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SEXUAL PROBLEMS IN THE GYNAECOLOGY CLINIC: ARE WE MAKING A MOUNTAIN OUT OF A MOLEHILL?

Hypothesis / aims of study

Prevalence estimates have shown that up to 54% of women in the general population suffer with sexual problems [1]. However less than 1 in 5 women seek medical help for it. Barriers for seeking help could be embarrassment, believing that the physician will not be able to provide help, and age and gender of the physician. Therefore in order to identify sexual problems a proactive attitude from the physician is necessary. However recent studies have shown that physicians infrequently raise the topic of sexual health during clinic visits with the most important barrier being lack of time. Screening for sexual problems doesn't need to be time consuming and making a brief assessment of sexual function is very effective and indicates to the patient that the discussion of sexual concerns is appropriate.

The aim of this study was to assess the prevalence of sexual problems in new patients attending a gynaecology clinic using a simple screening tool. Secondly we aimed to compare the prevalence between gynaecology and urogynaecology patients.

Study design, materials and methods

As part of routine practice new patients attending the gynaecology outpatient clinic are asked to complete a 'Health Questionnaire' which addresses the primary complaint, gynaecological, obstetrical, surgical, and medical history. To assess sexual function 3 questions were included: 1) Are you sexually active? (yes/no) If not, state reason 2) Is sex painful? (yes/no) 3) Do you have any problems with sex? (yes/no) If yes, state problems. These 3 questions were based on a previous questionnaire which has been shown to be as affective as a detailed enquiry in detecting sexual problems [2]. However on preliminary analysis at the end of August 2009 it became apparent that these questions did not address bother. This led to the introduction of a fourth question: 'Are any of your sexual problems bothersome? (yes/no)'.

Statistical analysis was carried out using Student's t-test for continuous variables and Chi-Square test for dichotomous variables. Subjects were divided based on their primary complaint into gynaecology or urogynaecology patients. For the purpose of comparison we corrected for possible confounding factors by fitting a binary logistic regression model using forward selection. Possible confounders were selected based on previously published or expected associations.

Results

From May 2008 until February 2010 a total of 1215 questionnaires were collected. Twenty-one women were excluded because of missing data on sexual activity. Of the 1194 women included, mean (SD) age was 47 years (15.9) and mean (SD) parity 2.0 (1.5). Overall 739 (62%) women were sexually active and 455 (38%) were not. Sexually inactive women were significantly ($p<0.05$) more likely to be older, have a higher parity and were more likely to suffer from concomitant diseases. Sexually active women were more likely to be smokers ($p<0.05$).

Overall 437 (37%) women complained of sexual problems; 320 (27%) complained of dyspareunia and 202 (17%) of 'other' sexual problems (multiple answers possible). Included in the 'other' problems were loss of libido, partner problems, dryness and problems associated with prolapse and urinary problems. Of the 437 women with sexual problems 75 (17%) overtly presented with these while the remaining only admitted to having them on questioning. The distribution for women who were sexually active and those who were inactive is presented in Figure 1.

Overall 641 (54%) women presented with gynaecology and 553 (46%) with urogynaecology complaints. Women suffering from urogynaecological complaints were more likely to be older, have a higher parity and were more likely to suffer from concomitant diseases ($p<0.05$). Women with gynaecological complaints were more likely to be smokers ($p<0.05$) and to be sexually active: 467 (73%) compared to 272 (49%) in urogynaecology patients, $p<0.001$. The prevalence of sexual problems in gynaecology and urogynaecology is presented in Table 1. On multivariate analysis urogynaecology complaints ($p=0.001$), smoking ($p=0.01$), age ≤ 30 years ($p=0.001$) and previous vaginal repair surgery ($p=0.03$) were independently associated with sexual problems. Women > 60 years of age were less likely to have sexual problems ($p=0.001$). Associated with dyspareunia were: sexual activity ($p=0.001$), age ≤ 30 years ($p<0.001$) and smoking ($p=0.01$). Women > 60 years of age were less likely to have dyspareunia ($p<0.01$). Associated with 'other' problems were: urogynaecology complaints ($p<0.001$) and age between 40 and 60 ($p=0.01$).

