their testosterone levels, clinicians may wish to explain that:

- *Commonly available blood and salivary testing techniques are not accurate for detecting testosterone concentrations at the low values typically found in postmenopausal women.*
- *Ultrasensitive testing techniques (such as equilibrium dialysis) are used in research settings, but generally these tests are not commercially available.*
- *No specific testosterone level has been correlated to sexual desire.*

Second, there remains considerable clinical controversy about off-label use of testosterone in women. Two respected sources have offered opposing clinical guidelines.

In 2005, The North American Menopause Society (NAMS) published a position statement generally supporting a role (albeit a limited one) for testosterone therapy in postmenopausal women when they “present with symptoms of decreased sexual

desire associated with personal distress and have no other identifiable cause for their sexual concerns” – provided the testosterone preparation is given concomitantly with estrogen therapy.<sup>37</sup>

In contrast, in 2006, the Endocrine Society published clinical practice guidelines in which they recommended against the use of testosterone even for surgically menopausal women for whom scientific evidence shows some benefit.<sup>38</sup> The authors stated that their decision was made because “the indications are inadequate and evidence of safety in long-term studies is lacking.”<sup>39</sup>

A thoughtful analysis of these opposing views appeared in the *Journal of Clinical Endocrinology and Metabolism* in 2007.<sup>40</sup> Inspired by the late Yogi Berra’s advice, “When you come to a fork in the road, take it,” author Braunstein explored how differences in the conceptual framework, risk/benefit analysis, and professional practice concerns of the two organizations may have influenced their recommendations. (Clinicians interested in exploring this controversy in more depth can find links to both practice guidelines and the Braunstein commentary in the Resources section of this curriculum.)

Finally, even among members of the Expert Panel, there were differences in practice and philosophy regarding off label use of testosterone. However, all agreed that any clinician discussing this issue with his or her female patients must carefully counsel them about:

- *The limited evidence for testosterone therapy providing a benefit to women with HSDD*
- *The lack of long-term safety data for women using testosterone preparations*
- *The difficulty in making an informed risk/benefit assessment of medications not approved for use in the United States*
- *The importance of monitoring liver function tests, lipids, and testosterone levels if taking testosterone preparations*

### When to Refer

While many patients with HSDD can be treated successfully in primary care, the Expert Panel recommends that family medicine physicians consider referral to a specialist when the patient has:

- *Longstanding dysfunction*
- *Multiple/complex dysfunction(s)*
- *Marital conflict*
- *Current/past physical or sexual abuse*
- *Psychological disorder as the primary diagnosis*
- *Lack of response to family practice intervention*

In addition, clinicians with a low level of comfort or expertise in treating patients with FSD may wish to refer their patient to a specialist to improve outcomes.

Options for referral include a sex therapist, obstetrician/gynecologist, or a primary care provider or nurse practitioner who specializes in female sexual dysfunction. To prevent the patient from feeling rejected or that they are being “pushed out the door,” it is helpful to explain that referral is a common procedure and the goal is to achieve the best possible outcome for the patient.

## Conclusion

HSDD is a common, treatable condition that can often be managed in primary care. The exact prevalence varies based on changing definitions and different instruments used for assessment. However low sexual desire is consistently found to be the most common female sexual complaint. Distress, a second and critical criteria required for a diagnosis of HSDD, tends to decline as women grow older.

For patients, the most significant barrier to dealing with HSDD is embarrassment, followed by mistaken beliefs that treatment is lacking. The clinician can address these issues by initiating screening of all women for sexual concerns.

A brief, validated screening tool, the Decreased Sexual Desire Screener, is available to specifically identify HSDD, while the ALLOW and PLISSIT models can help to assess and manage a range of female sexual concerns. A thorough clinical assessment should include a detailed patient sexual history, a focused physical exam (when relevant and appropriate to the practice setting), and rarely, lab work or medical tests.

