Body System: Reproductive-Female

Session Topic: Female Sexual Dysfunction

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Sexual dysfunction is often poorly understood. • Physicians are often uncomfortable discussing comprehensive sexual histories with female patients who have achieved sexual maturity. • Physicians often receive inadequate sexual health education in medical school and residency, & are often inconsistent with their approach in the management of women complaining of low sexual desire and sexual dysfunction. • Since the publication of the ACOG Female dysfunction guidelines, the changes in the DSM-5 regarding female sexual dysfunction are significant. • FDA recent (Aug 2015) approval of flibanserin to treat acquired, generalized hypoactive sexual desire disorder (HSDD) in premenopausal women	1. Use a standardized method (e.g. PLISSIT, or ALLOW) to identify the underlying physiological and psychological factors that can influence female sexual dysfunction. 2. Diagnose and evaluate sexual dysfunction in accordance to current DSM-5 and ACOG guidelines, or coordinate referral and follow-up with a trained specialist. 3. Analyze symptoms and conduct a thorough medical and sexual history to determine when sexual dysfunction may be a symptom of an underlying illness and recommend additional testing as necessary. 4. Develop collaborative care plans with patients for the treatment of sexual dysfunction; emphasizing patient education, treatment options, and coordination of care with a mental health or sexual dysfunction specialist as necessary.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

ACGME Core Competencies Addressed (select all that apply)			
X	Medical Knowledge	X	Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide strategies for using a standardized method (e.g. PLISSIT, or ALLOW) to identify the underlying physiological and psychological factors that can influence female sexual dysfunction.
- Provide recommendations for diagnosing and evaluating sexual dysfunction in accordance to current DSM-5 and ACOG guidelines, or coordinate referral and follow-up with a trained specialist.
- Provide recommendations and strategies for analyzing symptoms and conduct a thorough medical and sexual history to determine when sexual dysfunction may be a symptom of an underlying illness and recommend additional testing as necessary.
- Provide strategies and resources for developing collaborative care plans with patients for the treatment of sexual dysfunction; emphasizing patient education, treatment options, and coordination of care with a mental health or sexual dysfunction specialist as necessary.
- Provide an overview of new FDA approved medications (e.g. Addyi, *flibanserin*), including safety, efficacy, cost, recommendations for use; including a comparison to currently available treatment options.

Needs Assessment

Sexual problems are highly prevalent in women. Approximately 40% of women report female sexual problems; in fact, the National Health and Social Life Survey found that sexual dysfunction was more prevalent among women than men, with lack of sexual desire identified as the most common problem.[1,2]

Sexual dysfunction is complex and poorly understood, and physicians are often uncomfortable with and poorly educated about obtaining a comprehensive sexual history.[2] This is validated by an analysis of recent American Academy of Family Physicians (AAFP) CME Needs Assessment Survey data suggesting that family physicians have knowledge gaps regarding female sexual dysfunction, sexual counseling, and abnormal libido.[3] More specifically, CME outcomes data from 2012 and 2015 AAFP FMX (formerly Assembly): *Sexual Dysfunction* sessions suggest that physicians have knowledge and practice gaps with regard to screening; how and when to approach female patients about sexual dysfunction during the office visit; taking an effective history; knowing what counseling to provide vs. referring to a specialist; knowing when to test hormone levels; awareness of effective treatment options (both pharmacologic & non-pharmacologic), and being aware of current clinical guidelines.[4,5]

Barriers to providing optimal patient care include inadequate sexual health education in medical school and residency, difficulty initiating conversations about sexual problems in the clinical setting, perceived lack of effective therapies, and an overall inconsistent approach in the assessment and management of women complaining of low sexual desire.[6] Physicians consistently underestimate the prevalence of sexual concerns in their patients, and they should develop a routine way to elicit the patient's sexual history that avoids judgmental attitudes and asks the patient for permission to discuss sexual function will make it easier to gather the necessary information.[7] Additional challenges include the evaluation of treatments and complex, multi-faceted therapies. Most studies use validated questionnaire scores as an outcome measure; however, there are multiple questionnaires, each with its own questions and scales.

