Graziottin A. Whipple B. Dennerstein L. Alexander J.L. Banner L. Giraldi A.
Female sexual disorders: future trends and conclusions
in: Porst H. Buvat J. (Eds), ISSM (International Society of Sexual Medicine) Standard Committee Book, Standard practice in Sexual Medicine, Blackwell, Oxford, UK, 2006, p. 374-375

Female Sexual Disorders: Future Trends and Conclusions

Alessandra Graziottin, Beverly Whipple, Lorraine Dennerstein Jeanne L. Alexander, Linda Banner, and Annamaria Giraldi

Historically, recognition and treatment of the biological basis of female sexual health issues mirrored the recognition and treatment of female urologic disorders [1]. Both were poorly understood, and therefore, under diagnosed and under treated.

On a positive note, urologists have been the specialists who recently took the lead in the revolutionary understanding on the biological basis of FSD. The contribution of key urologists, including Raz, McGuire and Kursh, began a new era [2,3]. Women's anatomy, and specifically the role of the pelvic floor, was reconsidered, with increasing attention to the physiologic role of sexual hormones in the bladder, genitals and in sexual response [4,7].

Research on neurobiological bases of women' s sexual response added further visibility to the physical basis of their sexual function or disorders, with a multidisciplinary involvement [8-11]. Parallel research on hormonal, vascular, psychosexual and contextual factors is contributing to give meaning to the complexity of women's sexual function and disorders [4-17].

Urologists deserve as well to be credited for a tremendous educational effort, aimed at involving a larger audience of clinicians in this biologically based medical perspective. The first International Consensus Conference on FSD was convened in October 1998, in Boston, under the auspices and sponsorship of the American Foundation for Urologic Diseases (AFUD) [18]. In 2003, under the same AFUD' sponsorship, the Consensus Conference was further updated [19].

Since then, research on the biological pathophysiology of FSD has had a renaissance. Similarities and differences between men's and women's sexual function and disorders have undergone intense scrutiny [1-3, 7-8, 11-14, 15-18, 20]. A significant research commitment to investigate the biological basis of FSD is ongoing. However, so far (December 2005) no specific pharmacologic treatment has been specifically approved for FSD. The gap between the different research speeds between the two genders has not yet been filled.

The International Society for Sexual Medicine (ISSM), with a prominent urologic component, is to be acknowledged for a tremendous educational effort in sexual medicine, for men first, and now also for women. This book witnesses the increasing attention dedicated to the biological basis of FSD, and to the educational effort to translate a huge data set into a meaningful clinical practice.

The FSD sub-committee wishes to express his gratitude to ISSM for hosting this section, and for promoting awareness of women's rights to be counseled on their sexual concerns and appropriately treated for their sexual problems with a balanced approach between medical and psychosexual/contextual co-factors.

The future of FSD is challenging and exciting, in the research, in the educational and in the clinical arena. The commitment is huge, the effort demanding, the reward (emotional, ethical and human) is increasing. But it requires an integrated, multidisciplinary work, witnessed in the various scientific and clinical backgrounds of different specialists and health care providers working with passion in the FSD field.