Communication is the key to both diagnosis and treatment of HSDD. The primary treatment is patient education and counseling combined with clinical treatment of contributing factors. Patient education may include counseling about female sexual anatomy, the female sexual response cycle (Basson model), normative changes in sexual desire associated with aging and long-term stable relationships, and contributing factors. In addition, clinical treatment may include identification and treatment of related organic conditions and/or modifying medications that can contribute to sexual dysfunction.

At this time, there are no pharmacological treatments approved for the treatment of HSDD in the United States.

Debate is ongoing about off-label use of testosterone products. Questions remain about the need for pharmacological treatment of HSDD, the efficacy of testosterone for treating low desire, and its long term safety.

In conclusion, the Expert Panel recommends that family physicians initiate a dialog about sexual matters with their female patients and engage them in conversation to determine if they are experiencing distress related to sexual concerns. When women are troubled by sexual problems (most frequently low desire), family physicians can perform an assessment in a relatively short time. After making a diagnosis, physicians can provide their patients with education and counseling, treatment of related health issues that may contribute to low desire, and referral to specialists when it seems likely to provide the best outcome. By helping women achieve a more satisfying sex life, Family Physicians can improve a woman’s quality of life and her overall health.

## Faculty Disclosures

NJAFP adheres to the conflict-of-interest policy of the AAFP, as well as to the guidelines of the Accreditation Council for Continuing Medical Education and the AMA. Current guidelines state that participants in CME activities should be made aware of any affiliation or financial interest that may affect an author’s article. The members of this expert panel have completed conflict-of-interest statements. Disclosures do not suggest bias, but provide readers with information relevant to the evaluation of the contents of these recommendations.

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## Professional Resources for Health Care Providers and Patients

