The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACOG PRACTICE BULLETIN SUMMARY

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 213

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For a comprehensive overview of these recommendations, the full-text version of this Practice Bulletin is available at http://dx.doi.org/10.1097/AOG.0000000000003324.

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Committee on Practice Bulletins—Gynecology. This Practice Bulletin was developed by the American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology in collaboration with Stacy Tessler Lindau, MD, MAPP, and Emily Abramsohn, MPH.

Female Sexual Dysfunction

Female sexual dysfunction encompasses various conditions that are characterized by reported personal distress in one or more of the following areas: desire, arousal, orgasm, or pain (1). Although female sexual dysfunction is relatively prevalent, women are unlikely to discuss it with their health care providers unless asked (2), and many health care providers are uncomfortable asking for a variety of reasons, including a lack of adequate knowledge and training in diagnosis and management, inadequate clinical time to address the issue, and an underestimation of the prevalence (2). The purpose of this document is to provide an overview of female sexual dysfunction, to outline updated criteria for diagnosis, and to discuss currently recommended management strategies based on the best available evidence.

Clinical Management Questions

- *How should women be screened for female sexual dysfunction?*
- *What is the initial approach to a patient who presents with possible female sexual dysfunction?*
- *What is the role of psychologic interventions in the treatment of female sexual dysfunction?*
- *What is the role of estrogen therapy or estrogen receptor modulator therapy in the treatment of female sexual dysfunction?*
- *What is the role of androgen therapy in the treatment of female sexual interest and arousal disorders?*
- *What is the role of nonhormonal medications and devices in the treatment of female sexual interest and arousal disorder?*
- *What are the treatment options for genito–pelvic pain and penetration disorders?*

Recommendations

The following recommendations are based on good and consistent scientific evidence (Level A):

- Low-dose vaginal estrogen therapy is the preferred hormonal treatment for female sexual dysfunction that is due to genitourinary syndrome of menopause.
- Low-dose systemic hormone therapy, with estrogen alone or in combination with progestin, can be recommended as an alternative to low-dose vaginal estrogen in women experiencing dyspareunia related to genitourinary syndrome of menopause as well as vasomotor symptoms.
- Ospemifene can be recommended as an alternative to vaginal estrogen for the management of dyspareunia caused by genitourinary syndrome of menopause.
- Systemic DHEA is not effective and, therefore, is not recommended for use in the treatment of women with sexual interest/arousal disorders.

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- Psychologic interventions, including sexual skills training, cognitive–behavioral therapy (with or without pharmacotherapy), mindfulness-based therapy, and couples therapy, are recommended as part of female sexual dysfunction treatment.
- A physical examination should be performed to diagnose female sexual dysfunction related to genitourinary syndrome of menopause before starting vaginal or systemic hormone therapy.
- Short-term use of transdermal testosterone can be considered as a treatment option for postmenopausal women with sexual interest and arousal disorders who have been appropriately counseled about the potential risks and unknown long-term effects.
- Evidence is insufficient to recommend for or against testosterone for the treatment of sexual interest and arousal disorders in premenopausal women.
- Sildenafil should not be used for the treatment of female interest/arousal disorders outside of clinical trials.
- Intravaginal prasterone, low-dose vaginal estrogen, and ospemifene can be used in postmenopausal women for the treatment of moderate-to-severe dyspareunia that is due to genitourinary syndrome of menopause.
- Estrogen or SERM therapy is not recommended for the treatment of female sexual dysfunction that is not due to a hypoestrogenic state.
- Vaginal carbon dioxide (CO_2) fractional laser for treatment of dyspareunia that is due to genitourinary syndrome of menopause should not be used outside of a research setting.
- Flibanserin can be considered as a treatment option for hypoactive sexual desire disorder in premenopausal women without depression who are appropriately counseled about the risks of alcohol use during treatment.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Obstetrician–gynecologists should initiate a clinical discussion of sexual function during routine care visits to identify issues that may require further exploration and to help destigmatize discussion of sexual function for patients.
- The initial evaluation of a patient with female sexual dysfunction symptoms may require an extended visit and should include a comprehensive history and physical examination to evaluate possible gynecologic etiologies.
- Laboratory testing typically is not necessary in the initial evaluation of female sexual dysfunction unless an undiagnosed medical etiology is suspected.
- If transdermal testosterone therapy is used in postmenopausal women with sexual interest and arousal disorders, a 3–6-month trial is recommended with assessment of testosterone levels at baseline and after 3–6 weeks of initial use to ensure levels remain within the normal range for reproductive-aged women. Transdermal testosterone therapy should be discontinued at 6 months in patients who do not show a response. If ongoing therapy is used, follow-up clinical evaluation and testosterone measurement every 6 months are recommended to assess for androgen excess. The long-term safety and efficacy of transdermal testosterone have not been studied.
- Pelvic floor physical therapy is recommended for the treatment of genito–pelvic pain and penetration disorders to restore muscle function and decrease pain.
- Lubricants, topical anesthesia, and moisturizers may help reduce or alleviate dyspareunia.

References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): APA; 2013. (Level III)
2. Kingsberg SA. Taking a sexual history. Obstet Gynecol Clin North Am 2006;33:535–47. (Level III)

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force. Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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