Female sexual function and urinary incontinence

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Chapter 5

The place of female sexual dysfunction in the urological practice: results of a Dutch survey.

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Introduction

Female sexual dysfunctions (FSDs) are highly prevalent and often underestimated problems in the general community (1). However, FSDs have not yet been studied as extensively as male sexual dysfunction. Improved knowledge on the female pelvic anatomy and recent insights in female sexual physiology helped to classify FSDs more adequately. Today, FSD is a term used to describe various sexual problems, such as low desire or interest, orgasmic difficulties, diminished arousal, and dyspareunia (2;3). Due to the use of different instruments, published prevalence estimates of FSD show a great deal of variation (4). FSD is considered common in the general population, with a quoted prevalence of 43% (1;5;6). In these studies however, distress caused by sexual dysfunction has not been inquired. The prevalence of sexual problems accompanied by personal distress was estimated to be 12-24% from large population-based surveys in the United States (1;3;5).

A number of studies have demonstrated a strong association between pelvic floor disorders, lower urinary tract symptoms, overactive bladder with or without urinary incontinence, and FSD (7-14). The prevalence of FSD in sexual active women attending an urogynecologic outpatient clinic ranges from 48 to 64% (15;16), which is higher than the afore mentioned 43% in the general population. In patients attending an urogynecologic outpatient clinic, FSD is unlikely to be the sole complaint, i.e., the reason for women to consult their urogynecologist. Only seven out of 70 women with FSD presented with this problem at a urogynecology clinic (16). Therefore, women who seek urological care will be of greater risk of having sexual function disorders and urologists should be aware of this potential co-existing problem.

Besides the frequent coexistence of FSD in patients with urological complaints, urological surgery such as (simple/radical) cystectomy, prolapse and incontinence surgery may enhance FSD (17;18). Sexual dysfunction may arise due to nerve or vessel damage and/or alteration of vaginal anatomy. In this respect, the growing interest in the preservation of the neurovascular bundles is an important new topic in oncological pelvic surgery (19). Literature on incontinence surgery is conflicting: some reports suggest a deterioration of sexual function (20-22), some an equivocal effect (23-27), whereas others show improvement (28-34). Whatever the effect may be, the possible effects on sexuality should be discussed both pre- and postoperatively with the patient and her partner.

A web-based survey of 3,807 women aged 18-75 years in the USA indicated that the most important barriers for women to seek help were embarrassment and the idea that physicians would not be able to provide adequate help (35). Only 42% of this cohort sought help from a physician. In our experience, there appear to be two major groups of women suffering from FSD, namely, those who present symptoms and those who prefer not to broach the subject and perhaps hope that the discussion will emerge during the consultation. Therefore, the doctor is the pivot on which discussing FSD hinges and he or she should therefore be proactive and endeavor to identify sexual problems.

Recent surveys among members of the American Urogynecologic Society (AUGS) and the British Society of Urogynecology (BSUG) showed that only a minority screened all their patients for FSD (36;37). Dutch urologists have not yet been surveyed regarding patient assessment of FSD in their practices.

Aims

The purpose of this survey was to investigate whether Dutch urologists and residents address patients' sexual function as part of history taking, to delineate perceived barriers to perform this assessment, and to document current attitudes towards female sexual dysfunction.

Methods

In the autumn of 2007, a questionnaire was mailed to all urologists and residents registered at the Dutch Urologic Association (405). Nearly all Dutch urologists and residents are member of this association (20% female, 80% male). The 17-item questionnaire (appendix) was designed by an urologist/sexologist from our clinic (H.W.E) in order to address FSD-related practices at outpatient clinic visits, beliefs and overall impression of FSD and FSD related to surgery. Five of the 17 questions concerned the topic of taking the history of possible sexual abuse. Sexual abuse is strongly related to urological complaints and sexual dysfunction. Because of its complexity it was decided to present these data separately.

Demographic data included type of practice, medical degree (resident or urologist), gender and age. The survey was accompanied with a letter explaining the objectives of the study. All date were collected anonymously.