### *Related to the Diagnosis and Treatment of Female Sexual Disorders*

PROVIDER	CONTACT INFORMATION	DESCRIPTION
The American Association of Sex Educators, Counselors and Therapists	AASECT, P.O. Box 1960 Ashland, Virginia 23005-1960 <a href="http://www.aasect.org">www.aasect.org</a> Phone: 804.752.0026 Email: <a href="mailto:aasect@aasect.org">aasect@aasect.org</a>	<ul style="list-style-type: none"> <li>• Educational materials for the public</li> <li>• Professional education and certification of sex educators, counselors and therapists, and instructors of sex therapy education</li> <li>• Referral resource for sex therapists</li> </ul>
International Society for the Study of Women's Sexual Health	<a href="http://www.isswsh.org">www.isswsh.org</a> Two Woodfield Lake, 1100 E Woodfield Road, Ste 520 Schaumburg IL 60173 Phone: (847) 517-7225	<ul style="list-style-type: none"> <li>• Book list by members: <a href="http://www.isswsh.org/publications/books.aspx">http://www.isswsh.org/publications/books.aspx</a></li> </ul>
The American Board of Sexology	<a href="http://www.americanboardofsexology.com">www.americanboardofsexology.com</a> PO Box 1166 Winter Park, FL 32790-1166 Phone: (407) 645-1641	<ul style="list-style-type: none"> <li>• Certification board for those working in sexual medicine</li> <li>• Listing of certified members by state</li> </ul>
The Society for Sex Therapy and Research	<a href="http://www.sstarnet.org">www.sstarnet.org</a> 409 12th Street, SW, PO Box 96920 Washington, DC 20090-6920 Phone: (202) 863-2570	<ul style="list-style-type: none"> <li>• Society for professionals with clinical and/or research interests in human sexual concerns. Goals are to facilitate communication among clinicians who treat sexual problems and to provide a forum for exchange of ideas</li> <li>• Publication and newsletters for professionals</li> </ul>
Sexual Medicine in Primary Care by William L. Maurice	<a href="http://www.amazon.com/Sexual-Medicine-Primary-William-Maurice/dp/0815127979">http://www.amazon.com/Sexual-Medicine-Primary-William-Maurice/dp/0815127979</a>	<ul style="list-style-type: none"> <li>• Part I: Sexual history taking, Interviewing and Assessment</li> <li>• Part II: Sexual Dysfunction in Primary Care: Diagnosis, Treatment and Referral</li> </ul>
<b>EDUCATIONAL RESOURCES FOR PATIENT EDUCATION</b>		
Good Vibrations <a href="http://www.goodvibes.com/">http://www.goodvibes.com/</a>	Customer Service 934 Howard Street San Francisco, CA 94103 voice: (800) BUY-VIBE or (800) 289-8423 fax: (415) 974-8989 email: <a href="mailto:customerservice@goodvibes.com">customerservice@goodvibes.com</a>	<ul style="list-style-type: none"> <li>• San Francisco-based multi-venue retailer that aims to provide a comfortable, safe environment for finding sex-positive products and educational materials to enhance a couple's sex life.</li> </ul>
What You Should Know About Vaginal Atrophy (Handout prepared by Diane E. Judge, APN/CNP)	PDF available for download at <a href="http://www.femalepatient.com/pdf/">http://www.femalepatient.com/pdf/</a>	<ul style="list-style-type: none"> <li>• Patient handout describe the causes and treatments of vaginal atrophy</li> </ul>
<b>TESTOSTERONE CLINICAL PRACTICE GUIDELINES AND CONTROVERSY</b>		
Endocrine Society Clinical Practice Guide (against generalized use of testosterone in women)	<b>Website:</b> <a href="http://www.endo-society.org/guidelines/Current-Clinical-Practice-Guidelines.cfm">http://www.endo-society.org/guidelines/Current-Clinical-Practice-Guidelines.cfm</a>	<ul style="list-style-type: none"> <li>• <b>Source:</b> Wireman ME, Basson R, Davis SR, et al. Androgen Therapy in Women: an Endocrine Society Clinical Practice Guideline. <i>J Clin Endocrinol Metab</i> 2006 Oct;91(10):3697-710.</li> </ul>
The North American Menopause Society Position Statement on the Role of Testosterone Therapy (in favor of limited use of testosterone in women)	<b>Website:</b> <a href="http://www.menopause.org/aboutmeno/consensus.aspx">http://www.menopause.org/aboutmeno/consensus.aspx</a>	<ul style="list-style-type: none"> <li>• <b>Source:</b> The North American Menopause Society. The role of testosterone therapy in postmenopausal women: position statement of The North American Menopause Society. <i>Menopause</i> 2005 Sep 1;12(5):497-511.</li> </ul>

## Case Study 1: Linda Rogers

Linda Rogers is a 54-year-old mother of two who is seeing her long-time primary care physician, Dr. Michaels for a routine annual physical. A review of Mrs. Rogers' medical record indicates that she is 5 years postmenopausal, has mild hypertension well controlled with lisinopril 10 mg, and that she is due for lipid and glucose testing, a breast exam, and a Pap smear.

Dr. Michaels, who is several years younger than his patient, enters the exam room and greets Mrs. Rogers who is seated and wearing street clothes. They chat comfortably while she reports feeling well and enjoying her "empty nest" status. Since her husband's recent retirement, they have been fulfilling a dream of taking their RV to all 50 states.

Dr. Michaels reaches for an exam gown to hand to Mrs. Rogers, confirms that she is sexually active, and asks, "Before the nurse comes in for the breast and pelvic exams, what sexual concerns would you like to discuss?" There is a slight pause before Mrs. Rogers responds. "You'd probably do better asking Bob that. I think retirement has given him more of a 'new-lease-on-life' in that department than me."

### 1) What should be Dr. Michaels's next step?

- While Mrs. Rogers is changing into the exam gown, check her husband Bob's medical record to see if he was recently prescribed treatment for erectile dysfunction.**
- Pause while heading to the exam room door and say, "If you're having problems in that department, there might be help."**
- Proceed with the breast exam and Pap smear as planned, and check for signs of vaginal atrophy while doing the pelvic exam.**
- Sit down and say, "At this stage of life, sexual issues are fairly common. Tell me about it."**

As a result of his request for more information, Dr. Michaels learns that Mrs. Rogers feels there is a "mismatch" between her desire for sex and her husband's. "When we're traveling in the RV, Bob gets all romantic and wants to have sex. But, for me... well... I certainly wouldn't want you to say this to Bob...but, sex just isn't something I want anymore. In fact, sometimes it's getting pretty uncomfortable." Follow-up questioning reveals that she is experiencing a lack of vaginal lubrication during intercourse.

