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Physician Dysfunction and Sexual Dysfunction

HOW WE CAN IDENTIFY THE PATIENT WHO HAS SEXUAL ISSUES AND HELP THEM GET APPROPRIATE TREATMENT

You are listening to ReachMD, the channel for medical professionals. Welcome to Advances in Women's Health sponsored, in part, by Eli Lilly. Your host is Dr. Lauren Streicher, Assistant Clinical Professor of Obstetrics and Gynecology at Northwestern University Medical School, The Feinberg School of Medicine.

Physician dysfunction and sexual dysfunction, help is on the way. Welcome to Advances in Women's Health. I am Dr. Lauren Streicher your host and with me today is Dr. Laura Berman, an Assistant Clinical Professor of Obstetrics/Gynecology and Psychiatry at the Feinberg School of Medicine at Northwestern University in Chicago. Dr. Berman completed a fellowship in sexual therapy with the Department of Psychiatry, New York University Medical Center and has been working as a sex educator, researcher and therapist for 18 years. Today, she is going to share her insights as to how we can identify the patient who has sexual issues and help them get appropriate treatment.

DR. LAUREN STREICHER:

Dr. Berman, we all know we should address our patient's sexual concerns, but too often we don't. There is never enough time during a typical office visit and quite frankly if the patient does not ask it is a whole lot easier to just not go there and even if they do have the time, many physicians do not even know how to broach the subject of sexual dysfunction or know how to help their patients. So, to start with, when a patient comes to see you, how often, does she find her way there on her own or that she actually discuss the problem with her physician and was referred to you for help.

DR. LAURA BERMAN:

Well, I think it has really been evolving because certainly when we first started talking about this whole topic of female sexual dysfunction, which honestly really was only probably since the mid 90s, in the beginning medical profession was really resistant and hesitant to even address these issues at all or even acknowledge them as being real. There is a whole range of medical resources and literature on male sexual dysfunction, but very little on female sexual dysfunction. The majority of the women were finding their way to me through their own research and through their own advocacy without their physicians help. How, just over the past several years, I have seen many, many, many more and I would say it is probably equal the number of women who find me through having seen me in the media or heard me somewhere versus from doctor referrals.

DR. LAUREN STREICHER:

And I am kind of curious does any specialty better added to another's and you get more referrals from gynecologist, internist, and family practice?

DR. LAURA BERMAN:

It really ranges. Not only do we get referrals from general therapists who do not really deal with sex in their therapy practices to every field that matters them. Even pain specialists or heart specialists across the board.

DR. LAUREN STREICHER:

Across the board.

DR. LAURA BERMAN:

Across the board.

DR. LAUREN STREICHER:

There is a practical matter. What is the best way for a physician to broach the subject of sexuality? Should it be part of written questionnaire, should we bring it up, how do we bring it up, what recommendations?

DR. LAURA BERMAN:

I think in an ideal world outside the managed care system were 15 minutes in our fantasy medical world you would be taking a detailed sexual history, in addition to the vigilant other aspect of medical history that you are taking. In our typical present day unideal world even asking just 1 question on the intake form, have you noticed any change in your sexual function and please describe and when you are going through that form, upon meeting with the patient, you can just say you I noticed you wrote here at you are experiencing some changes in desire which you like to address that and one thing that I have noticed that a lot of doctors, especially doctors who are really interested in actually treating and not just referring out you know because of that point of the person saying yes, and you spoke about her low libido, you could then say okay. Well, here is your referral to someone who can help you, but if you are a physician who wants to address that then what I recommended really setting up another separate appointment to really go over everything then.

DR. LAUREN STREICHER:

Such a great point because I generally have always said you're patient are you having any problems in sexual function and I just like so much the idea saying have you noticed any changes.

DR. LAURA BERMAN:

Right, because a lot of women do not really want to acknowledge is as a problem and though even come in thinking they want to bring it up to you, but they check in and out whether, or they feel you are in a hurry.

DR. LAUREN STREICHER:

O if becomes one of these hand on the door questions, you are on the way out and all of a sudden day they just remember, oh by the way.

DR. LAURA BERMAN:

Right.

DR. LAUREN STREICHER:

You know, from a patient's point of view, do you think it matters if the physician is a male or female, is she more likely to want to bring this up with a female physician.

DR. LAURA BERMAN:

You know, it depends. I think it has been surprising to me as long as I have been doing this. How many women have negative experiences, more negative experiences with female physicians than male physicians, so I do not know that we can assume just because physicians are female, but they are going to be empathetic to this issue or able to deal with it effectively, but the most it has to do with is the patient's perception of the doctors comfort. The #1 predictor of the patient not bringing these issues up is actually the belief that they will be embarrassing the doctor.

DR. LAUREN STREICHER:

So, what can we do to let them know that they wouldn't be embarrassing?

DR. LAURA BERMAN:

Well, I think putting a question on your intake form is a really simple way or even a notice in your waiting room, you know letting patients know, are you having any of these symptoms, we want to know about it, giving those cues that you are open to discussion that you know it is a real issue that you do not think it is all in her head, necessarily, that you are not just going to ponder off upon on someone else are all going to make her more willing to bring these things up.

DR. LAUREN STREICHER:

Can you comment on the different types of sexual dysfunction that you typically see in your practice?