References

1. Kellogg-Spat S, Whitmore K. Role of the female urologist/urogynecologist. In: Goldstein I, Meston C, Davis S, Traish A, ed. Women's Sexual Function and Dysfunction: Study, Diagnosis and Treatment. Taylor and Francis: Abingdon, UK, 2006, pp.708-714
2. Raz S. Female Urology. WB Saunders, Philadelphia, 1983
3. Kursh ED, McGuire EJ. Female Urology, JB Lippincott, Philadelphia, 1994
4. Basle K, Schuster B. Pregnancy, childbirth and pelvic floor damage. in: Bourcier AP. McGuire EJ. ARAMs P. Pelvic Floor Disorders. Elsevier Saunders: Philadelphia, 2004, pp. 33-42
5. Bourcier AP. McGuire EJ. ARAMs P. Pelvic Floor Disorders. Elsevier Saunders: Philadelphia, 2004
6. Graziottin A. Treatment of sexual dysfunction. In: Bo K, Berghmans B, van Kampen M, Morkved S, ed. Evidence Based Physiotherapy for the Pelvic Floor. Bridging Research and Clinical Practice, Elsevier: Oxford, UK, 2005
7. Bancroft J. Biological factors in human sexuality. J Sex Res 2002;39:15-21.
8. Pfaus J, Everitt B. The Psychopharmacology of Sexual Behaviour. In: Bloom FE, Kupfer D, ed. Psychopharmacology. Raven Press: New York, 1995, chapt. 65, pp 743-758.
9. Komisaruk B, Whipple B. Brain activity imaging during sexual response in women with spinal cord injury. In: Hyde J, ed. Biological Substrates of Human Sexuality. American Psychological Association: Washington, DC, 2005, pp 109-146
10. Meston CM, Frohlich PF. The neurobiology of sexual function. Arch Gen Psychiatry 2000;57:1012-30
11. Graziottin A. Libido: the biologic scenario. Maturitas 2000;34(suppl 1):S9-16.
12. Dennerstein L, Hayes R. The Impact of Aging on Sexual Function and Sexual Dysfunction in Women: A Review of Population-Based Studies. J Sex Med 2005;2:317-330.
13. Dennerstein L, Randolph J, Taffe J, Dudley E, Burger H. Hormones, mood, sexuality, and the menopausal transition. Fertil Steril 2002; 77(suppl 4):S42-8.
14. Goldstein I, Berman JR. Vasculogenic female sexual dysfunction: vaginal engorgement and clitoral erectile insufficiency syndromes. Int J Impot Res 1998;10(suppl 2):S84-90; discussion S98-101
15. Bancroft J, Loftus J, Long JS. Distress about sex: A national survey of women in heterosexual relationships. Arch Sex Behav 2003; 32;3:193-204
16. Klausmann D. Sexual motivation and the duration of the relationship Archives of Sexual Behaviour 2002; 31: 275-287
17. Liu C. Does quality of marital sex decline with duration? Archives of Sexual Behavior, 2003; 32 (1): 55-60,
18. Basson R, Bertian J, Burnett A, Derogatis L, Ferguson D, Fourcroy J, Goldstein I, Graziottin A. et Al. Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications. J Urol 2000; 163: 888-93
19. Basson R, Leiblum S, Brotto L, Derogatis L, Fourcroy J, Fugl-Meyer K, Graziottin A, Heiman JR, Laan E, Meston C, Schover L, van Lankveld J, Schultz WW. Definitions of women's sexual dysfunction reconsidered: advocating expansion and revision. J Psychosom Obstet Gynaecol 2003; 24:221-9.
20. Graziottin A Similarities and differences between male and female sexual dysfunctions. In Kandeel F. Lue T. Pryor J. Swerdloff R (eds**):** Male Sexual Dysfunction: Pathophysiology and Treatment, New York , Marcel Dekker, 2006 (in press)

Female sexual disorders may be secondarily categorized as lifelong or acquired; situation-specific or generalized; and mild, moderate, or severe based on the degree of distress it causes the woman. Although research is limited, these disorders probably apply equally to women in heterosexual and homosexual relationships. Etiology. The traditional separation of psychologic and physical etiologies is artificial; psychologic distress causes changes in hormonal and neurologic physiology, and physical changes may generate psychologic reactions that compound the dysfunction. There are often several c Masculine Female Homosexuality (MFH) is the form of gender disorder in women parallel to EHM. A woman of this type acts like a man. She does not necessarily dress in men's clothing, although she might.Â The Greek legend of the Island of Lesbos lends credence to this conclusion: Lesbos was a female sanctuary where men were not allowed. Such sanctuary communities are not uncommon even today.Â Every type of sexual disorientation can be viewed, what sexualizes individuals, both male and female. The addiction to soft drugs often leads to harder drugs. In the same way, pornography often leads to sexual experimentation as a means of attempting to reap greater sexual gratification.[33]. Treatment for sexual disorders. Studies have shown major categories of sexual dysfunction are linked with reduced physical and emotional satisfaction and general well-being, the researchers say. "FSD can have a major effect on women's quality of life," said study team member Dr. Debra Fromer, head of the Center for Bladder, Prostate and Pelvic Floor Health at Hackensack University Medical Center in New Jersey.Â However, a recent review of 101 studies on female orgasm disorder, in which a woman has trouble climaxing or reaching orgasm at all, showed treatments for the disorder are inadequate. In addition, the Food and Drug Administration recently determined the drug flibanserin (female Viagra) didn't increase a woman's sexual desire.