### 2) How should Dr. Michaels proceed?

- Reassure Mrs. Rogers about doctor-patient confidentiality and that there are approaches to managing this difference in interest in sex between her and her husband.**
- Confirm that studies indicate it is common for women in long-term, stable relationships to report declines in sexual desire although it is not an inevitable result of the passage of time.**
- Perform a pelvic exam to assess for vaginal atrophy or other pelvic organ pathology, inflammation, or infection.**
- Encourage Mrs. Rogers to discuss sexual matters with her husband including ways to "spice up" their sex life with erotic literature, movies, vibrators, sex toys, etc.**
- All of the above.**

The pelvic exam reveals signs of vulvar/vaginal atrophy (vaginal epithelium pale rather than rosy, tissue friable, absence of vaginal rugae, occasional petechiae, and reduced pubic hair on external genitalia).

When the exam is completed and Mrs. Rogers is dressed, Dr. Michaels provides patient education about common changes in vulvar/vaginal tissue following menopause. He explains the differences between vaginal lubricants and vaginal moisturizers, as well as topical estrogen products. Following this discussion, they agree on an initial trial of vaginal lubricants/moisturizer, and if discomfort persists, a follow-up appointment to further consider topical estrogen therapy.

### ANSWERS AND COMMENTARY: LINDA ROGERS

- The correct answer is d: Sit down and say, "At this stage of life, sexual issues are fairly common. Tell me about it."*

**Commentary:** Further assessment is needed to clarify the patient's concerns. It's important for Dr. Michaels to sit down so that it's clear to Mrs. Rogers that he recognizes that this topic is worth taking time to discuss. He can legitimize her complaint by using an appropriate tone of concern and interest, and by first making a general statement followed by an open-ended request for more information.

- The correct answer is e: All of the above.*

**Commentary:** Each step above is important for addressing the patient's concerns, especially distress about low sexual desire and contributing physical conditions. By providing reassurance, information, and education, the clinician can often significantly reduce a patient's distress about sexual concerns.

## Case Study 2: Kimberly Edwards

Kimberly Edwards is a 32-year-old, single, computer analyst, who is seeing Dr. Hayes, for a follow-up appointment. At their previous meeting Ms. Edwards expressed considerable distress about low libido causing difficulties in a new, as well as in past, relationships. Following an initial assessment and physical exam that revealed no obvious organic ailment, Dr. Hayes and Ms. Edwards discussed the possibility that oral contraceptives might be playing a role in reducing sexual desire. Dr. Hayes suggested that Ms. Edwards switch from an oral contraceptive to an IUD to see if it might help.

At the follow-up appointment, scheduled with adequate time for hormone levels to normalize after discontinuation of the oral contraceptive, Dr. Hayes is disappointed to hear Ms. Edwards report continued distress about a lack of sexual desire.

### 1) What should Dr. Hayes do next?

- a) *Switch the patient back to an oral contraceptive with a higher estrogen level.*
- b) *Reassess the original diagnosis and treatment plan. Initiate further assessment including more detailed inquiry about characteristics of low libido (generalized vs. situational, etc.), possible contributing medical conditions, and personal/relationship issues.*
- c) *Prescribe off-label testosterone supplementation.*
- d) *Tell Ms. Edwards that nothing else can be done.*

When Dr. Hayes makes additional inquiries, the patient begins to reveal more complex sexual problems, including difficulties with arousal and orgasm. The patient's body language becomes increasingly agitated and her speech becomes halting. Suddenly, she blurts out, "Ya know, I really didn't have a very good introduction to sex. My step-father was a real S.O.B."