We analyzed the data using SPSS release 16 (SPSS Inc., Chicago, Ill). Bivariate associations between demographic information and frequency of FSD screening were calculated using the chi-square procedure and p-values < 0.05 were considered statistically significant.

Ethical approval was not required and thus asked for in this study.

Results

Of the 405 mailed surveys, 190 were completed and returned. From the 215 non-respondents we did not receive a refusal note or notification of unavailability to complete the questionnaire. Four questionnaires were from non-eligible respondents, namely pediatric urologists. Their questionnaires were excluded for analysis. All returned surveys were complete, i.e. more than 80% of all applicable questions were answered. For analysis we used the completed questionnaires of eligible respondents which gave a response rate of 45.9% (186/405). One hundred respondents requested the survey results to be mailed at the end of the study (53.8%).

Table 1: Demographic characteristics of respondents (n=186)

Demographic characteristic	*n (%)*
Age (years)	
20-30	3 (1.6)
31-40	66 (35.5)
41-50	56 (30.0)
51-60	51 (27.4)
>60	8 (4.3)
missing	2 (1.1)
Gender	
Male	154 (82.8)
Female	32 (17.2)
Medical degree	
Urologist	148 (79.6)
Urology resident	38 (20.4)
Type of clinic/practice	
Academic (teaching) hospital	44 (23.7)
District general teaching hospital	54 (29.0)
District general hospital	88 (47.3)

The majority of respondents were urologists (79.6%) and most (65.5%) were between 31-50 years old. Consistent with the distribution within the surveyed population, there were more male respondents (82.8%) than female (17.2%). Forty-seven percent of the respondents worked in a district general hospital, 29% in a district general teaching hospital and 24% in an academic teaching hospital. The demographic characteristics are presented in Table 1.

One of the primary goals of the survey was to assess if urologists and residents address patients' sexual function as part of history taking. Only 10 respondents (5.4%) stated they ask each female patient for her sexual function. In contrast, 81.8% stated they ask for sexual function when a patient has a specific complaint like lower abdominal pain (86.8%), urgency or frequency (77.1%), incontinence (73.6%) and urinary tract infections (66.7%). Among 'other complaints' to ask for female sexual function, the respondents mentioned dyspareunia, pelvic floor dysfunction and neuropathic bladder disorders. (Table 2)

We were also interested in reasons why 176 respondents do not ask each patient for sexual function. 40.3% stated that they do not find it meaningful in urological practice, 22.7% mentioned insufficient knowledge how to ask for FSD, others lack of time (18.2%) or lack of knowledge in therapeutic options if they diagnose FSD (13.6%). Only a minority (10.8%) said they find it difficult to bring up the subject. Other reasons given (12.5%) were 'older patients (especially those without a partner)', 'no relevance to ask for FSD for example when a patient suffers from urinary stone disease' and 'FSD belongs to the field of a gynaecologist'.

There was a significant difference in age of respondents who stated to have insufficient knowledge how to ask for FSD; i.e. respondents aged 40 years and younger (16/65) more often

Table 2: Asking for sexual function (n=186)

Do you ask each patient for sexual function?	n=186	
Yes	10	5.4%
No	176	94.6%
Do you ask for sexual function when a patient has certain urological complaints?	n=176	
Yes	144	81.8%
No	32	18.2%
Which complaints?	n=144	
Lower abdominal pain	125	86.8%
Urgency or frequency	111	77.1%
Incontinence	106	73.6%
Urinary tract infections	96	66.7%
Hematuria	4	2.8%
Other	9	6.2%

feel their insufficient knowledge in asking for FSD as a reason not to ask for sexual function than older colleagues (24/109). (p=0.01)

