An integrative treatment model for patients with sexual dysfunctions

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Sexuality is recognised as a fundamental and natural need, regardless of age or physical state. Sexual dysfunctions (SDs) are prevalent in the general population and can have a major impact on quality of life and psychosocial and emotional well-being. A high standard of sexual health is regarded as a fundamental right. However, these are self-reported conditions and patients may be reluctant to seek medical help because they are embarrassed. Surveys suggest that men appear to believe that the doctor should initiate questions about sexual health. In addition, conditions such as erectile dysfunction may be markers for comorbid conditions. Hence, a multidisciplinary approach to SDs is required.

The ICSM-5 diagnostic and treatment algorithm

The International Consultation of Sexual Medicine-5 (ICSM-5) stepwise diagnostic and treatment algorithm leads family practitioners through a stepwise progression in the assessment of SDs (Fig. 1).20 The algorithm comprises five steps that may assist practitioners through (i) basic evaluation and history taking; (ii) consideration of the need for specialist care; (iii) patient sexual education; (iv) treatment options; and (v) follow-up evaluation of the patient’s sexual well-being following treatment.

Step 1: Basic evaluation

Step 1 includes the initial evaluation, which covers the patient’s sexual, medical and psychosocial history, as well as a focused physical examination and laboratory testing.16 Because of misinformation and lack of awareness about sexuality and reproduction, male patients may present with concerns or questions about penis size, refractory period after ejaculation, early-morning erections, penile curvature and sexual myths.11 Distinguishing between sexual concerns, SDs and sexual disorders is essential in the initial evaluation.

Sexual history

In obtaining the patient’s sexual history it is important for practitioners to be sensitive to the social, personal and cultural issues that influence individuals’ sexual practices. A structured interviewing process should include enquiry about the patient’s (i) sexual activity; (ii) sexual orientation; (iii) sexual practices; (iv) sexual experiences (including development, body image and trauma); (v) sexual cycle; (vi) fertility needs; and (vii) symptoms, duration and severity of the SD.21 A non-judgemental, empathic and positive attitude may assist the patient in sharing this very personal and sensitive information.

Medical history

The medical history should allow the family practitioner to establish whether the SD is a stand-alone medical condition or a symptom of another disease.14 It should also indicate aetiology, addressing the extent to which there are medical, psychiatric, and mixed aetiologies. The coexistence of medical and psychological factors may be important in couples or individuals with chronic SDs.13

Enquiring about a medical history of the following will assist in determining aetiology: (i) medical conditions such as CVD, diabetes (including thyroid disease), hypogonadism, lower urinary
Fig. 1. The International Consultation of Sexual Medicine-5 (ICSM-5) diagnostic and treatment algorithm (for men and women).

Laboratory tests
The choice of investigations depends on the individual circumstances of the patient. ED, for example, is an independent marker for cardiovascular risk and can be the presenting feature of diabetes, so serum lipids and fasting plasma glucose should be measured in all patients. Hypogonadism is a treatable cause of ED that may also make men less responsive, or even non-responsive, to phosphodiesterase type 5 (PDE5) inhibitors. Therefore, all men with ED should have serum testosterone measured in a blood sample taken in the morning between 08h00 and 11h00. Additional tests will depend on the physical examination and history.

Step 2: Need for specialised treatment
The ICSM-5 stepwise diagnostic and treatment algorithm includes consideration of the basic evaluation findings to determine the need for specialist care. Specialised tests and referrals are usually indicated in lifelong or primary SDs, in the case of specific anatomical or endocrine factors, or in complicated psychiatric or interpersonal problems. Specialised treatment is also indicated following failure of initial therapy. Specialised tests for assessing aetiology include nocturnal penile tumescence and rigidity, dynamic duplex ultrasound, dynamic infusion cavernosometry, cavernosography internal pudendal arteriography and biothesimetry. These investigations are typically used to tailor specific vascular surgery in arterial disease (for cyclists and as a result of trauma), hypogonadism or Peyronie's disease.

Step 3: Patient and partner sexual education
This step focuses on educating the patient and partner about general sexual function and dysfunction, as well as relationship enhancement techniques. This educational process may assist with improved subjective well-being by equipping the patient with knowledge and techniques to manage sexual health and sexual functioning in a more adaptive manner, improving quality of life and empowering the patient.

Step 4: Treatment options
A number of treatment options are available, depending on the aetiology of the SD. An integrative treatment model emphasises a patient-centred approach towards sexual health that includes counselling and lifestyle modification, psychological therapies (including cognitive behavioural therapy and sex therapy), medical interventions (pharmacology and devices) and surgery.

Step 5: Evaluating the patient's sexual well-being after treatment
After treatment the family practitioner evaluates the patient's sexual well-being in relation to treatment outcomes (current sexual functioning and adherence to treatment), the patient-partner relationship (including interpersonal and sexual satisfaction), and the patient's reported life satisfaction or quality of life.

Herbal medicine use in the treatment of male SDs
Working from an integrative approach, it is important for family practitioners to acknowledge that health is grounded in a broad cultural, spiritual and religious context. Herbal and traditional medicine are part of indigenous African knowledge and healing systems and have a potential role in sexual health. It is important to understand...
why some patients use these traditional medications for the treatment of SDs. Sexual health concerns can be interpreted as the result of natural (disease, psychological stress) or supernatural (displeased ancestral and religious spirits, witchcraft) causes.[20] The World Health Organization (WHO) estimates that 75% of the African population use traditional medicines.[21] Such herbal remedies have been used to treat impotence, prostate problems and male menopause, while aphrodisiacs have been used to increase libido (sexual desire, arousal and motivation), sexual potency (effectiveness of erection) and sexual pleasure.[19,20] Male patients may turn to medicinal plants because of the relatively low cost of these medicines, the difficulty in obtaining orthodox medication, particularly in rural areas, the understanding that traditional plant medications may be safer than other medications, and because community experiences indicate efficacy.

Conclusion
In managing patients who present with SDs, family practitioners are encouraged to draw from an integrative model such as the ICSM-5 stepwise diagnostic and treatment algorithm. This tool is key to assessing men's health status. Furthermore, it is important to consider the broader cultural, spiritual and religious context within which sexual healthcare exists.

Take home messages
• SD may have a major impact on quality of life and psychosocial and emotional well-being.
• Several chronic diseases, not directly linked to SD, may still have a major impact on sexual health.
• SD may be the key to assessing men’s health status.

References