Female sexual dysfunction

د. نور فوزي شهيد
كلية الطب\ الجامعة المستنصرية
2026-2025

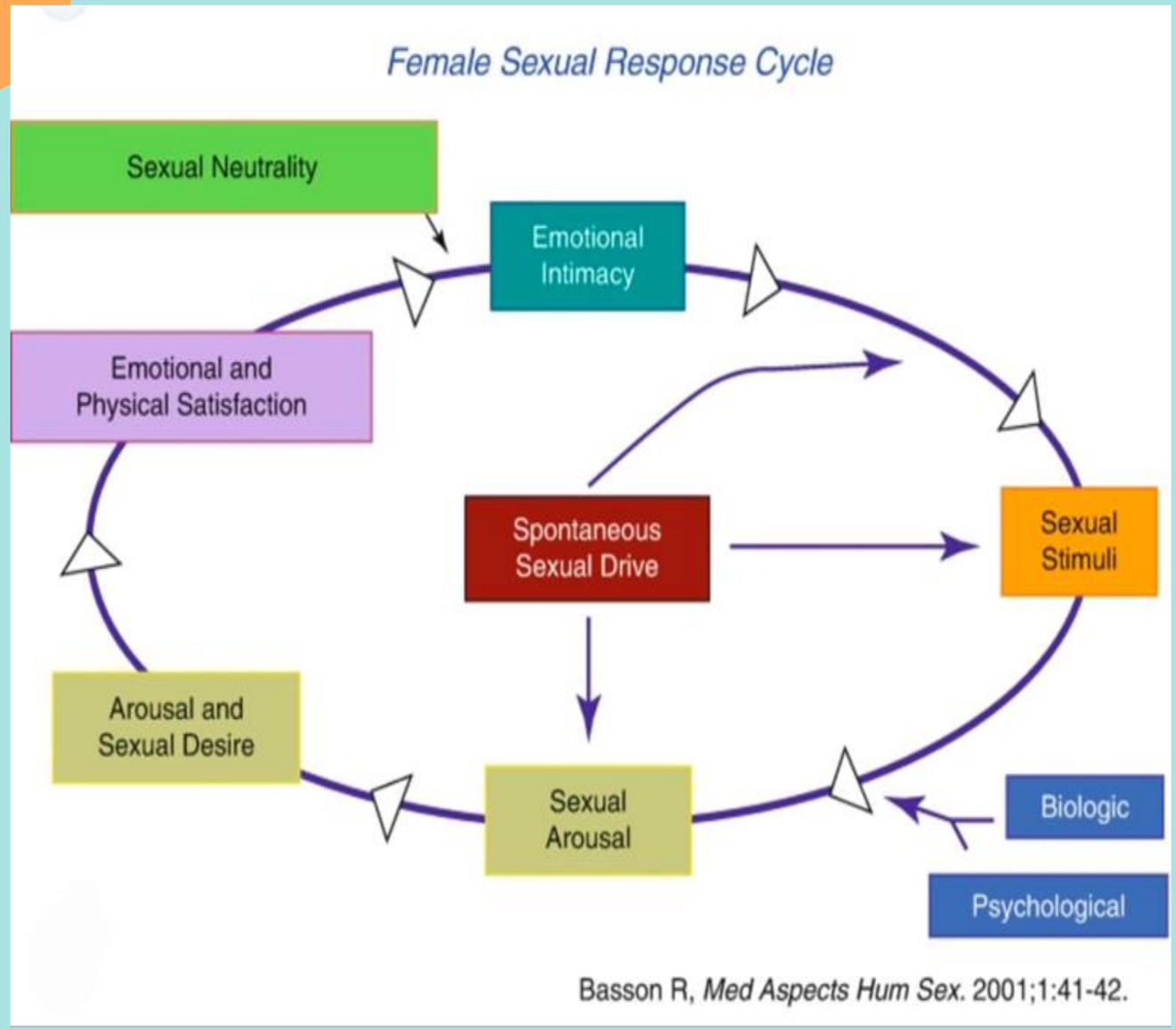


OBJECTIVES

1. Understand the components of normal female sexual response
2. Describe the classification of female sexual dysfunction (FSD)
3. Identify major risk factors
4. Recognize the clinical features and evaluation steps
5. Outline the management strategies

Includes problems with desire, arousal, orgasm, or sexual pain, and can significantly affect quality of life. Understanding normal sexual variations is essential, as diagnosis depends on the woman’s personal distress and the impact on her functioning.