Another goal of our survey was to document physicians' perception of the prevalence of FSD. Respondents were asked to esteem how many of their patients are experiencing sexual dysfunction. The majority reported less than the estimated 48-64% of patients.(15;16) Of the respondents 37.8% believed less than 10% of their patients suffer from FSD. Prevalences of 11-20, 21-30, 31-40, 41-50 and 51-60% were estimated by 22.8%, 20.6%, 10% and 6.7% respectively. Only 2.2% estimated between 51-60%. No respondents perceive a prevalence of FSD higher than 60%. Nine respondents acceded to have no insight in the frequency of FSD in their patient population whatsoever and therefore did not give a percentage (missing). (Fig. 1) In the group of responders, who thought of a prevalence of at least 30% or higher (n=58), 10.3% asked each patient for sexual function and 84.5% asks for sexual function when a patient had a specific urological problems. Compared to the rest of the group, respondents who believed the frequency of FSD to be at least 30% tended to ask for FSD more often but no statistical significant difference was found (p=0.08). These groups showed no significant difference in asking for sexual function when a patient has a specific urological complaint. (p=0.57)

Prior to a radical cystectomy, the potential effects of surgery on sexual function were discussed with patients by 83.9% of the respondents, by 81.2% prior to a simple cystectomy and by 58.6% prior to incontinence surgery. After surgery patients are asked for changes in sexual function by 47.3%. One hundred and seventy (91.4%) respondents stated that female sexual function should be integrated in post-graduate urological training programs.

Analysis, performed to determine whether certain demographic factors had any impact on frequency of asking for sexual function when a patient has a specific urological complaint, showed no statistical differences in frequency of screening bases on medical degree, type of practice, gender or age. (Table 3)

Figure 1: Physician perceptions of the prevalence of FSD in their patient population

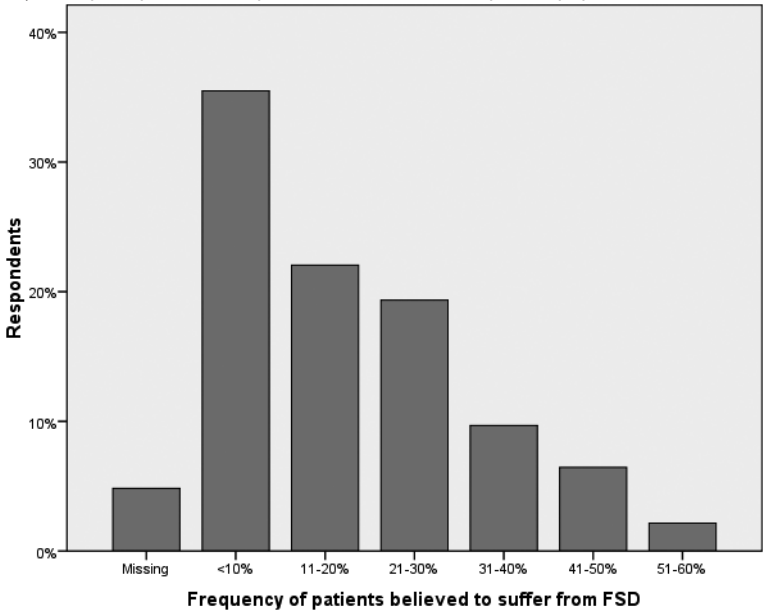

Table 3: Frequency of asking for sexual function when a patient has a specific urological complaint and respondent characteristics.

Demographic characteristics	Ask for sexual function when a patient has a urological complaint		Total	P value
	Yes	No		
Medical degree				
Urologist	126	22	148	1.00
Resident	28	10	38	
Type of practice				
Academic (teaching) hospital	36	8	44	0.98
District general teaching hospital	45	9	54	
District general hospital	73	15	88	
Gender				
Male	127	27	154	1.00
Female	27	5	32	
Age				
< 40 years	56	13	69	0.69
> 40 years	97	18	115	

Discussion

This study was performed to asses the approach of Dutch urologists towards female sexual dysfunction in urological patients. Most urologists do not consistently address female sexual dysfunction. The prevalence of FSD is underestimated and not all urologists address FSD prior and following surgery.