### 2) How should Dr. Hayes proceed?

- a) *Ask if she has a history of anxiety or panic attacks, eating disorders, insomnia, or substance abuse to indirectly assess if there are symptoms of childhood sexual abuse.*
- b) *Say there is not enough time during this appointment to get her entire sexual history and suggest that Ms. Edwards schedule another appointment for the following week.*
- c) *End any further assessment and make an immediate referral to a specialist in sexual abuse.*
- d) *Show empathy, determine if she is a survivor of incest/sexual abuse/domestic violence, and then legitimize treatment and referral, noting that even long-standing, complex sexual dysfunctions can be successfully treated, and that you think she would benefit from talking with a specialist in treating female sexual dysfunction.*

To avoid having her patient feel she is "tainted goods" or is being "pushed out the door," Dr. Hayes is careful to normalize the referral process and explain why it is likely to help Ms. Edwards achieve the best possible outcome.

### Answers and Commentary: Kimberly Edwards

- 1) *The correct answer is b: Reassess the original diagnosis and treatment plan. Initiate further assessment including more detailed inquiry about characteristics of low libido (generalized vs. situational, etc.), possible contributing medical conditions, and personal/relationship issues.*

**Commentary:** When initial diagnosis and treatment fails to produce an expected outcome, it is important to reassess the patient's complaint. There are no indications that either a higher estrogen oral contraceptive or testosterone supplementation would be appropriate.

- 2) *The correct answer is d: Show empathy, determine if she is a survivor of incest/sexual abuse/domestic violence, and then legitimize treatment and referral, noting that even long-standing, complex sexual dysfunctions can be successfully treated, and that you think she would benefit from talking with a specialist in treating female sexual dysfunction.*

**Commentary:** Although many patients with HSDD can be treated successfully in primary care, family medicine physicians are encouraged to consider referral to a specialist when a patient has multiple complex dysfunctions and/or a history of physical or sexual abuse. The specific type of referral may be influenced by the nature of the patient's history (incest vs. domestic violence, etc).

## Case Study 3: Mildred Halaby

Mildred Halaby is a 67-year-old, married, homemaker with a medical history that includes a myocardial infarction (MI) just under a year ago, followed soon thereafter by a coronary artery bypass graft (CABG) procedure. She experienced post-CABG depression and is on sertraline in addition to simvastatin, metoprolol, and aspirin. She needs her prescriptions refilled, but because of a change in her medical insurance, she is switching primary care providers. This is her first appointment with Dr. Patel.

Dr. Patel introduces himself and begins to review a standardized initial intake form. Reaching the section on sexual history, he says, “Many of my patients who have undergone CABG tell me that sexual issues affect their quality of life. Tell me, what sexual matters are of concern to you?”

Mrs. Halaby tosses back her head with a slight laugh. “Sex? That’s been pretty low on the priority list lately. Since my heart attack, I don’t know who’s been more afraid—Harry or me.”

Further assessment reveals that Mr. and Mrs. Halaby had previously enjoyed a meaningful sex life, but that they have not resumed intercourse since her heart attack, surgery, and lengthy recovery which was complicated by post-CABG depression. She wistfully describes missing the intimacy that sex afforded her relationship with her husband, “...but at this point, I don’t know if we’ll ever get that back again.”

### 1) With the appointment time nearly over, what should Dr. Patel do?

- a) *Wrap up the discussion of sexual concerns as gracefully as possible and use the remaining time to focus on the efficacy and side effects of medications before renewing her prescriptions.*
- b) *Try to quickly assess if the patient is most troubled by body image problems related to her CABG scar, sexual side effects related to prescription medications, or anxiety about sex following MI/CABG.*
- c) *Acknowledge that loss of sexual intimacy can have a negative impact on quality of life, reassure her that there are common and treatable issues involved, and explain that a follow-up appointment would allow time to sort out and address possible factors such as post-MI sex anxiety, post-CABG depression, body image problems, and medication side effects.*

- d) *Indicate that the treatment of sexual problems with multiple contributing factors is beyond of the scope of family practice and recommend she consider therapy with a specialist if she wants to resume an active sex life.*

When Dr. Patel recommends scheduling a follow-up appointment to focus on this issue, Mrs. Halaby is pleasantly surprised, since sexual concerns were largely ignored by both her cardiologist and heart surgeon.

