Int Urogynecol J (2012) 23:145–152
DOI 10.1007/s00192-011-1516-y

ORIGINAL ARTICLE

Sexual problems in the gynecology clinic: are we making a mountain out of a molehill?

Anne-Marie Roos · Abdul H. Sultan · Ranee Thakar

Received: 15 December 2010 / Accepted: 11 July 2011 / Published online: 28 July 2011

Abstract
Introduction and hypothesis This study aims to assess the prevalence of sexual problems in general gynecology and urogynecology clinics using a simple screening tool and to compare the prevalence between patients presenting with gynecology or urogynecology complaints.
Methods Patients attending (uro)gynecology clinics completed three screening questions for sexual problems to be assessed. A fourth question was later introduced to address sexual problems which bother them. Student's *t*-test, chi-square test, and logistic regression were used.
Results Of 1,194 women, 37% had a sexual complaint. Seventeen percent volunteered this information as part of their main complaint, while the remaining only admitted it on questioning. The last 290 questionnaires included the question on "bother." Of these, 37% had a sexual complaint and only 45% found them bothersome. Multivariate analysis showed that urogynecology complaints were significantly associated with sexual complaints.
Conclusions As most women only volunteer symptoms when asked directly, clinicians should be vigilant in identifying sexual problems but always establish the question of bother to avoid over-diagnosis.

Keywords Female sexual dysfunction · Gynecology clinic · Screening tool · Dyspareunia

A.-M. Roos · A. H. Sultan · R. Thakar (✉)
Department of Obstetrics and Gynecology,
Croydon (Mayday) University Hospital,
530 London Road,
Croydon, Surrey CR77YE, UK
e-mail: ranee.thakar@mayday.nhs.uk

Introduction

Female sexual dysfunction (FSD) is a common problem that can have a devastating effect on a woman's quality of life and social and sexual relationships. A national British survey found that, in the preceding year, 54% of women reported at least one sexual problem lasting for at least 1 month [1]. Studies have shown that women suffering from pelvic floor disorders are at risk of suffering from sexual problems as a result of pelvic organ prolapse or lower urinary tract symptoms [2–5]. Sixty-four percent of sexually active patients presenting to a urogynecology practice suffer from FSD [6], although the prevalence of FSD appears to be comparable to women seeking gynecological care [7]. Geiss et al. [7] showed that 50% of sexually active gynecology patients compared to 48% of urogynecology patients showed signs of FSD.

Despite the reported high prevalence, only one in five women sought help for their sexual concerns [1,8,9]. Help-seeking behavior is dependent on age, type of sexual problem, and culture [8]. Furthermore, when sexual problems cause distress, women are more likely to seek medical attention [9]. Barriers for seeking help could be embarrassment, believing that the physician will not be able to provide help [10], and the perception that sexual problems are not a "severe" health problem [11]. Therefore, in order to identify sexual problems, a proactive attitude from the physician is necessary. A study on current attitudes towards sexual function amongst physicians showed that they infrequently raise the topic of sexual health during clinic visits with the most important barrier being lack of time [12]. Screening for sexual

problems does not need to be time-consuming; making a brief assessment of sexual function part of the review of systems is very effective and indicates to the patient that the discussion of often embarrassing sexual concerns is appropriate [13].

The aims of this study were, firstly, to assess the prevalence of sexual problems in patients attending general gynecology and urogynecology clinics, using a quick and simple screening tool. Secondly, we aimed to compare the prevalence between patients presenting with gynecology and urogynecology complaints.

Materials and methods

This cross-sectional study includes women attending the gynecology outpatient clinic in Croydon (Mayday) University Hospital between May 2008 and February 2010. As part of our routine practice, new patients attending general gynecology and urogynecology clinics and who are able to read and write in English were asked to complete a "health questionnaire" (see "Appendix"). Women have time to complete the questionnaire in the general waiting area while waiting to see the gynecologist, and completion of the questionnaire takes only a couple of minutes. Women attending oncology and fertility clinics were not included.

The "health questionnaire" addresses the primary complaint and includes a gynecological, obstetrical, surgical, medical, and family history, as well as questions regarding allergies and medications, and constitutes a part of the routine practice in our gynecology and urogynecology clinics. To assess sexual function, three questions are included: (1) Are you sexually active? (yes/no). If not active, state reason. (2) Is sex painful? (yes/no). (3) Do you have any problems with sex? (yes/no). If yes, state problem. These three questions were based on a previous questionnaire, which has been shown to be as effective as a detailed enquiry in detecting sexual problems [14]. Upon analysis of the collected data at the end of August 2009, it became apparent that these questions did not address the issue of bother which can lead to over-diagnosis of sexual problems. This led to the introduction of a fourth question: Are any of your sexual problems bothersome? (yes/no). It was then decided that data collection would continue until February 2010

Health questionnaires were collected after several clinic sessions each week based on the schedule and availability of the researcher who was not involved in the direct clinical care of the patient. Selection bias, however, is considered to be absent as questionnaires were collected for all patients attending a specific clinic session and the availability of the researcher was at random. The collected questionnaires are considered to be a random selection of the group under study. After the collection of questionnaires, a further review of the medical notes was performed in order to complete the medical and surgical history where necessary.

