

Sexual Dysfunction, Part II: Diagnosis, Management, And Prognosis

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Abstract: *Background:* Sexual problems are common but infrequently diagnosed. They are classified into four major categories: (1) sexual desire disorders, (2) sexual arousal disorders, (3) orgasmic disorders, and (4) sexual pain disorders.

Methods: MEDLINE files from 1966 to the present were searched using the specific sexual dysfunctions as key words along with the general key word "sexual dysfunction" to review the published literature. Additional articles came from the reference lists of dysfunction-specific reviews.

Results and Conclusions: The key to diagnosis often rests on the physician's willingness to raise the issue with patients. A rational protocol can be followed to identify causative organic and psychogenic factors using the psychosexual and medical history, a comprehensive physical examination, psychological assessment instruments, laboratory tests, and special procedures.

Current psychological treatment includes one or more of the following components: sensate focus exercises, cognitive-behavioral therapy, relaxation training, hypnosis and guided imagery, and group therapies. Specific techniques, such as directed self-stimulation, the stop-start and squeeze techniques, the sexological examination, systematic desensitization, and Kegel exercises, are added therapy when appropriate. Marital therapy to improve communication and resolve conflict is also part of standard therapy.

Medical management can include pharmacologic agents to correct endocrine dysfunctions or to alter the progression of the sexual response. Surgical management can involve arterial revascularization, venous ligation, and penile implants. A noninvasive vacuum constriction device is also used to treat erectile disorders.

The long-term prognosis of the sexual dysfunctions varies with the type of disorder and its causes. Generally good results (80 to 95 percent satisfaction) are obtained when treating vaginismus, dyspareunia, male erectile disorders, and female orgasmic dysfunctions. Long-term results are modestly successful (40 to 80 percent) when treating inhibited male orgasm and premature ejaculation. Long-term success is poorest at present for treating sexual desire disorders. (*J Am Board Fam Pract* 1992; 5:177-92.)

Sexual problems are common. According to the literature summarized in Part I of this review,¹ 75 percent of all women and 50 percent of all men will experience sexual difficulties. Sexual dysfunctions are present in one-half of all marriages and in 75 percent of couples who seek marital therapy. Yet, although common, sexual dysfunctions are infrequently recorded by primary care physicians when diagnostic encounter lists or patient charts are reviewed. Many sexual problems remain hidden; therefore, primary care physicians need to search for them in their patients. Once dis-

covered, physicians must know how to approach these problems diagnostically, evaluating them thoroughly by history, physical examination, and laboratory testing. Furthermore, physicians must know how to initiate management for those problems they can treat and how to request timely and appropriate consultation and referral from other professionals for those problems that are beyond their expertise or interest.

Part II of this review focuses on diagnosis and management. It provides information that can increase both the physician's comfort and competence in addressing patient's sexual concerns and in helping them to enjoy sexual health.

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Diagnosis

General Sexual History

Physicians do not regularly ask about sexual concerns.² Patients also do not often initiate discus-