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FEMALE SEXUAL DYSFUNCTION

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Summary

Female sexual dysfunction affect up to 43% of women causing a "distress" or a psychological strain for the patients. A variety of chronic diseases in addition to menopause and different drugs represents the risk factors to a female sexual dysfunction. Since 2015 the FDA has approved Flibanserin for the treatment of female libido although several other drugs have been proven efficacious.

Key words

Female sexual dysfunction, ogasms disorders, flibanserin.

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Conflict of interests

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ЖЕНСКАЯ СЕКСУАЛЬНАЯ ДИСФУНКЦИЯ

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Резюме

Около 43% женщин предъявляют жалобы на расстройство сексуальной функции, вызывая дистресс или серьезную психологическую нагрузку для пациенток. Большое количество различных хронических заболеваний, наряду с менопаузой и влиянием некоторых лекарственных препаратов, являются факторами риска нарушения сексуальной функции у женщин. В 2015 г. Управление по контролю над пищевыми продуктами и лекарственными препаратами США официально одобрило препарат флибансерин, хотя и другая терапия продемонстрировала положительный эффект.

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Ключевые слова
Нарушение сексуальной функции у женщин, нарушения оргазма, флибансерин.

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Конфликт интересов
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Background

With the approval of Flibanserin (Addyi®) for the treatment of female sexual desire deficiency in America by the FDA are the sexual problems of women in the public attention. Female sexual dysfunction is a very common problem. Up to 43% of women suffering from this problem temporarily or permanently. Aging, diseases and their treatment with various drugs, lifestyle, but also pregnancies affect sexuality [1]. Female sexual dysfunction is divided in the following symptom:

1. Pain during penetration or sexual intercourse;
2. Orgasm disorders and
3. Excitation and libido disturbances.

These problems can either be lifetime or be acquired and be either generalized (always) or situation – depending, partner-related or in a particular context. The Complaints should for more than 6 months for definition and cause a "distress" or a psychological strain for the patients. The prevalence of various disorders ranges from 16% (pain syndromes) and 22 to 36% for libido loss, the most common female sexual dysfunction [2]. This is a lack of sexual fantasies and a lack of desire for sexual activity from which the patient suffers (American Psychiatric Association) persistent or recurring: A possibly occurring in the older age in sexual problems without personal suffering is therefore not as disorder classified.

Drug therapy of female sexual dysfunction

In Europe, there is no drug, that is approved for the treatment of female sexual dysfunction. Since August 2015, Flibanserin has been "approved" by the FDA and will there be available by "trained & certified doctors and pharmacists". Flibanserin was originally developed as an antidepressant and has been tested so far in the approved dose of 100 mg to 2700 women. Flibanserin is an agonist at the 5-HT1A serotonin receptor and an antagonist at 5-HT2A at the dopamine receptor D4; Flibanserin behaves as a weak partial agonist [5]. So inhibiting on the one hand the release of sexuality-inhibiting serotonin and increases on the other hand, the release of sexuality-enhancing neurotransmitters dopamine and norepinephrine. Encountered side effects such as dizziness, blood pressure waste and syncope can be largely prevented by taking in the evening, if indication and strong observance of the indications and contraindications (CAVE: alcohol).

Vaginal atrophy and / or reduced lubrication and existing estrogen deficiency and thus increased pain during sexual intercourse is an indication for local estrogen therapy. If local estrogens are not allowed you can use preparations with hyaluronic acid. For sexual intercourse you should recommend lubrications too, water or silicon based.

Testosterone in combination with estrogen enhances sexual satisfaction in patients in surgical menopause. Testosterone alone showed a slight improvement of sexuality in postmenopausal women, while long term data remains to be seen.

Risk factors of female sexual dysfunction – chronic diseases and medications

The risk factors to a female sexual dysfunction lead, can represent in particular surgical menopause and a variety of chronic diseases in addition to menopause [4].

The depression can have female sexual dysfunction as a symptom or vice versa the female sexual dysfunction can be caused by antidepressants (SSRI).

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Spectrum	Details
Cardiovascular disease:	Coronary heart disease, hypertension, stroke
Neurological and psychiatric diseases:	Depression, anxiety, dementia, Parkinson's disease, multiple sclerosis, spinal cord injury
Endocrine disorders:	Hyperthyroidism, hypothyroidism, Prolactinoma, diabetes
Gynaecological problems:	Postpartal, menopausal, menstrual disorders, genital prolapse
Urologic diseases:	Chronic cystitis, incontinence, sexually transmitted diseases, chronic renal failure, dialysis
Chronic diseases:	Breast CA, rheumatic diseases
Metabolic disorders:	Obesity, fat metabolism disorders

Table 1. Risk factors of female sexual dysfunction – chronic diseases and medications.

Over 50% of patients with diabetes mellitus is disturbed to sexual function due to endothelial dysfunction and this is associated reduced in swelling of the vaginal corpora cavernosa and reduced lubrication. Because of diabetic neuropathy genital sensation can be enhanced by Mediterranean diet and exercise. In patients with morbid obesity, a significant improvement of sexual function could be seen after bariatric surgery [3].

Over 63% of all patients with coronary heart disease suffering from to sexual dysfunction.

Loss of libido can be caused by hyperprolactinemia, which can be caused by a pituitary gland tumor or by a variety of drugs (psychotropic drugs, antihypertensive agents. hormone preparations, anticholinergic agents, antihistamines, chemotherapy drugs).

Diagnosis & management

In any case, the sexual function should be addressed by the attending physician as part of the "vegetative" or general history. Permisson is obtained from the patient to talk about sexuality. Subsequently there is limited information of physiological and pathophysiological processes. E.g. *"an estrogen deficiency can lead to vaginal dryness by the patients!"* Through concrete proposals is entered on the complaints of the patient (E.g.,*"Sports and nutrition improve your sex life"*). After that you can start with an intensified therapy (sex therapy or pharmacologic therapy / psychotherapy).

In any case, an accurate drug history should be carried out and sexual function are addressed by the attending physician and in individual cases be converted on a different formula: so the antidepressant "Bupropion" in contrast to the SSRi s has a positive effect on sexual function. Treatment at spironolactone or thiazide can cause in women dysorders of lubrication cycle changes, what could make sense a changeover to Eplerenone. From the substance class of AT II antagonists seems valsartan to have a more positive effect on sexual function.

Conclusion

It can be said the "female sexual dysfunction" is a serious disorder that affects up to 43% of all women and represents a significant deterioration in the quality of life of the patient and also their partners and for which there is a variety of therapeutic interventions. A basic clarification should be routinely performed in the context of a general or specialist investigation and transferred to an intensified therapy specialists as needed. Up to 80% of all sexual medical can be resolved by a doctor.

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