Serotonin-enhancing medications have an inhibitory effect on sexual function. Sexual dysfunction induced by selective serotonin reuptake inhibitor use is common, with an incidence between 30% and 70%, and may include difficulty with sexual desire, arousal, and orgasm. Further, many other commonly prescribed medications may adversely affect sexual functioning, including antiestrogens, such as tamoxifen and aromatase inhibitors, and oral estrogens, including combined hormonal contraception.[8] Additionally, the available data available on the effect of hormonal contraceptives on female sexuality are inconsistent.[9]

Physicians may improve their care of female patients with sexual dysfunction by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:[8]

- Bupropion (Wellbutrin) in higher dosages (150 mg twice daily) has been shown to be effective as an adjunct for antidepressant-induced sexual dysfunction in women.
- Sildenafil (Viagra) may benefit women with sexual dysfunction induced by selective serotonin reuptake inhibitor or serotonin-norepinephrine reuptake inhibitor use.
- Female genital sexual pain disorders are complex and most effectively managed with a comprehensive, multidisciplinary approach that addresses contributing biopsychosocial factors.
- Group cognitive behavior therapy has been shown to effectively treat low sexual desire.
- Mindfulness-based interventions have been shown to effectively treat low sexual desire and arousal, and acquired anorgasmia.
- Directed masturbation is recommended for lifelong anorgasmia.

- Local vaginal estrogen therapy is recommended and preferred over systemic estrogen therapy for treatment of genitourinary syndrome of menopause and related dyspareunia when vaginal dryness is the primary concern. Because of potential adverse effects, the use of estrogens, especially systemic estrogens, should be limited to the shortest duration compatible with treatment goals.
- Ospemifene (Osphena) is modestly effective for treatment of dyspareunia.
- Transdermal testosterone, with or without concomitant estrogen therapy, has been shown to be effective for short-term treatment of low sexual desire or arousal in natural and surgically induced menopause.

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Additionally, physicians may improve their care of women with sexual dysfunction by integrating current evidence-based guidelines into their standards of care. Current American College of Obstetricians and Gynecologists (ACOG) Female sexual dysfunction guidelines consider diagnosis, evaluation, management, and treatment.[10] Cognitive and behavioral psychotherapy is among many of the evidence-based treatment options, and while primary care physicians deliver half of all mental health services; increasingly, family physicians are finding that the best option is to collaborate closely with a behavioral health specialist or integrate one into their practice.[10,11]

Since the publication of the ACOG Female dysfunction guidelines, the changes in the DSM-5 regarding female sexual dysfunction are significant. Physicians may also not be aware of the changes in the DSM-5 regarding sexual dysfunction. In DSM-5, gender-specific sexual dysfunctions have been added, and, for females, sexual desire and arousal disorders have been combined into one disorder: female sexual interest/arousal disorder. To improve precision regarding duration and severity criteria and to reduce the likelihood of over-diagnoses, all of the DSM-5 sexual dysfunctions (except substance-/medication-induced sexual dysfunction) now require a minimum duration of approximately 6 months and more precise severity criteria. These changes provide useful thresholds for making a diagnosis and distinguish transient sexual difficulties from more persistent sexual dysfunction.[12]

Physicians should also be kept up to date on new FDA approved medications, like the recently approved Addyi (flibanserin) to treat acquired, generalized hypoactive sexual desire disorder (HSDD) in premenopausal women.[13] A recent meta-analysis of eight placebo-controlled randomized trials provided the best available evidence of the safety and efficacy of flibanserin; which resulted in small but significant increases in sexual desire and the number of sexually satisfying events per month, but also increased the risk for mild adverse events, such as

dizziness, somnolence, nausea, and fatigue.[14] The education should include an overview of safety, efficacy, cost, and recommendations for use; including a comparison to other treatment options currently available.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Sexual Dysfunction in Women: A Practical Approach[8]
- Diagnosis and treatment of female sexual dysfunction[2]
- ACOG Practice Bulletin No. 119: Female sexual dysfunction[10]
- Managing difficult encounters: understanding physician, patient, and situational factors[15]
- Integrating a behavioral health specialist into your practice[11]
- Adding health education specialists to your practice[16]
- Engaging Patients in Collaborative Care Plans[17]
- Health Coaching: Teaching Patients to Fish[18]
- Medication adherence: we didn't ask and they didn't tell[19]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[20]
- Simple tools to increase patient satisfaction with the referral process[21]
- Sexual Dysfunction (Women) | Overview (patient education)[22]

