Maturitas 108 (2018) 31–36

Contents lists available at ScienceDirect

Maturitas

journal homepage: www.elsevier.com/locate/maturitas

# The sexual health approach in postmenopause: The five-minutes study

Marcos J. Cuerva[a,*], Daniel Gonzalez[b], Marta Canals[c], Borja Otero[d], Jose Angel Espinosa[e], Francisca Molero[f], Levent M. Senturk[g], Nicolas Mendoza[h], SMS Young Experts Group[1]

[a] Hospital Universitario La Paz, Dept. of Obstetrics and Gynecology, Madrid, Spain
[b] Hospital Universitario Maternoinfantil de Canarias, Dept. of Obstetrics and Gynecology, Las Palmas de Gran Canaria, Spain
[c] Clínica Perpetuo Socorro, Dept. of Obstetrics and Gynecology, Lleida, Spain
[d] Hospital Universitario Cruces, Dept. of Obstetrics and Gynecology, Bilbao, Spain
[e] Hospital Quironsalud San José, Dept. of Obstetrics, Madrid, Spain
[f] Institut de Sexologia de Barcelona, Barcelona, Spain
[g] Istanbul University Cerrahpasa School of Medicine, Dept. of Obstetrics and Gynecology, Division of Reproductive Endocrinology, IVF Unit, Istanbul, Turkey
[h] University of Granada, Dept. of Obstetrics and Gynecology, Granada, Spain

ARTICLE INFO

*Keywords:*
Menopause
Sexual dysfunction
Medical history taking

ABSTRACT

*Objectives:* To determine whether actively addressing sexuality in a gynaecological consultation with menopausal patients improves the diagnosis of sexual problems.
*Study design:* A multi-centre analytical cross-sectional study was conducted at 12 Spanish hospitals. In gynaecological consultations the usual medical histories were taken, except that, initially, issues relating to sexuality were omitted, unless the patients raised them. Then, after 5 min, gynaecologists offered the possibility of talking about sexuality and asked about possible sexual problems. Main outcome measures Observed prevalence of sexual problems.
*Results:* A total of 256 postmenopausal women participated in the study. Of them, 12.1% reported a sexual problem during the first 5 minutes of the interview. The prevalence of patients with a sexual problem increased by 35.9% (from 12.1% to 48.0%) when they were asked about sexuality after 5 min ($p < 0.0001$). The main factors associated with having a sexual problem were genitourinary syndrome of menopause (GSM) and having a stable sexual partner.
*Conclusions:* Asking postmenopausal women about sexuality in gynaecological consultations is an important tool that increases the number of diagnoses of sexual problems. Gynaecologists should routinely ask about sexuality.

## 1. Introduction

Sexuality is a key aspect of women's health. The advances made in the study of sexual dysfunctions and their treatments mean that there is a greater demand for assistance; however, patients are often reluctant to request this help from their doctors for fear of being rejected or ashamed [1].

It has been estimated that between a third and a half of women experience some form of sexual disorder, such as low desire, poor lubrication, dyspareunia, lack of pleasure, or the inability to reach orgasm [2–5]. It is known that the prevalence of sexual dysfunction increases with menopause. The prevalence of sexual dysfunction peaks among middle-aged women [6]. In Spain, a study using the Female Sexual Function Index-6 (FSFI-6) showed that 36.9% of postmenopausal patients had scores compatible with sexual dysfunction [7]. Many such sexual problems (and even some sexually transmitted diseases) do not present with overt physical symptoms, and so good physician–patient communication is therefore of great importance.

Gynaecologists, because of their specialisation in the female genital tract and reproductive health, have good opportunities to talk openly about sexuality with patients; in fact, several studies report that gynaecologists are the doctors who most frequently deal with their patients' sexual problems [8–10]. Gynaecologists have to know the difference between sexual symptoms and sexual dysfunctions, to offer the best treatments available or refer the patients to a sexologist. One of the most important criteria for the diagnosis of sexual dysfunction is that it must have created distress and interpersonal difficulty [6,11].

In 2016, our group sent a survey via mail to 600 members of the Spanish Menopause Society (SMS) based on the survey conducted in 2011 in the USA by Sobecki et al. [12]. This questionnaire asked

* Corresponding author at: Hospital Universitario La Paz, Dept. of Obstetrics and Gynecology, Madrid, Spain.
*E-mail address:* marxichos@hotmail.com (M.J. Cuerva).
[1] Spanish Menopause Society Young Experts Group / EMAS Junior Mentorship Programme.

https://doi.org/10.1016/j.maturitas.2017.11.009
Received 26 July 2017; Received in revised form 25 September 2017; Accepted 9 November 2017

whether they routinely addressed sexuality with their patients, and only 53.3% of respondents indicated that they did so, despite sexuality being included in the SMS clinical guidelines as an item of the basic menopause history [13].

The purpose of our study was to evaluate whether actively addressing sexuality in a gynaecological consultation with postmenopausal patients improves the diagnosis of sexual problems.

## 2. Material and methods

This multi-centre, analytical cross-sectional study was conducted in the gynaecology departments of 12 Spanish hospitals. The 12 investigators were members of the SMS young experts group, and the study was designed as part of the European Menopause and Andropause Society (EMAS) Junior Mentorship Programme (JuMP). Ethical clearance was obtained from the institutional ethics committee (PI 159/2016).

Eligible patients were seen at normal gynaecological consultations. They all gave informed consent, after it had been explained to them that one of the areas of the usual medical history was going to be postponed for 5 min unless the patient requested information about it, in which case the consultation would be carried out in the usual way.