Female sexual dysfunction



Sexual Response – Anatomy & Physiology

Female sexual response depends on coordinated neural, vascular, and hormonal mechanisms.

Parasympathetic activation (S2–S4) increases vaginal blood flow and creates vasomotion (random opening/closing of capillaries).

Vaginal lubrication occurs through transudation plus Bartholin's and Skene's gland secretions.

Clitoral erectile tissue becomes engorged during arousal, enhancing sexual sensation.

Consequences of FSD??

Risk factors

Psychosocial & Psychosexual Factors

Psychological factors: mood disorders, stress, trauma, and substance use.
Relationship factors: communication, satisfaction, self-esteem.
Life-stage factors: infertility, postpartum changes, ageing, menopause.
Ageing: reduced desire, lubrication issues, orgasm difficulties.
Sociocultural influences and ethical considerations.

Physical Factors :

Endocrine: ↓Estrogen/androgens, ↑Prolactin (treat → improves FSD)
Neurologic/Vascular: impaired arousal, ↓lubrication
Iatrogenic: medications, pelvic surgery (hysterectomy)
Gynecologic: cancers, prolapse, incontinence
Dermatologic: lichen sclerosus, eczema
Metabolic: PCOS, obesity, metabolic syndrome, DM↑ (strongest link)



Classification of FSD

1. **Desire disorders**: Hypoactive sexual desire disorder (HSDD)
2. **Arousal disorders**: Female sexual arousal disorder (FSAD)
3. **Orgasmic disorders**: Delayed or absent orgasm, Anorgasmia
4. **Sexual pain disorders / Genitopelvic pain-penetration disorder**: Dyspareunia, Vaginismus, Vulvodynia

.

❖ **Sexual arousal disorder** is a persistent or recurring inability to attain or maintain adequate sexual excitement, which leads to personal distress. It is common with aging and the menopause, Psychosocial factors and peripheral neuropathy.

❖ **Orgasmic disorder** is either complete absence or recurrent difficulty in attaining orgasm after sufficient sexual stimulation, Primary orgasmic disorder is usually due to emotional trauma or sexual abuse.

Secondary orgasmic disorder can be caused by hormonal deficiency, surgical trauma, or medications

Sexual Pain Disorders

Vaginismus: To understand it well, we need to comprehend that it is an element of 2, psychological and physical.

- **Definition**: psychological disorder manifested by fear and anxiety of vaginal penetration and a physical disorder as noted by recurrent or persistent involuntary pelvic muscle contraction (levator ani muscle).

The diagnosis of vaginismus is made by history. It has an incidence of 5-17%.

- Reasons for sexual pain, such as herpes virus, lichen sclerosis, and other medical conditions, need to be ruled out as a source of sexual pain.
- Can be categorized as primary or secondary, and it varies in severity.
- Affected women are unable to tolerate a GYN examination, leads to marital problems and depression, and to feelings of isolation, and is a major cause of unconsummated marriages.
- In comparison with other types of pelvic pain, it has good success rate in treatment.

Vulvodynia is chronic vulval pain, often burning, that occurs without infection or skin disease and is considered neuropathic. It may be generalized or localized and can be provoked or unprovoked. It commonly coexists with vaginismus due to pelvic floor spasm. Management focuses on symptom relief through perineal massage, desensitization, pelvic floor physiotherapy, lubricants, and avoiding triggers. Neuromodulators such as amitriptyline may help some patients. A supportive, multidisciplinary approach is essential, with emphasis on improving comfort and quality of life rather than complete cure.

Vestibulodynia: A similar condition causes pain only when pressure is applied to the area surrounding the entrance of vagina.