References

1. Centers for Disease Control and Prevention. A Public Health Approach for Advancing Sexual Health in the United States: Rationale and Options for Implementation, Meeting Report of an External Consultation. 2010. http://www.cdc.gov/sexualhealth/docs/SexualHealthReport-2011-508.pdf. Accessed June 2014.

2. Frank JE, Mistretta P, Will J. Diagnosis and treatment of female sexual dysfunction. *American family physician.* Mar 1 2008;77(5):635-642.

3. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.

4. American Academy of Family Physicians (AAFP). AAFP FMX CME Outcomes Report. Leawood KS: AAFP; 2015.

5. American Academy of Family Physicians (AAFP). 2012 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2012.

6. Abdolrasulnia M, Shewchuk RM, Roepke N, et al. Management of female sexual problems: perceived barriers, practice patterns, and confidence among primary care physicians and gynecologists. *The journal of sexual medicine.* Jul 2010;7(7):2499-2508.

7. Nusbaum MR, Hamilton CD. The proactive sexual health history. *American family physician.* Nov 1 2002;66(9):1705-1712.

8. Faubion SS, Rullo JE. Sexual Dysfunction in Women: A Practical Approach. *American family physician.* 2015;92(4):281-288.

9. Boozalis A, Tutlam NT, Chrisman Robbins C, Peipert JF. Sexual Desire and Hormonal Contraception. *Obstet Gynecol.* Mar 2016;127(3):563-572.

10. American College of O, Gynecologists Committee on Practice B-G. ACOG Practice Bulletin No. 119: Female sexual dysfunction. *Obstet Gynecol.* Apr 2011;117(4):996-1007.

11. Reitz R, Fifield P, Whistler P. Integrating a behavioral health specialist into your practice. *Family practice management.* Jan-Feb 2011;18(1):18-21.

12. American Psychiatric Association (APA). *Diagnostic and statistical manual of mental disorders: DSM V.* 5th ed. Washinton DC: American Pyschiatric Publishing; 2013.

13. U.S. Food and Drug Administration. FDA approves first treatment for sexual desire disorder. *FDA News Release* 2015; http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm458734.htm. Accessed Aug, 2015.

14. Jaspers L, Feys F, Bramer WM, Franco OH, Leusink P, Laan ET. Efficacy and Safety of Flibanserin for the Treatment of Hypoactive Sexual Desire Disorder in Women: A Systematic Review and Meta-analysis. *JAMA internal medicine.* Apr 1 2016;176(4):453-462.

15. Cannarella Lorenzetti R, Jacques CH, Donovan C, Cottrell S, Buck J. Managing difficult encounters: understanding physician, patient, and situational factors. *American family physician.* Mar 15 2013;87(6):419-425.

16. Chambliss ML, Lineberry S, Evans WM, Bibeau DL. Adding health education specialists to your practice. *Family practice management.* Mar-Apr 2014;21(2):10-15.

17. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management.* 2013;20(3):35-39.

18. Ghorob A. Health Coaching: Teaching Patients to Fish. *Family practice management.* 2013;20(3):40-42.

19. Brown M, Sinsky CA. Medication adherence: we didn't ask and they didn't tell. *Family practice management.* Mar-Apr 2013;20(2):25-30.

20. Stewart EE, Fox CH. Encouraging patients to change unhealthy behaviors with motivational interviewing. *Family practice management.* May-Jun 2011;18(3):21-25.

21. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management.* Nov-Dec 2011;18(6):9-14.

22. FamilyDoctor.org. Sexual Dysfunction (Women) | Overview 2000; http://familydoctor.org/familydoctor/en/diseases-conditions/sexual-dysfunction-women.html. Accessed June, 2014.