The usual medical history was taken with the exception of items concerning sexuality unless the patients raised such issues. For the patients who did not request sexual information or refer to sexual problems in the first 5 min, the gynaecologists then offered the possibility to talk about sexuality and asked about possible sexual problems (as it would have been done in the usual anamnesis). Afterwards, a complete sexual history was performed. Sexual problems were recorded using the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) criteria.

The inclusion criteria were: patients were postmenopausal (at least one year without a menstrual period); patients were older than 45 years; patients had not been to a gynaecologist in the previous 3 months; patients were not being followed due to any gynaecological disease.

The sample size was calculated using the results of a pilot study with 20 menopausal patients in our centre. Only three of these patients requested information or asked about sexual problems if we did not initially include this topic in the anamnesis (15%). The prevalence of sexual problems after menopause in Spain has been reported to be around 36% (5). Using an alpha value of 0.05 and a power (1–beta) of 80% to demonstrate a difference of at least 15% (based on a possible 15% of patients who would ask questions or request information directly about sexual problems if they were not asked and assuming a possible 15% loss), the required sample size would be 112 patients. We decided to continue the recruitment of 250 patients to account for secondary variable analysis.

The clinical and demographic data recorded included: the treatments performed at menopause; if they had been previously asked by another gynaecologist about sexuality; if they had a stable sexual partner; if they were religious; the time since the last sexual event, including masturbation; the frequency of sexual events, including masturbation (divided into 4 categories: sexual events more than once a week, sexual events more than once a month but less than once a week, sexual events more than once a year but less than once a month and sexual events less than once a year); the gender of the investigator; whether the patients came alone or with a companion; and whether there were signs of the genitourinary syndrome of menopause (GSM).

## 3. Statistical analysis

The distribution of variables was verified using the Kolmogorov–Smirnov test and histograms. As all numeric variables were normally distributed, they were displayed as means and standard deviations. Between-group comparisons were performed using a Student's *t*-test, Pearson's chi-squared test, or Fisher's exact test, as appropriate. Binary logistic regression was used to obtain the factors that increased the odds of diagnosing a sexual problem. The level of significance was set at 95% ($p < 0.05$). All analyses were performed in SPSS version 22.0 (SPSS Inc, Chicago, Ill).

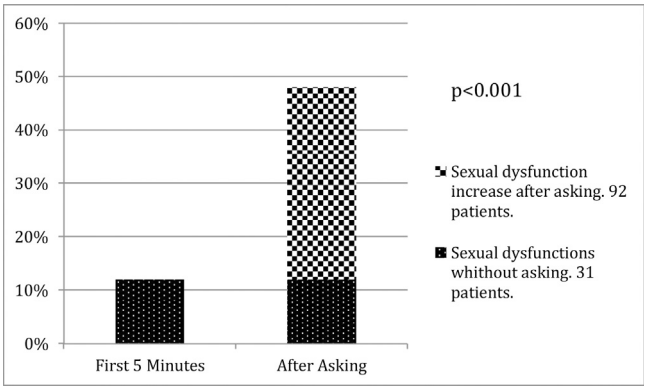


**Fig. 1.** Increase in the observed prevalence of sexual problems after asking about sexuality.

## 4. Results

Between February 2017 and June 2017, 256 eligible women participated in the study. No patient refused to participate in the study, and there were no patient losses. Of all patients, 12.1% (31 patients) reported sexual problems during the first 5 min (without being asked about sexuality). The reported prevalence of patients with a sexual problem increased by 35.9 percentage points (an extra 92 patients) when they were asked about sexuality after 5 min. Thus the prevalence rose from 12.1% (95% confidence interval 8.37%–16.74%) to 48.0% (95% confidence interval 41.80%–54.40%) (Fig. 1).

Reporting a sexual problem (in the first 5 min or after being asked) was not statistically related to the researcher's gender, whether the patient was accompanied or not during the consultation, whether she had been previously asked about her sexuality or not, or whether she was religious. The patients with sexual problems were younger and had more recently gone through menopause. Fifty-three women (20.7% of patients) reported having a sexual event less than once a year. Out of these 53 women, 16 (30.2%) reported a sexual problem, whereas 107 (52.7%) of those who reported having a sexual event more than once a year reported a sexual problem ($p = 0.003$) (Table 1).

Women who had used hormone replacement therapy (HRT) or any treatment for GSM were statistically significant more likely to have talked spontaneously about a sexual problem in the first five minutes (Table 2).

Binary logistic regression showed that the most important factors increasing the odds of diagnosing a sexual problem were having GSM (OR: 6.778; 95% confidence interval 3.916–11.734) and having a stable sexual partner (OR: 6.293; 95% confidence interval 2.345–16.890). The time since menopause was negatively related to the odds of diagnosing a sexual problem (OR: 0.951; 95% confidence interval 0.917–0.986). Time since menopause, having GSM, and having a stable sexual partner were the only factors independently related to the probability of diagnosing a sexual problem.

Only 21.9% (56/256) of the patients in the study had been previously asked by a gynaecologist about sex. Sexual problems were not more common among these patients (32 out of 56 versus 91 out of 200; p = 0.123), and those with a sexual problem that had been previously with a gynaecologist did not talk more about sexuality without being asked (10 out of 32 versus 21 out of 91; p = 0.360).

Patients who had a stable sexual partner were more likely to be diagnosed with a sexual problem (118 out of 223 versus 5 out of 23;