This survey had a response rate of 45.9% which is equal to the previous survey amongst AUGS members but lower than the 67% response in the British survey (36;37). Our response rate is higher than the average, observed in postal questionnaires (38). This may be due to a second preannounced mailing after which the response rate nearly doubled.

This study has some limitations. Firstly, the use of a non-validated questionnaire with dichotomic answers and without cultural components taken into account. Secondly, as non-respondents may have different beliefs, attitudes, and practice patterns than responders, there may be a selection bias. As in all questionnaire studies, there may be a bias in reporting, as the respondents may overestimate frequency of asking for sexual function in their practices. However, attempts were made to reduce such a bias by making the survey anonymous.

Recent surveys among members of the American Urogynecologic Society (AUGS) and among members of the British Society of Urogynecology (BSUG) showed that only a minority screen all patients for FSD (22% and 0% respectively). Lack of time, uncertainty about therapeutic options, and older age of the patient were cited as potential reasons for failing to address sexual complaints as part of routine history (36;37).

Although we did not use the same questionnaire, some comparisons to the American and British surveys can be made. Similar in all three surveys is that only a minority of respondents ask each patients for female sexual (dys)function. When asked for reasons not to address FSD, the majority of the American and British respondents stated lack of time to screen for FSD after surgery (78% and 66%) while in our survey only 18.2% stated lack of time. Another objection given in these surveys was fear of, by asking for FSD, to offend their patients. In our survey, we did not ask for this objection, however respondents did not state this barrier at the 'Other' answers.

When asked for reasons not to ask, female sexual function is thought not to be meaningful in a urological practice, while it is known that there is a strong association between FSD and urological problems. Obviously this is contradictory. Unfortunately the survey did not give us information about why urologists think female sexual function to have no meaning in their practices. One would expect an increased attention to sexual disorders in urologists with special interest in treatment of lower urinary tract disorders but unfortunately we have no data on this issue. Although respondents stated they think female sexual function not to be meaningful, they agree female sexual function should be part of their graduate and post-graduate training.

Even though female sexual function is included as a required topic in the education of urology residents and currently part of graduate and post-graduate training programs, a reason not to ask for sexual function was insufficient knowledge how to ask for FSD, especially for respondents aged 40 years and younger. This illustrates the fact that apparently current training programs are insufficient. Furthermore, even though older urologists have dealt with sexual dysfunction in men for decades, the interest in female sexual function lags behind. Only during the last five years, female sexuality has become a topic in the training of urology residents.

Important in this respect is the underestimation of the frequency of FSD in a urological practice. The majority reported a prevalence far below the estimated prevalence of 48-64%

of patients (15;16). Reasons for this underestimation could be insufficient education or lack of interest in FSD. The group of 58 respondents who estimated a frequency of FSD at least 30% do not ask more often for FSD. So even if a doctor has knowledge of the prevalence of FSD, asking for sexual function it is still not part of the daily routine. Lack of knowledge but also understanding may contribute to many doctors' lack of willingness to deal with the sexual issues.

It is known that urological surgery such as a cystectomy, prolaps and incontinence surgery may enhance FSD (17;18). Prior to a (simple or radical) cystectomy the possible effects on sexual function are discussed with patients by most of the urologists (81.2 and 83.9%). Before incontinence surgery however, only 58.6% discuss potential risks. Perhaps not all urologists are aware that not only surgery such as a cystectomy but also surgery for incontinence may cause FSD. Remarkably, even though most urologists discuss it prior to surgery, only 47.3% ask if changes in sexual function have occurred after surgery. Unfortunately the questionnaire does not provide us the information why urologists do not ask for changes in sexual function after surgery but this topic does need attention. After surgery, patients should be assessed for sexual problems and informed on therapeutic options. In both the FSD, as the surgery related FSD section of the questionnaire, no gender-related differences were found.