Dyspareunia: is pain during or after sexual intercourse and can be:
Superficial: pain at the vagina, clitoris, or labia → often psychosexual.
Deep: pain felt in the pelvis → often due to pathology (e.g., endometriosis, PID).
Prevalence 10–20%
Risk factors: FGM, PID, endometriosis, menopause, depression/anxiety, history of sexual assault.



Clinical Evaluation
Delay speculum exam if superficial pain with no red flags.
Use topical lidocaine gel before exam if needed.
Take full sexual, reproductive, and medical history.
Examine for: skin disorders, scarring, anatomical anomalies, vaginismus, tenderness, and pelvic masses.
investigations
Superficial dyspareunia: evaluate for vulval dermatoses or atrophy; biopsy only if malignancy is suspected.
Deep dyspareunia: consider transvaginal ultrasound, swabs, and possibly laparoscopy.

Management

A. Non-pharmacological

Education and mirror-guided vulvar anatomy awareness

Pelvic floor physiotherapy and biofeedback

CBT-based therapy for fear, trauma, and pain anticipation
Couples therapy and communication

Graduated vaginal dilators



Management

B. **Pharmacological**

Treat infections / micro abrasions (fluconazole, itraconazole)

Topical anesthetics (lidocaine)

Neuropathic pain medications: Amitriptyline, Carbamazepine, Gabapentin, Pregabalin

Botox injections

Vaginal estrogen therapy for atrophy (Vagifem, Estring, Ovestin)

Topical testosterone for vulvar dystrophy

Topical steroids for lichen sclerosus

For refractory deep dyspareunia or vulvodynia: consider surgery (laparoscopy for pelvic disease; vestibulectomy for provoked vulvodynia).

C. Multidisciplinary Care

Referral to pain management

Long-term psychotherapy when required

Approach to Female Sexual Dysfunction (FSD)



Preparation:

Provide privacy, empathy, non-judgmental attitude.

Normalize discussion (“Sexual problems are common and treatable”).

Involve partner if appropriate and with consent.

History (Biopsychosocial)

Sexual history Type of problem (desire, arousal, orgasm, pain); onset (lifelong/acquired); frequency, severity; partner & relationship factors

Medical Chronic illness, diabetes, CVD, thyroid disease, menopause, neurological disorders

Medications SSRIs, antihypertensives, others

Psychological Depression, anxiety, trauma, abuse history

Sociocultural Religious/cultural restrictions, body image

Gynecologic Obstetric trauma, atrophy, lubrication problems

Physical Examination

Gentle, explained, with chaperone.

Inspect vulva, vagina, pelvic floor tone, mucosal atrophy, tenderness.

Measure vaginal pH ≤4.5.

Delay exam if anxiety is high.

Investigations

Hormonal panel: Testosterone, SHBG, FAI, FSH, Estradiol

Lipids profile

LFT, B12, Folate (for orgasmic disorder)

Tests as indicated (infection screen, etc.)

Management (Multidisciplinary)

General principles: Education, evaluate and manage psychological factors adequate stimulation, sensate focus, manage comorbidities, partner communication

Desire/Arousal: Lubricants, pelvic floor training, topical/systemic estrogen, off-label: sildenafil, yohimbine, ephedrine, L-arginine

Orgasmic: CBT, psychotherapy, off-label: bupropion, buspirone, oxytocin, topical estrogen/testosterone

Pain/Penetration: Education, physiotherapy, CBT, antifungals, lidocaine, neuropathic agents (amitriptyline, gabapentin), topical estrogen/testosterone, lubricants, CO_2 laser has been proposed but is not FDA-approved.

Follow-Up

Reassess regularly for improvement.



female sexual dysfunction is best managed by identifying the specific problem, addressing medical and psychological contributors, and providing supportive, multidisciplinary care.

A patient with vaginismus is progressing well in therapy. Which management option directly targets gradual desensitization of penetration?



A.Pelvic floor physiotherapy

A.CBT / Psychosexual therapy

A.Lubricants & vaginal estrogen

A.Neuropathic pain medications (e.g., amitriptyline, gabapentin)

A.Graduated vaginal dilators