At the follow-up appointment, Mrs. Halaby arrives with husband, Harry, in tow. During a three-way conversation, it becomes apparent that both husband and wife have misconceptions about the safety of sex after MI/CABG.

### 2) How should Dr. Patel proceed?

- a) *Use the remaining appointment time for “cardiac couples counseling.”*
- b) *Recommend discontinuing or changing Mrs. Halaby’s antidepressant medication since it may have sexual side effects that are contributing to her problems.*
- c) *Recommend a referral to a sex therapist who specializes in treating cardiac patients.*
- d) *Provide an overview of factors that can negatively impact the sex life of cardiac patients (post-MI sex anxiety, body image after surgery, post-CABG depression, medication side effects, etc.) and use shared decision making to determine the patient’s treatment priorities.*

During basic “cardiac couples counseling,” Dr. Patel reviews the potential of an SSRI to have sexual side effects. However, both husband and wife agree that they are more concerned about a potential relapse of her post-CABG depression, than they are about medication side effects. They agree to maintain her current medication regimen and review it at follow-up appointments. Later that year, they decide to taper her off the SSRI, and at her annual physical, she thanks Dr. Patel for helping her “get her old ‘spark’ back.”

## ANSWERS AND COMMENTARY: MILDRED HALABY

1) *The correct answer is c: Acknowledge that loss of sexual intimacy can have a negative impact on quality of life, reassure her that there are common and treatable issues involved, and explain that a follow-up appointment would allow time to sort out and address possible factors such as post-MI sex anxiety, post-CABG depression, body image problems, and medication side effects.*

**Commentary:** Quality of life issues such as loss of sexual intimacy following heart surgery can cause patient considerable distress. When time limitations appear to be a potential barrier, is important to remember that patients often have low expectations of receiving help from clinicians. Therefore, it is important to legitimize the patient's concern, provide

reassurance that help is available, and to schedule adequate time to address the issue.

2) *The correct answer is d: Provide an overview of factors that can negatively impact the sex life of cardiac patients (post-MI sex anxiety, body image after surgery, post-CABG depression, medication side effects, etc.) and use shared decision making to determine the patient's treatment priorities.*

**Commentary:** While "cardiac couples counseling" will be an important component of treatment, a single educational session is not likely to resolve all of this patient's issues. With high potential for interaction among multiple, complex contributing factors, shared decision making is ideal. By engaging the patient in setting treatment goals and priorities, she is more likely to be satisfied with the outcome.

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## CME Accreditation Procedures

***Family Physician's Guide to Diagnosing Hypoactive Sexual Desire Disorder: First, Communication*** has been reviewed and is acceptable for up to 2.5 Prescribed credit(s) by the American Academy of Family Physicians. AAFP accreditation begins May 1, 2010. Term of approval is for two year(s) from this date, with option for yearly renewal.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to

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NJAFP has developed a website where you may take the post-test, receive immediate feedback on your answers, and have your certificate electronically submitted to the AAFP. To take the post test log onto [www.njafp.org/HSDD2010](http://www.njafp.org/HSDD2010) and follow the instructions or fax to 609-394-7712 with credit card payment.