A total number of 290 (24%) questionnaires included the question on 'bother'. One-hundred and six (37%) women had one or more sexual problem, but only 48 (45%) of these had bothersome symptoms.

Interpretation of results

Although these 3 simple questions have previously been used as an interview based screening tool [2], we are unaware of it being used as part of a written questionnaire. The previous study showed that 45% of women admitted to a gynaecology ward on an elective basis had a sexual complaint. We were able to identify sexual problems in 37% of women. Furthermore we found that less than 1 in 5 women overtly presented with these concerns which shows us that screening for sexual problems increases our ability to detect them and need not be time consuming. Additionally women with urogynaecology complaints were more likely to suffer from sexual problems.

In accordance with the definition of female sexual dysfunction and to decide when clinical intervention is necessary, the element of 'personal distress' caused by the sexual problem should be assessed. By introducing a fourth question we showed that only 45% of the women with sexual problems actually found them to be bothersome. Other studies that have looked at distress found similar results as their prevalence of sexual problems was twice as high as the prevalence of sexually related distress [3].

Concluding message

This study highlights that the vast majority of women experiencing sexual problems only volunteer symptoms when asked directly. By using a simple and quick screening tool, sexual problems were 5 times more likely to be identified by the physician. However by inquiring about bother with this four question screening tool we have recognised that nearly half of them do not find their symptoms bothersome. This is highly relevant because by definition sexual problems can not be classified as female sexual dysfunction unless they cause distress. As urogynaecology complaints were independently associated with sexual problems this screening tool could be included as part of the initial evaluation of these patients.

Figure 1: Prevalence and presentation of sexual problems

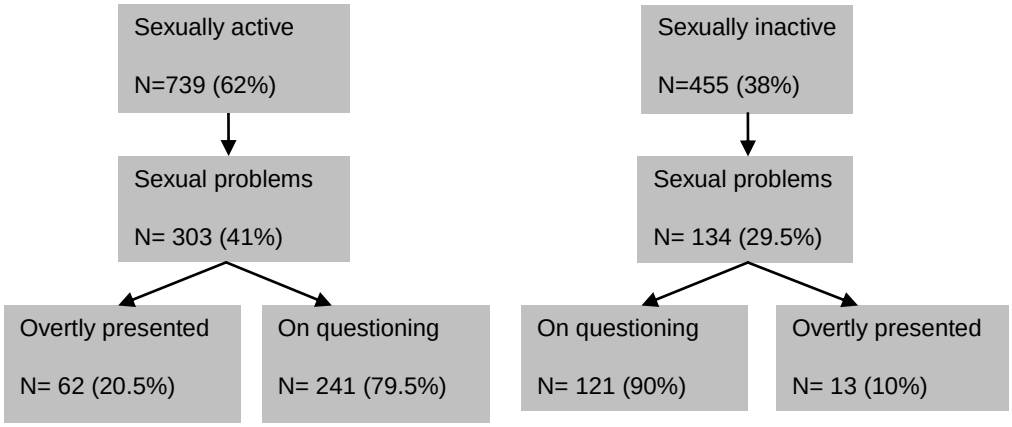

Table 1: Sexual problems in gynaecology and urogynaecology patients #

	Gynaecology patients 641 (54%)	*Urogynaecology patients 553 (46%)*	*Multivariate p-value*	*Multivariate Odds–ratio (95% CI)*
Sexual problems	226 (35%)	211 (38%)	0.001	1.58 (1.19 - 2.09)
- Dyspareunia	199 (31%)	121 (22%)	>0.05	
-'Other' sexual problems	60 (9%)	142 (26%)	<0.001	3.72 (2.56 - 5.38)

References

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What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require eithics committee approval because	**Observational study of our normal clinical practice**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**No**