General Practitioners' attitudes to taking a sexual history and therapeutic approaches in the Management of Sexual Dysfunction

Sofia Ribeiro[1], Violeta Alarcão[1], Rui Simões[1], Filipe Leão Miranda[1], Mário Carreira[1], Alberto Galvão-Teles[2]

sofiafigribeiro@gmail.com

[1] Institute of Preventive Medicine, Faculty of Medicine, University of Lisbon, Portugal, [2] Endocrinology, Diabetes and Obesity Unit, Lisbon, Portugal

Background

Good history-taking skills are an important step towards achieving a correct diagnosis of sexual dysfunctions. However, studies show that there is both a lack of opportunities for medical students to learn how to do a sexual history[1] and a lack of opportunistic sexual history taking by doctors[2]. A study conducted among Swiss GPs and Urologists showed that both prefer using their own diagnostic criteria in male SD, however they are often not reliable and valid[3].

This study **aims** to characterize: a) **GPs'** attitudes towards **taking a sexual history**, identifying its frequency and focus, b) describe GPs' **therapeutic approaches**, including patients' and doctor-related differences.

Materials and Methods

Cross-sectional study part of the SEXOS Study, using structured questionnaires applied to general practitioners working on Lisbon Area (ACES Odivelas).

Invitation to ACES Odivelas Health Cluster Units (10 Health Centers) → 90% response rate → Invitation to eligible GPs (68 GPs) → 74% response rate → Filling of the questionnaires (50 GPs) → Data validation → Data analysis α=0.05 Chi-square test or Mann-Whitney Test

Study population:

1. Being a General Practitioner (intern or specialist)
2. Working in one of the selected Health Centers
3. Expressing his/her consent to participate in the study

Results

The 50 participants (30 females) are in average 52±8.6 years old. There are no statistically significant differences between male and female GPs in what concerns age and years of practice, but male GPs tend to follow more patients than female GPs. Female GPs indicate a higher average appointments length in which SD is mentioned and also indicate a higher percentage of patients that they actively ask about sexual problems (the last one without statistical significance) (Table 1).

Table 1. Socio-demographic characteristics and medical practice details

	Male GP (N=20) Mean±SD	Female GP (N=30) Mean±SD	Total (N=50) Mean±SD	p-value*
Age (years)	49.8±10.0	53.2±7.5	51.9±8.6	0.27
Years since start of GP career	19.5±8.7	22.0±7.8	21.0±8.6	0.34
Approximate size of patients' list	1738.8±256.3	1541.7±399.6	1613.4±363.9	**0.01**
Number of medical appointments / week	102.6±27.1	96.9±30.9	99.2±29.2	0.93
Number of medical appointments / week in which SD is mentioned	5.4±6.8	8.3±8.4	7.4±7.9	0.25
Time of medical appointments in which SD is mentioned (minutes)	21.4±6.5	25.7±8.8	24.0±8.2	**0.05**
Estimated % of patients GPs actively ask about patient' sexual problems	13.2±12.4	17.0±17.0	15.5±16.7	0.69
Estimated % of patients that actively ask about sexual problems	11.6±9.9	15.4±15.0	13.9±13.2	0.64

Most GPs prefer an open conversation (90.0%) when it comes to talk about sexual problems. GPs consider that the exploration of the definition of "sexual life without sexual problems" depends highly on the patient they have (82.0%), as for "sexual satisfaction as a whole" (85.0%). Table 2 shows the main reasons for asking for SD.

Table 2. Reasons for opening a discussion about SD in primary care

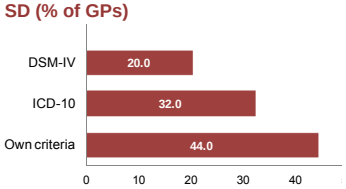
Reason for opening a discussion about SD	Male GPs % (n)	Female GPs % (n)	Total % (n)
Routine sexual history	8.2 (4)	14.3 (7)	22.4 (11)
Menopause	22.4 (11)	42.9 (21)	65.3 (32)
Andropause	20.4 (10)	28.6 (14)	49.0 (24)
Urologic diseases	26.5 (13)	40.8 (20)	67.3 (33)
Cardiovascular diseases	22.4 (11)	34.7 (17)	57.1 (28)
Mental diseases	10.2 (5)	24.5 (12)	34.7 (17)
Neurologic diseases	2.0 (1)	26.5 (13)	28.6 (14)
Diabetes	28.6 (14)	55.1 (27)	83.7 (31)
Obesity	8.2 (4)	16.3 (8)	24.5 (12)
Other endocrine diseases	2.0 (1)	16.3 (8)	18.4 (9)
Family planning	24.5 (12)	46.9 (23)	71.4 (55)
Medication with adverse effects on sexuality	28.6 (14)	49.0 (24)	77.6 (38)

The main reasons for asking patients about their sexuality are diabetes (83.7%), prescription of medication with adverse effects on sexuality (77.6%), family planning (71.4%) and urologic diseases (67.3%). Routine sexual history-taking (22.4%) appears as the least appointed motive for asking patients about their sexuality. There were no significant differences considering the sex of the GPs. Table 3 shows sexual problems usually enquired by GPs in specific diseases.