Statistical analysis was performed by calculating the frequencies of responses. The main outcome measure was the mentioning of any sexual complaint on the "health questionnaire." A division was made between dyspareunia or "other sexual problems." An analysis of continuous variables was done using Student's *t*-test and an analysis of dichotomous variables was done using chi-square test. For the purpose of comparison, subjects were divided into gynecology or urogynecology patients based on their primary complaint. We corrected for possible confounding factors by fitting a binary logistic regression model. Included in the analysis as possible confounders were: age (comparing over and under 60 years of age), parity, smoking, diabetes, hypertension, previous hysterectomy, previous vaginal repair, previous incontinence surgery, cardiovascular disease, chronic rheumatic disease, psychological diseases, HRT use, and sexual activity. These variables were selected based on previously published [15] or expected associations. Odds ratios (OR) were calculated on multivariate analysis and are presented with their 95% confidence interval. A *p*-value of less than 0.05 was considered significant. Analysis was conducted using SPSS for Windows software (version 16.0; SPSS Inc, Chicago, IL, USA).

All collected data formed part of our routine evaluation of new patients attending our gynecology clinics. Therefore, no ethical approval was deemed necessary. A favorable opinion to exempt this study from seeking approval was given by the Croydon University Hospital Research and Development committee.

Results

During the period between May 2008 and February 2010, a total of 1,215 questionnaires were collected. Twenty-one (1.7%) women were excluded from the analysis because of missing data on sexual activity. The demographics of the 1,194 remaining women are presented in Table 1.

Of the 1,194 women, 739 (62%) were sexually active. The differences in demographic factors between sexually active and inactive women are presented in Table 1. The reasons given for sexual inactivity by the 455 sexually inactive women (multiple answers possible) include: not being in a sexual relationship in 146 (32%), older age in 29 (6%), pain in 37 (8%), partner has a problem in 30 (7%), prolapse or pessary use in 10 (2%), no desire in 16 (3.5%), urinary problems in 10 (2%), and mutual agreement in 11 (2%) women. Other problems like dryness or marital

Table 1 Patient characteristics presented as *N* (%)

	Total (*n*=1,194)	Sexually active		*p*-value[a]
		Yes (*n*=739)	No (*n*=455)	
Age[b]	47 (15.9)	41 (12.0)	56 (17.0)	<0.001
Parity[b]	2.0 (1.5)	1.85 (1.45)	2.21 (1.61)	<0.001
Diabetes	66 (5.5%)	22 (3%)	44 (10%)	<0.001
Hypertension	211 (18%)	71 (10%)	140 (31%)	<0.001
Hysterectomy	131 (11%)	48 (6.5%)	83 (18%)	<0.001
Prolapse repair	59 (5%)	20 (3%)	39 (9%)	<0.001
Incontinence surgery	52 (4%)	25 (3%)	27 (6%)	0.036
Cardio-vascular disease	62 (5%)	11 (1.5%)	51 (11%)	<0.001
Chronic rheumatic disease	74 (6%)	27 (4%)	47 (10%)	<0.001
Psychiatric diseases	118 (10%)	66 (9%)	52 (11%)	0.160
Smoking	196 (16%)	143 (21%)	53 (13%)	0.002
HRT use	64 (5%)	36 (5%)	28 (6%)	0.339

[a] Comparing sexually active and inactive women

[b] Presented as mean (SD)

problems were cited by less than 2%, while 142 (31%) did not comment.

Overall 437 (37%) women had a sexual complaint; 320 (27%) complained of dyspareunia and 202 (17%) of "other sexual problems" (multiple answers possible). Forty (3%) women complained of bleeding during or after sexual activity. These complaints were not considered as sexual problems. The nature of the "other sexual problems" is noted in Table 2. Examples of problems associated with prolapse were: "avoiding sex because of lump", "afraid of making prolapse worse", and "embarrassed to let him see or touch vagina." Problems associated with urinary incontinence were: "no partner as leak urine," "wetting on penetration," "embarrassed because of pad use/about bladder problem," and "too wet for sex."

