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Female sexual function in urological practice

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CHAPTER 9

Summery and future perspectives

CHAPTER 1

In this chapter we give a short overview of the relation between urology and female sexual function. Different aspects are discussed, like anatomy, urological complaints, pelvic and vaginal surgery and sexual abuse. The question “Why should the urologist play a role in managing female sexual dysfunction?” is asked. In order to answer this question the outline of this thesis is described.

CHAPTER 2

Introduction

Recent studies have demonstrated a relationship between urogynecological complaints and female sexual dysfunction; evaluation of female sexual function in an urological outpatient clinic has not been undertaken before.

Aim

The aim of this study was to assess the prevalence of female sexual complaints in an outpatient urological clinic related to a variety of urological complaints.

Methods

We evaluated 326 female patients during the first visit at an outpatient urological university clinic using a general questionnaire, urological complaints questionnaire and two sexual questionnaires: Female Sexual Function Index (FSFI) for evaluating sexual function and the subscales; non-communication and female dissatisfaction of the Golombok Rust Inventory of Sexual Satisfaction (GRISS) as bother scales.

Results

A total of 326 patients were included in the study, 119 (36.5%) were sexually inactive and 207 (63.5%) patients were sexually active. The major reasons for sexual inactivity were related to not having a partner, and to partner- and patient related health issues. The total FSFI score of the sexually active patients was 28.3 (3.9-36) and of these, 41.4% had a FSFI score below 26.55, which could be indicative of sexual complaints. Female patients with urological complaints such as lower abdominal pain and lower urinary tract symptoms (LUTS) were more likely to have sexual complaints. In the FSFI score below 26.55 group the patients reported more difficulties to discuss sexual issues with their partner, were more dissatisfied and experienced sexual contact as less enjoyable.

Conclusion

In urological practice female sexual complaints are common. We therefore recommend integrating female sexual function questionnaires in standard urological care.

CHAPTER 3

Introduction

The relationship between sexual abuse and urinary tract symptoms, sexual abuse and gastrointestinal symptoms, or sexual abuse and sexual dysfunction have been described before. A correlation between all these symptoms and sexual abuse has not yet been reported.

Aims

The first aim of this study was to document the prevalence rates of reported sexual abuse in a large sample of female patients with complaints of the pelvic floor. The second aim was to evaluate the frequency of complaints in the different domains of the pelvic floor, such as complaints of micturition, defecation and sexual function in female patients reporting sexual abuse and comparing these data with female patients without a history of sexual abuse.

Methods

Female patients with pelvic floor complaints were evaluated in a tertiary referral center. History taking was assessed by a pelvic-floor clinician. The number of domains with complaints of patients with a history of sexual abuse was compared to the number of domains with complaints of patients without sexual abuse.

Results

Twenty-three percent (42/185) of the patients reported a history of sexual abuse. Female patients with a history of sexual abuse had significantly more complaints in three domains of the pelvic floor (35/42) compared to non-abused (69/143) (83% vs. 48%, $p < 0.001$).

Conclusions

Twenty-three percent of the female patients in a pelvic floor center evaluated by a pelvic-floor clinician reported a history of sexual abuse. This is comparable to the percentage of sexual abuse observed in the population at large. In our sample, patients with multiple pelvic floor complaints (micturition, defecation and sexual function) related to pelvic floor dysfunction were more likely to have a history of sexual abuse than patients with isolated complaints.

CHAPTER 4

Introduction

Sexual abuse and sexual functioning are topics that health professionals find difficult to discuss. Women who present with pelvic floor complaints often experience sexual difficulties; therefore, questions regarding sexual function should be a routine part of screening. Furthermore, pelvic floor complaints are correlated with sexual abuse and asking about abuse should be a routine part of screening as well. Considering the fact that many practitioners have difficulty enquiring about abuse, we have suggested that a questionnaire may be helpful in improving the recognition and management of patients who have a history of sexual abuse. The aim of the study was to assess the accuracy in the efficiency of detecting sexual abuse of a self-administered questionnaire

Methods

Report of sexual abuse in a self-administered pelvic floor questionnaire before visiting our outpatient pelvic floor department was evaluated with the Pelvic Floor Leiden Inventories (PelFIs) administered by a pelvic floor clinician in a later stage.

The percentage of sexual abuse detected by a taken questionnaire administered by a pelvic floor clinician not mentioned in a previous self-administered questionnaire was taken as main outcome measure.

Results

Sexual abuse was reported in 20 patients with pelvic floor dysfunction during administration of the PelFIs and were also evaluated on our pelvic floor department. Six of them (30%) did not mention in the self-administered questionnaire their history of sexual abuse.

Conclusion

A self-administered questionnaire for pelvic floor complaints does contribute substantially in detecting sexual abuse and can be helpful in daily practice

CHAPTER 5

In a retrospective study we evaluated sexual function after tension-free vaginal tape (TVT) placement for urinary stress incontinence based on responses to a mailed questionnaire at least 3 months after the operation, to a maximum of 1 year. From 1999 to 2002, a sexual function questionnaire was mailed to 128 women (and their partners) who had undergone a TVT procedure for genuine

urinary stress incontinence, without pelvic organ prolapse or detrusor instability. The questionnaire was returned by 96 women (75%), 69 (72%) of whom reported being sexually active. Mean frequency of intercourse did not change. Overall, 26% described improved intercourse compared to before the operation. Only one patient described worsening of intercourse after the TVT operation because of an increase in her incontinence. Overall, in this study the technique of tension-free vaginal tape as such seems to have no negative impact on sexual function. However, because of its successful outcome on incontinence, it has a positive overall effect on sexual function. The possible causes of postoperative partner discomfort require further investigation.

