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FEMALE SEXUAL DYSFUNCTION: ARE UROGYNAECOLOGISTS READY FOR IT?

Hypothesis / aims of study

Female sexual dysfunction (FSD) is a highly prevalent condition occurring in 50% of women attending a gynaecology clinic, and 64% of those attending an urogynaecology clinic (1). Barriers to patients for seeking help could be embarrassment and feeling that the physician will not be able to provide help.

The aims of the study were to determine whether members of the British Society of Urogynaecology (BSUG) address patient's sexual function as part of their gynaecological history, to identify any barriers in performing this assessment, and to establish current attitudes towards FSD. Secondly we aimed to compare our practice to that of members of the American Urogynecologic Society (AUGS) published previously (2).

Study design, materials and methods

In 2006 an electronic questionnaire was sent to all members of the BSUG to complete online and submit anonymously. We used the same questionnaire (with permission) as that used in a previous study that surveyed members of the AUGS (2). The questions were designed to specifically assess FSD-related practices at clinic visits and following surgery, as well as attitudes, beliefs, and overall impressions of FSD.

Statistical analysis was performed calculating frequencies of responses. Associations between demographic factors and practice management were calculated using Chi Square test.

Results

Of 150 invited members 100 responded (response rate 67%). Five responders were excluded from analysis because of incomplete questionnaires.

Of the 95 responders 57% were male, 60% had been a consultant for over 5 years, 22% had been a consultant for < 5 years and 16% were still training. Seventy-five percent were over 40 years of age. The practice composition was all urogynaecology patients in 12% and mainly urogynaecology in 68%. The respondents were predominantly based in England (84%) and the area population size consisted of > 50000 inhabitants in ninety-two percent. Fifty-nine percent worked in a teaching or university based hospital and 38% in a general district hospital.

Nearly all respondents acknowledged screening for FSD was important to some level. Fifty-one percent believed screening for FSD was somewhat important, 36% very important and 10% found it extremely important. Only 2% thought screening for FSD was not important at all. Comparing this to the responses by AUGS members shows importance is graded the same way with 47% responding somewhat important, 42% very important and 9% extremely important.

Questionnaires for assessing FSD were known by 60% of respondents. The PISQ was cited by most of them (90%), either alone or in combination with others.

Screening for FSD was done either most of the time (50%) or rarely (47%) (Table 1).

When screening most of the time, respondents were asked how the information was elicited from the patient. The majority did this by asking the patient questions (79%) and 19% used a form which the patient had to fill. Questions about different domains of sexual function were asked, and 13% used a validated questionnaire. The majority asked about sexual activity (87%) and dyspareunia (94%). Other sexual domains addressed were libido (47%), arousal/lubrication (36%) and orgasm (36%).

Table 1: Screening for FSD in BSUG members and AUGS members

	BSUG	AUGS
Never/Rarely	47%	23%
Most of the time	50%	55%
Always	0	22%

Barriers for screening for FSD are reported in table 2. Most respondents cited more than one, with not enough time as most important barrier.

Table 2: Barriers for screening for FSD in BSUG and AUGS members

	BSUG	AUGS
Not enough time	66%	78%
Unsure about therapeutic options	25%	28%
Do not know what/how to ask	20%	8%
Most patients are elderly	20%	20%
Afraid to offend patients	19%	7%

Differences across demographics did not have an impact on frequency of screening for FSD. There was no significant difference based on gender, age, years of practice more or less than 5, practice composition and practice population.

The physician's perception of the prevalence of FSD showed that the majority thought that the percentage was less than 30 (75%) compared to 49% amongst AUGS members. Compared to the rest of the group, of those who believed the prevalence for FSD to be over thirty percent, 67% thought screening for FSD was very/extremely important compared to 38% (P= 0.023) and 86% stated that they screened for FSD most of the time compared to 41% (P < 0.001).

After surgery patients were never/rarely screened for FSD by 30.5% of physicians, 49.5% screened most of the time and 20% did not respond to this question. Barriers for screening post operatively were not enough time in 52%, 21% didn't know what/how to ask, 14% thought surgery was not related to FSD, 28% was unsure about therapeutic options and 21% quoted their patients were mostly elderly.

When asked about training for FSD, 76% said it was unsatisfactory, 18% found it to be somewhat satisfactory and only 4% found it very to extremely satisfactory. In AUGS members training with respect to FSD was unsatisfactory in 50%.

Interpretation of results

Although most physicians admitted that screening for FSD was important, only half of them regularly screened for it. Lack of time is the most important barrier for screening, both in clinic visits as well as after surgery. Many were unsure about therapeutic options or did not know what to ask when screening for FSD reflecting a deficiency in this aspect of training.

Although both members of AUGS and BSUG considered screening for FSD important, a larger percentage of AUGS members screened for FSD. Although lack of time was the reason given as the most important barrier for FSD screening by both groups, a more plausible explanation would be that they were inadequately trained to approach this subject. However it has been shown that a simple questionnaire consisting of 3 questions is as effective as a detailed enquiry (3).

Concluding message

FSD is not included in the regular assessment of patients by a large group of BSUG members, and its prevalence appears to be underestimated. The subject of FSD should be given more importance in the undergraduate and postgraduate curriculum so that clinicians enquire about this embarrassing problem which has an impact on marital and social relationships. The similarity in trends between the UK and USA highlights that this may be a more global problem that needs wider exploration.

References

1: Int Urogynecol J Pelvic Floor Dysfunct (2006) 17; 576-80.
2: Int Urogynecol J (2005) 16; 460-67.
3. Am J Obstet Gynecol (1985) 151; 166-8.

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Was this study approved by an ethics committee?	**No**
This study did not require eithics committee approval because	**Its a survey which describes routine clinical practice**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**No**