The results of this survey show that awareness of FSD is apparently insufficient. There is a need for better implementation of education and training at both undergraduate and postgraduate levels. Education should inform clinicians about the prevalence and the current knowledge of FSD, especially in relation to urological complaints and treatments. Furthermore, training should be based on studies on women's attitudes towards sexuality in relation to the expectations of the physician. Women expect initiatives from physicians in raising the issue of sexual health. They want both routine and more frequent physician inquiry about sexual concerns, as well as a more open, clear, comfortable, and empathic discussion of these issues (39). Physicians should be aware of their patients' needs in this area. Because lack of time is also mentioned as a reason not to ask for sexual function, urologists should be trained in time management strategy. Furthermore, training should aim to teach urologists how to communicate more effectively with patients as this is important in assessment of FSD.(40) Finally, they should be informed about the validated questionnaires which could help them in their assessments of female sexual function.

Conclusion

Overall, many urologists do not consistently ask each female patient for sexual function and underestimate the prevalence of FSD. For the majority of the members of the Dutch Urological Association FSD is not part of routine urological practice. There is, therefore, a need for better implementation of education and training at both undergraduate and postgraduate levels.

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Appendix

I. Female sexual function

1. Do you ask each female patient for sexual function?
   Yes ☐ No ☐
2. Do you ask for sexual function in female patients with specific urological complaints?
   Yes ☐ No ☐
3. If so, which urological complaints?

Hematuria	Yes ☐	No ☐
Incontinence	Yes ☐	No ☐
Urgency and frequency	Yes ☐	No ☐
Lower abdominal pain	Yes ☐	No ☐
Urinary tract infection	Yes ☐	No ☐

   Other, _____

4. A reason not to ask is;

I don't find it meaningful in a urological clinic	Yes ☐	No ☐
Not enough time	Yes ☐	No ☐
I find it difficult to address	Yes ☐	No ☐
I have insufficient knowledge how to ask for FSD	Yes ☐	No ☐
If a patient has FSD, I am unsure about therapeutic options	Yes ☐	No ☐

   Other, _____

5. What percentage of female patients that you see do you believe experience sexual dysfunction? (Please give a percentage)
   _____%

II. Sexual abuse:

6. Do you always ask patients before performing a physical examination for a history of negative sexual experiences (sexual abuse)?
   Yes ☐ No ☐
7. Do you ask patients with specific urological complaints for a history of negative sexual experiences (sexual abuse)?
   Yes ☐ No ☐
8. If so, which urological complaints?

Hematuria	Yes ☐	No ☐
Incontinence	Yes ☐	No ☐
Urgency and frequency	Yes ☐	No ☐
Lower abdominal pain	Yes ☐	No ☐
Urinary tract infection	Yes ☐	No ☐

   Other, _____

9. A reason not to ask is;

I don't find it meaningful in a urological clinic	Yes ☐	No ☐
Not enough time	Yes ☐	No ☐
I find it difficult to address	Yes ☐	No ☐
I do not know what/how to ask	Yes ☐	No ☐
If a patient has a problem, I am unsure about therapeutic options	Yes ☐	No ☐

Other, _____

10. What percentage of female patients that you see do you believe have a history of sexual abuse? (Please give a percentage)

_____%

III. Surgery and female sexual dysfunction

11. Do you address the (possible) effects of surgery on female sexual function prior to the following procedures?

Radical cystectomy	Yes ☐	No ☐
Simple cystectomy	Yes ☐	No ☐
Incontinence surgery	Yes ☐	No ☐

12. Do you ask for the (possible) effects of these surgeries on female sexual function after the procedure? Yes ☐ No ☐

13. Should female sexual function related to urology be integrated in post-graduate training programs? Yes ☐ No ☐

IV. Demographics

14. What is your age? _____ Years

15. What is your gender? Male ☐ Female ☐

16. What is you profession?
    - Urologist ☐
    - Resident urology ☐
    - Paediatric urologist ☐

17. Where do you work?
    - Academic (teaching) hospital ☐
    - District general teaching hospital ☐
    - District general hospital ☐

END