DR. LAURA BERMAN:

The 4 categories that are the most common are the most, most common is low desire about 30% of women experience this and this is lack of thoughts, fantasies, motivation to be sexual and that can range from sort of just trying to avoid sex, but being a little relatively receptive when it is initiated to being aversive to sex at all costs and then there is orgasmic disorder which are women who either are not able to achieve to orgasm at all or for whom the ability in the intensity of the orgasm have changed. So, they are harder to come by and there are more muscle that are less intense and then there are arousal disorders, which are women who complain of lack of sensation, lack of genital swelling, dryness and then a range of pain disorders, which include genital pain either during intercourse or sometimes even chronically and there is a new category that is as not commonly reported, but doctors will definitely see in their practice which is called persistent sexual arousal disorder. Women who are experiencing a chronic and uncomfortable engorgement in their genital, which is only relieved through stimulation or sex, but it is constant, so they walk around almost in pain.

DR. LAUREN STREICHER:

Let us go to the libido issue again, because I think they persistent sexual arousals are really interesting, we probably do not see a lot of them in their practice, but libido issues is something that come up every single day and from my point of view there is enormous difference between someone who says they had a healthy wonderful libido and something has changed and very often I can identify something hormonally or situationally, but what about the women who comes and says she has never had much of libido.

DR. LAURA BERMAN:

Right, you know, it is a tricky thing, because with libido the trickiest part of that libido is that there are so much overlap, if she having low libido because she just has low libido and when she has sex it is satisfying and good, or is she having low libido because sex is an enjoyable and you know the cost benefit rewards. You know they work in favor of having sex and that is a really important distinction to make specially when you are looking at treatment because orgasmic disorders, certainly pain disorder, even arousal disorder will often turn out to be the primary diagnosis and low libido secondary.

DR. LAUREN STREICHER:

Hmm, hmm.

DR. LAURA BERMAN:

So, that is something that you will see in women, who have had it <_____> and also women who have been on hormonal contraceptives from an early age, from the time they really started to become sexual, will experience that and that I am sure you are familiar with the research that is shown that the hormonal contraceptives increase SHBG, which is sex hormone-binding globulin, protein in the blood that binds to testosterone and makes it unavailable for the body to use for things likely libido and sexual response. So, it limits free circulating testosterone. So, that is another common reason that you see in younger women, often women will have low libido and low testosterone after pregnancy, that is called postpartum testosterone deficiency syndrome and often it does not re-equilibrate and we also now know that chronic stress will effect testosterone level because women respond differently to stress, than men do. So, if they are chronically stressed, their oxytocin levels go up which is the chemical of attachment and that also increases SHBG as well, then there is a whole psychological peace because you know what I find is that women in general most women in their 30s and 40s and beyond were not raised to see sex as something joyous and wonderful and gift in its own sake. They kind of thoughts, more is means to an end. You know, the way to get the guy or the way to settle down or what you just did and they never really explore pleasure or thought in that. So, they just thought they did it and once they get the guy, the motivation isn't really there anymore to do it. So, that is why you see so many

men complaining of once we got married sex went by the wayside. So, you know certainly if she has been sexually abused or had any kind of sexual trauma if she has a lot of guilt or was raised in a very restrictive environment around sex that will also cause lifelong low libido.

DR. LAUREN STREICHER:

That is very helpful.

I would like to thank my guest, Dr. Laura Berman who has provided information that will make a significant difference in how we approach the patient with sexual dysfunction. I am Dr. Lauren Streicher. You are listening to ReachMD, the channel for medical professionals. For a complete program guide and pod cast visit our www.reachmd.com.

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DOCTOR:

So, Rachel,

RACHEL:

Hmm

DOCTOR:

Now that you are postmenopause and we have determined you have osteoporosis, I would like to start you on prescription only of Evista, raloxifene hydrochloride tablets.

RACHEL:

Why Evista?

DOCTOR:

Because it's the only medicine that reduces the risk of osteoporotic fractures and invasive breast cancer in women like you. It's important to know if the Evista does not treat breast cancer, prevent its return, or reduce the risk of all forms of breast cancer.

RACHEL:

Am I really at risk for invasive breast cancer?

DOCTOR:

Based on my risk assessment, you may be. Some risk factors for breast cancer included advancing age, family history, and personal history.

RACHEL:

So, even though no one in my family as ever had breast cancer and still at risk for other reasons including my advancing age.

DOCTOR:

Exactly, and I think the benefits outweigh the potential risks for you. It's the one medicine that treats osteoporosis and reduces the risk of invasive breast cancer in postmenopausal women with osteoporosis. Individual results may vary, of course, but that's exiting news.

RACHEL:

Exciting, I have to take your word on that doctor.

DOCTOR:

Evista increases the risk of blood clot, so it should not be used by women who have or have had blood clots in the legs, lungs, or eyes. Evista may increase the risk of dying from stroke and women at high risk for heart disease or stroke. Talk to your doctor about all your medical conditions, seek care immediately if you have leg pain or warmth, swelling of the legs, hands, or feet, chest pain, shortness of breath, or a sudden vision change. Do not use Evista if you are pregnant, nursing, or may become pregnant as it may cause fetal harm. Women with liver or kidney disease should use Evista with caution. Evista should not be taken with estrogens. Side effects may include hot flashes, leg cramps, and swelling. For more information about Evista, contact your Lily Sales representative, visit www.evista.com. See our ad in good housekeeping or call 1888-44 Evista.