How do you break the ice with patients to ask about their sexual health?

A patient may skip talking about sexual function out of embarrassment, and a clinician out of concern for the patient’s feelings. We may be overlooking women in need of treatment when we have the tools we need to assess and treat patients’ sexual dysfunction.

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**CASE** Patient may benefit from treatment for dyspareunia

A 54-year-old woman has been in your care for more than 15 years. Three years ago, at her well-woman examination, she was not yet having symptoms of menopause. Now, during her current examination, she reports hot flashes, which she says are not bothersome. In passing, she also says, “I don’t want to take hormone therapy,” but then is not overly conversational or responsive to your questions. She does mention having had 3 urinary tract infections over the past 8 months. On physical examination, you note mildly atrophied vaginal tissue.

Your patient does not bring up any sexual concerns, and so far you have not directly asked about sexual health. However, the time remaining in this visit is limited, and your patient, whose daughter is sitting in the waiting area, seems anxious to finish and leave. Still, you want to broach the subject of your patient’s sexual health. What are your best options?

We learned a lot about women’s perceptions regarding their sexual health in the 2008 Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking study (PRESIDE). Approximately 43% of 31,581 questionnaire respondents reported dysfunction in sexual desire, arousal, or orgasm. Results also showed that 11.5% of the respondents with any of these types of female sexual dysfunction (FSD) were distressed about it. For clinicians, knowing who these women are is key in recognizing and treating FSD.

Important to the opening case, in PRESIDE, Shifren and colleagues found that women in their midlife years (aged 45 to 64) had the highest rate of any distressing sexual problem: 14.8%. Younger women (aged 18 to 44 years) had a rate of 10.8%; older women (aged 65 years or older) had a rate of 8.9%.

The most prevalent FSD was hypoactive sexual desire disorder, which in 2013 was renamed sexual interest and arousal disorder in the *Diagnostic and Statistical Manual of*
Sexual health counseling

Toward these ends, more discussion with patients is needed. According to a 2008 national study, although 63% of US ObGyns surveyed indicated that they routinely asked their patients about sexual activity, only 40% asked about sexual problems, and only 29% asked patients if their sex lives were satisfying.5

Without communication, information is missed, and clinicians easily can overlook their patients’ sexual dysfunction and need for intervention. For midlife women, who are disproportionately affected by dysfunction relative to younger and older women, and for whom the rate of menopausal symptoms increases over the transition years, the results of going undiagnosed and untreated can be especially troubling. As reported in one study, for example, the rate of bothersome vulvovaginal atrophy, which can be a source of sexual dysfunction, increased from less than 5% at premenopause to almost 50% at 3 years postmenopause.6 What is standing in our way, however, and how can we overcome the hurdles to an open-door approach and meaningful conversation?

Obstacles to taking a sexual history
Initiating a sexual history can be like opening Pandora’s box. How do clinicians deal with the problems that come out? Some clinicians worry about embarrassing a patient with the first few questions about sexual health. Male gynecologists may feel awkward asking a patient about sex—particularly an older, midlife patient. The problem with not starting the conversation is that the midlife patient is often the one in the most distress, and the one most in need of treatment. Only by having the sexual health discussion can clinicians identify any issues and begin to address them.

Icebreakers to jump-start the conversation
Asking open-ended questions works best. Here are some options for starting a conversation with a midlife patient:
1. say, “Many women around menopause

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Adding a sexual symptom checklist to your intake form can help bridge the sexual health communication gap that has persisted between physicians and patients.

**FIGURE 1** Brief sexual symptom checklist

1. Are you satisfied with your sexual function?  
   □ Yes  □ No  If No, please continue.

2. How long have you been dissatisfied with your sexual function?  ____________________

3. The problem(s) with your sexual function is:  
   (mark one or more)  
   a. Problems with little or no interest in sex  
   b. Problems with decreased genital sensation (feeling)  
   c. Problems with decreased vaginal lubrication (dryness)  
   d. Problems reaching orgasm  
   e. Problems with pain during sex  
   f. Other:  ____________________

4. Which problem (in question 3) is most bothersome?  
   (circle)  a  b  c  d  e  f

5. Would you like to talk about it with your health care provider?  
   □ Yes  □ No

Sexual status examination

Performing this examination helps clinicians see patterns in both sexual behavior and sexual health, which in turn can make it easier to recognize any dysfunction that might subsequently develop. The key to this process is establishing trust with the patient and having her feel comfortable with the discussion.

The patient remains fully clothed during this 15-minute session, which takes place with guarantees of nonjudgmental listening, confidentiality, privacy, and no interruptions. With the topic of sex being so personal,
During the sexual status examination, consider the patient’s current medications, psychiatric illnesses, and general health factors.
colleagues are thoroughly familiar with the kinds of issues that can arise, and can offer alternative and adjunctive therapies.

Referrals also can be made for the latest nonpharmacologic and FDA-approved pharmacologic treatment options. Specialists tend to be familiar with these options, some of which are available only recently.

It is important to ask patients about sexual function and, if necessary, give them access to the best treatment options.

**CASE Resolved**

During the sexual status examination, your patient describes her most recent sexual encounter with her husband. She is frustrated with her lack of sexual response and describes a dry, tearing sensation during intercourse. You recommend first-line treatment with vaginal lubricants, preferably iso-osmolar aqueous- or silicone/dimethicone-based lubricants during intercourse. You also can discuss topical estrogen therapy via estradiol cream, conjugated equine estrogen cream, estradiol tablets in the vagina, or the estrogen ring. She is reassured that topical estrogen use will not pose significant risk for cancer, stroke, heart disease, or blood clot and that progesterone treatment is not necessary.

For patients who are particularly concerned about vaginal estrogen use, 2 or 3 times weekly use of a vaginal moisturizer could be an alternative for genitourinary symptoms and dyspareunia.

**References**