CHAPTER 6

Introduction

Transobturator suburethral tape (TOT) and tension free vaginal tape obturator (TVT-O) procedures are relative new incontinence treatment procedures. Studies on influence on sexual function as a result of these procedures are limited. The aim of the study was to investigate the influence of TOT or TVT-O for the surgical treatment of stress urinary incontinence (SUI) on female sexual function.

Methods

We evaluated 77 sexual active patients after TVT-O (n=34, mean age 53.2 years) and TOT (OB-TAPE, Porges) (n=44, mean age 52.0 years) placement for SUI based on responses to a mailed questionnaire 3 months after operation. Difference in postoperative sexual complaints related to the TVT-O (inside-out) and TOT (outside-in) procedure was taken as main outcome measure.

Results

Postoperative TOT and TVT-O

There was almost no difference in frequency of sexual intercourse and an improvement of the continence during intercourse: continence was reported in 33 patients (42.3%) before and 67 patients (78.4%) after operation. The appreciation of sexual intercourse was improved in 15 patients (19.2%) and worsened in 8 patients (10.3%).

Postoperative TVT-O vs TOT

No difference was seen in lost of lubrication, clitoral tumescence reduction and clitoral sensibility reduction between both procedures. Pain because of vaginal narrowing was seen significantly more in the TOT procedure group.

Conclusion

Overall, in this study the technique of TOT gave rise to more sexual dysfunction

than TVT-O. However, because of the successful outcome on incontinence, both procedures had overall a positive effect on sexual function. The cause of significant more pain during intercourse as a result of vaginal narrowing in the TOT procedure requires further investigation. Like other studies this study demonstrated that incontinence surgery can have a positive and negative outcome on sexual function. It is important to include this issue in the informed consent.

CHAPTER 7

Introduction

There are limited data on female sexual function after cystectomy for benign indications.

To evaluate postoperative sexual items following cystectomy and continent urinary diversion for benign indications (e.g. severe incontinence, interstitial cystitis) in female patients. Furthermore, to review the studies investigating changes in women's sexual function after cystectomy were the aims of this study.

Methods

In a retrospective study 21 out of 23 patients (91%) that underwent a cystectomy for a benign indication completed a questionnaire. These women had a median age at the date of operation of 47.3 yr (range 25-66yr) and mean follow-up of 11.9 yr. Questions on preoperative and postoperative sexuality, postoperative sexual activity, sexual appreciation and the Female Sexual Function Index (FSFI) in patients at present were evaluated. Electronic databases were searched for published studies investigating female sexual function after cystectomy.

Results

Sexual complaints before operation were present in 48% of the patients. The most common complaints reported were incontinence during intercourse, pain and loss of libido. Seventeen out of 21 patients (81%) were sexual active preoperatively, 14 were still active postoperatively, and two preoperative inactive patients became active. Sexual inactivity postoperative is mainly due to patient-related or combination of patient- and partner-related issues (70%), such as pain during intercourse, loss of libido and impaired body image. In the sexual active group, the majority (62.5%) showed improved or unchanged intercourse postoperatively. In the FSFI in 11 sexual active patients at present (52%), domains of desire, arousal, lubrication, orgasm and pain scored above average. The domain of satisfaction scored below average.

Conclusions

Despite extensive surgery, female sexuality may remain unchanged or even improve, following cystectomy and continent diversion for benign indication. Sexual inactivity postoperatively needs more attention in respect to sexual counseling. Overall the results are reassuring.

CHAPTER 8

We report a case of a 32-year-old woman who underwent a partial cystectomy to preserve sexual function. After radiotherapy for stage IB1 cervical cancer, cystectomy was indicated because of severe radiation cystitis. During this procedure we resected the upper part of the bladder followed by stripping off urothelium of the remaining bladder to spare the neurovascular bundle. Follow-up after 3 months indicated intact sexual function including orgasm. In our opinion the cystectomy procedure described in this case report is a good, novel option in women who are candidates for cystectomy because of a crippled bladder, after radiotherapy, and want to retain sexual function.

FUTURE PERSPECTIVES

Female sexual (dys)function is a relative new topic in urological practice. This thesis illustrates the importancy of this issue. The most important final question is “How can we incorporate female sexual function in urological practice”.

More research has to be done in order to incorporate female sexual function as one of the outcome measurements in relation to uro-gynecological practice and operations, as was the case with erectile function in relation to radical prostatectomy. We state that the impact of an operation in the small pelvis on sexual function needs to be part of informed consent.

In order to achieve this goal in general, sexology should be an integrated part of clinical urological practice.

We realize that discussing sexuality is not only difficult for patients but also for physicians. However, this should not refrain patients and physicians to address these issues. Sexual patient care, as part of quality of life, should be independent of the interest of an individual doctor on the subject of sexual function. We need to create opportunities, to incorporate sexual function in clinical care

At the end I ask again: “Why should the urologist play a role in managing female sexual dysfunction?” Hopefully this thesis has illustrated that female sexual function is an important part of urological practice.