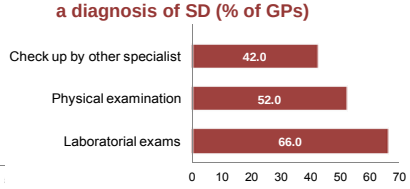
Table 3. Sexual problems usually enquired by GPs in specific diseases

Sexual problems usually inquired to patients with specific diseases	Cardiovascular diseases				Endocrine diseases				Urologic diseases				Mental illness			
	Men		Women		Men		Women		Men		Women		Men		Women	
	% (n)				% (n)				% (n)				% (n)			
Decreased libido	48.0	(24)	22.0	(11)	36.0	(18)	46.0	(23)	48.0	(24)	32.0	(16)	52.0	(26)	60.0	(30)
Increased libido	0.0	(0)	0.0	(0)	20	(10)	24.0	(12)	0.0	(0)	4.0	(2)	32.0	(16)	30.0	(15)
Sexual aversion	4.0	(2)	8.0	(4)	8.0	(4)	26.0	(13)	14.0	(7)	18.0	(9)	44.0	(22)	56.0	(28)
Erectile dysfunction	64.0	(32)			60.0	(30)			68.0	(34)			28.0	(14)		
Orgasmic disturbances	14.0	(7)	10.0	(5)	22.0	(11)	26.0	(13)	38.0	(19)	16.0	(8)	30.0	(15)	42.0	(21)
Premature ejaculation	2.0	(1)			10.0	(5)			46.0	(23)			34.0	(17)		
Sexual dysfunction due to a general medical condition	46.0	(23)	40.0	(20)	36.0	(18)	40.0	(20)	42.0	(21)	30.0	(15)	30.0	(15)	26.0	(13)
Dyspareunia			14.0	(7)			32.0	(16)			56.0	(28)			38.0	(19)
Sexual dysfunction related to substance use	50.0	(25)	40.0	(20)	30.0	(15)	28.0	(14)	44.0	(22)	24.0	(12)	44.0	(22)	56.0	(28)

Graphic 1. Methods used to diagnose SD (% of GPs)



Graphic 2. Methods used to clarify a diagnosis of SD (% of GPs)



When asked about the criteria used to diagnose SD, 44.0% say they use their own diagnostic criteria, whereas 32.0% mention ICD-10 and 20.0% DSM-IV (Graphic 1). Laboratorial exams are the ones GPs use the most to clarify a sexual problem (66.0%), followed by physical examination (52.0%) and check-up by other specialist (42.0%) (Graphic 2). Table 4 shows the therapeutic approaches in treating SD.

Table 4. Therapeutic approaches in treating SD

What is your therapy for…	Drug prescription				Looking for a solution together with the patient				Involving the partner				Sending to other medical specialty			
	Men		Women		Men		Women		Men		Women		Men		Women	
	% (n)				% (n)				% (n)				% (n)			
Hypoactive desire disorder	36.0	(18)	18.0	(9)	62.0	(31)	72.0	(36)	50.0	(25)	62.0	(31)	48.0	(24)	34.0	(17)
Erectile dysfunction	78.0	(39)			56.0	(28)			42.0	(21)			48.0	(24)		
Orgasmic disturbances	24.0	(12)	6.0	(3)	36.0	(18)	46.0	(23)	34.0	(17)	42.0	(21)	58.0	(29)	64.0	(32)
Premature ejaculation	38.0	(19)			46.0	(23)			46.0	(23)			48.0	(24)		
Sexual aversion			12.0	(6)			56.0	(28)			48.0	(24)			54.0	(27)
Dyspareunia			46.0	(23)			56.0	(28)			44.0	(22)			46.0	(23)

In all the SD, drug prescription was the least common approach. No significant differences in SD management were found considering GPs sex and age (p>0.05).

Discussion and Conclusions

Only a minority of the participants GPs implements sexual history-taking as a routine practice. Their diagnosis is mostly based on "own criteria" rather than in clinical guidelines, being this concordant to the literature, and a matter of concern since they are often not valid and reliable. Differences related to self-perceived competence in discussing and treating SD and need for training will be explored. Drug prescription is the least common therapeutic approach, except for erectile dysfunction, and again in line with the literature[3]. Considering patients' gender differences when treating hypoactive desire disorder, pharmacologic treatment was more frequent in male patients and involving the partner in female patients. Doctor-related differences in therapeutic approaches will be deeply explored.

References:

1. O'Keefe R, Tesar CM. Sex talk: what makes it hard to learn sexual history taking? Fam Med 1999; 31 : 315-16.
2. Temple-Smith MJ, Mulvey G, Keogh L. Attitudes to taking a sexual history in general practice in Victoria, Australia. Sex Transm Infect 1999; 75 : 41-4.
3. Platano G, Margraf J, Alder J, Bitzer J. Frequency and focus of sexual history taking in male patients--a pilot study conducted among Swiss general practitioners and urologists. *J Sex Med*. 2008;5:47-59.

Acknowledgments: ACES-Odivelas Health Units and SEXOS Study Research Team. **Grant:** Merck Sharpe and Dohme Foundation and Program "Educação pela Ciência", GAPIC / FMUL.