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## QUESTIONS

1) For a woman to be diagnosed with hypoactive sexual desire disorder (HSDD), she must have:

- a) Distress about engaging in sexual activity
- b) A lack of sexual desire that causes distress
- c) Lack of arousal and lubrication during sexual activity
- d) Difficulty reaching orgasm
- e) All of the above

2) Evidence finds that a woman is most likely to have HSDD if she is:

- a) Over age 60 and in a long-term, stable relationship
- b) From a cultural background that places more importance on sex
- c) From a cultural background that places less importance on sex
- d) Recently menopausal as a result of bilateral oophorectomy

- 3) What is most likely to prompt a female patient to discuss sexual concerns with her family physician?
- Having a long, well-established relationship with the physician*
  - Being young, outgoing, and not easily embarrassed*
  - Having the physician initiate the topic for discussion*
  - Seeing a female, rather than male, physician*
- 4) In which circumstance should a physician undertake a more thorough assessment of a patient's sexual function/dysfunction?
- When meeting a new patient for the first time*
  - Consultation around life-cycle events (puberty, postpartum, menopause)*
  - When treating a patient with chronic illness*
  - During follow-up after surgery or a recent major illness*
  - When managing depressed patients*
  - All of the above*
- 5) Assessment of female sexual function/dysfunction should always include the patient's medical and sexual history, a focused physical exam (when relevant and appropriate to the practice setting), and lab tests to measure estrogen and testosterone levels.
- True*
  - False*
- 6) When assessing sexual dysfunction, which of the following would be essential questions for a primary care clinician to ask the patient?
- Patient's perception of the problem*
  - Onset characteristics: sudden/gradual; recent/lifelong*
  - Sexual partner: same/opposite gender; short/long-term relationship*
  - Context: specific situation/partner; sexual activities/habits; things that make better/worse*
  - All of the above.*
- 7) For women taking SSRI's or SNRI's to treat depression and report distress about reduced libido, a clinician should:
- Recommend against making any changes in medication because treating depression is more important than managing sexual side effects*
  - Discuss options for managing antidepressant sexual side effects such as reducing dose, trying medication "vacations," and switching agents*
  - Explain that low libido is often a symptom of depression and there is no alternative except for the patient to keep taking the antidepressant as prescribed*
  - Explain that sexual side effects of antidepressant medication are likely to persist even after antidepressant medication is stopped*
- 8) A family physician may allay some or all of a patient's distress related to low sexual desire by providing education and counseling about: [mark all that apply]
- Normal fluctuations in sexual desire associated with aging and relationship duration.*
  - The linear nature of female sexual response which always starts with desire and then progresses to arousal and orgasm*
  - The role that certain medications can play in reducing sexual desire and options for managing this side effect*
  - The concept that sexual desire can be more than just craving intercourse; it can include desire for emotional intimacy with a partner through sexual activity*
  - The value of open communication with sexual partners*
- 9) When treating a post-menopausal woman who reports low sexual desire, the first thing a clinician should do is:
- Determine if low sexual desire is causing the patient distress*
  - Perform a pelvic exam to determine the health of genitalia*
  - Order lab tests to measure hormone levels*
  - All of the above*
- 10) There is consensus among all published practice guidelines regarding the off-label use of testosterone for the treatment of recently surgically menopausal woman diagnosed with HSDD.
- True*
  - False*
- 11) A family physician should consider referring a patient with HSDD to a specialist in treating female sexual dysfunction when there is evidence of:
- Psychological disorder as the primary diagnosis*
  - Longstanding or multiple/complex dysfunction(s)*
  - Current/past physical or sexual abuse, or marital conflict*
  - Lack of response to family practice intervention*
  - All of the above.*
- 12) The primary treatment for women with HSDD is:
- Androgen supplementation*
  - Patient education and counseling combined with clinical treatment of contributing factors*
  - Use of topical estrogen products, vaginal lubricants and moisturizers*
  - Long-term psychotherapy*
  - All of the above*

## Reflection

List two things you will do differently as a result of this educational activity.

1. \_\_\_\_\_  
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\_\_\_\_\_
2. \_\_\_\_\_  
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## Evaluation

*(Rating Scale: 5 is the highest rating, 1 is the lowest rating)*

Relevance of this topic to my practice: 5 4 3 2 1

Clinical material was current and useful: 5 4 3 2 1

This activity was free of commercial bias: 5 4 3 2 1

Overall rating for this activity: 5 4 3 2 1

Comments: \_\_\_\_\_  
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