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FEMALE PELVIC FLOOR DISORDERS AND SEXUAL DYSFUNCTION IN AFFECTED COUPLES

Hypothesis / aims of study

Sexual dysfunction in the context of a relationship is shared dysfunction. It is reasonable to suspect that, similar to erectile dysfunction, female pelvic floor disorders represent an area of shared dysfunction for affected couples and therefore have an effect upon the function of male partners. There is little data, however, on the impact of pelvic floor disorders on intimate partner relationships which takes into account the perspectives of both partners.

The goal of this study is to quantify the prevalence and areas of sexual dysfunction among urogynecology patients presenting for correction of stress urinary incontinence (SUI) and/or pelvic organ prolapse (POP) and their male partners.

Study design, materials and methods

All participants (both patients and their partners) gave written, informed consent to participate. Participants were couples with a female partner presenting for surgical treatment of SUI and/or POP at a tertiary care center. Each member of the dyad independently completed questionnaires on demographics and general health, sexual function, and relationship satisfaction. We present the results of the Golombok Rust Inventory of Sexual Satisfaction (GRISS) which was used to assess sexual function.

The GRISS consists of seven subscales, five of which are shared and two of which are gender specific. Scores range from 1 to 9 with higher scores indicating greater sexual dysfunction. A range of 1 to 4 is considered non-problematic; it is expected that a "normal" relationship will yield at least one score of 5 on one of the subscales. For this analysis, a score of 5 or more in any category was considered to be consistent with sexual dysfunction.

Overall and domain scores of patients were compared with the corresponding scores of their partners. Comparisons of proportions were made using the chi-square test while continuous variables were compared using the student's T test. For all calculations, p-values of < 0.05 were considered to be statistically significant. PASW Statistics version 18 was used for data management and statistical analysis.

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Results

Forty-nine couples provided data for analysis. The females had a mean age of 54.4 (range 32-71), the males had a mean age of 55.0 (range 35-75). Most (88%) were married. The mean length of relationship was 26 years (range 9 months-52 years). While 94% of men stated that they were sexually active, only 82% of women stated that they were sexually active. The 49 female patients were presenting for surgical correction of SUI only in 24%, POP only in 37%, and SUI and POP in 39%..

Overall dysfunction was present in 43% of male participants and 31% of female participants (chi-square=0.969, p=.325). Among couples, 41% were discordant on the overall dysfunction. Infrequency and Non-communication were the subscales with the highest levels of dysfunction for both men (69% and 45%) and women (76% and 57%). The prevalence of dysfunction was similar for men and women in all subscales except for Infrequency (chi-square=9.726, p=.002)

Evaluation of GRISS scores by diagnosis did not demonstrate a correlation between male overall dysfunction and partner diagnosis. There was, however, a significant correlation between a diagnosis of SUI alone or SUI and POP (p=0.024 and p=0.043 respectively) and overall sexual dysfunction for women. There was no correlation between a diagnosis of POP alone and overall sexual dysfunction (p=0.814) among women. There was no correlation between diagnosis and dysfunction in any of the domains for men or women.

Significantly more men scored in the dysfunctional range for Impotence (43%) than gave a history of erectile dysfunction on their demographic information (20%) (chi-square=7.078, p=.008).

	Male Mean (SD)	**Male % Abnormal**	**Female Mean (SD)**	**Female % Abnormal**
Total GRISS Score	4.0 (1.7)	43	3.3 (1.9)	31
Non-communication	4.5 (1.7)	45	4.9(1.8)	57
Infrequency	5.5 (2.0)	69	6.3 (2.2)	76
Dissatisfaction	3.2 (1.9)	29	3.1 (1.7)	16
Avoidance	2.5 (1.7)	18	3.9 (2.3)	37
Non-sensuality	2.9 (2.0)	27	3.7 (2.3)	39
Impotence	3.8 (1.9)	43	*	*
Premature Ejaculation	4.5 (1.6)	35	*	*
Vaginismus	*	*	3.3 (2.0)	29
Anorgasmia	*	*	3.7 (1.6)	22

Interpretation of results

Sexual function is infrequently addressed in the physician/patient dialogue. Reasons may include embarrassment on the part of the patient or physician, lack of time, physician lack of familiarity with obtaining a sexual history and/or therapeutic options, or

simply lack of awareness of the prevalence of sexual dysfunction. A study of members of the American Urogynecologic Society found that a majority (69%) of respondents underestimated the prevalence of female sexual dysfunction (1). Yet 42% of patients seek advice for sexual function symptoms from their primary Ob/Gyn (2).

The results of this study are further evidence of the need for physicians, particularly specialists in Female Pelvic Medicine and Reconstructive Surgery, to develop comfort in discussing sexual function with their patients.

Concluding message

Sexual dysfunction is common among urogynecology patients and their partners. In particular, couples demonstrate dysfunction in the areas of infrequency and non-communication.

References

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