Table 2 Nature and frequency of occurrence of "other" sexual problems

"Other" sexual problems (*n*=202)	*N* (%)
Bladder problems—cystitis	35 (17%)—6 (3%)
Partner problems	34 (17%)
Loss of libido	29 (14%)
Prolapse	20 (10%)
Dryness	14 (7%)
Vulval problems (enlarged labia/lumps/swelling)	11 (5%)
No or reduced sensation	9 (4%)
Other health issues	9 (4%)
Vaginal laxity	5 (2%)
No orgasm	5 (2%)
Itching/irritation	5 (2%)
Bowel problems	4 (2%)
Vaginismus	1 (0.5%)
Others	13 (10%)
No comment	21 (10%)

Of the 437 women with a sexual complaint, 75 (17%) volunteered this in the questionnaire as part of their main complaint while the remaining only admitted to it when completing the three screening questions regarding sexual function. Sexual complaints were classified as gynecology complaints (46, 61%) unless they were associated with urogynecology complaints (29, 39%). The distribution for women who were sexually active and those who were inactive is presented in Fig. 1. Sexually active women were significantly more likely to volunteer their sexual complaint as compared to women with sexual complaints who were not sexually active (p=0.006). Furthermore, women who volunteered their sexual complaint were younger (mean (SD) 36 (11.8) vs 46 (14.3), p<0.001) and had a lower parity (mean (SD) 1.4 (1.3) vs 2.0 (1.3), p=0.002) than women who only admitted to having problems on questioning. They were also less likely to be suffering from hypertension (p=0.02) and chronic rheumatic diseases (p=0.02) and to have undergone a hysterectomy (p=0.03). There were no significant differences in the other confounding factors studied.

Based on the primary complaint, patients were divided into gynecology (641, 54%) and urogynecology patients (553, 46%). The nature of gynecology complaints is mentioned in Table 3. The differences in patient characteristics between gynecology and urogynecology patients are presented in Table 4. The results of the screening questions were compared between gynecology and urogynecology patients and are presented in Table 5.

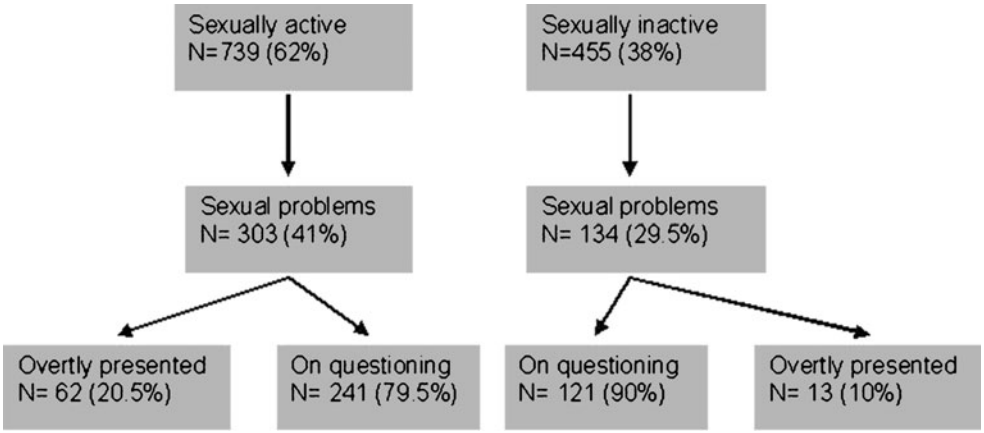

Fig. 1 Sexual problems in sexually active and inactive women

Multivariate analysis was performed to identify factors independently associated with the presence of a sexual complaint. This showed that (after adjustment for confounding factors) having a urogynecology complaint independently increased the risk of having a sexual complaint (OR 1.51, 1.13–2.01; $p=0.005$) and "other sexual problems" (OR 4.15, 2.79–6.17; $p<0.001$), but not dyspareunia (OR 0.95, 0.69–1.31; $p=0.756$).

Furthermore, an increased risk of the presence of a sexual complaint was found for: smoking (OR 1.59, 1.14–2.20; $p=0.006$) and women aged under 60 years (OR 2.35, 1.48–3.73; $p<0.001$).

Dyspareunia was positively associated with age under 60 years (OR 3.77, 1.95–7.29; $p<0.001$), smoking (OR 1.67, 1.18–2.36; $p=0.003$), and being sexually active (OR 1.97, 1.39–2.81; $p<0.001$). "Other sexual problems" were positively associated with age under 60 (OR 1.95, 1.14–3.36; $p=0.015$)

Table 3 Nature of gynecology complaints

Gynecology complaints (n=641)	N (%)
Menstrual problems (dysmenorrhea/ menorrhagia/intermenstrual bleeding)	209 (33%)
Abdominal pain	115 (18%)
Vulval abnormalities	64 (10%)
Incidental findings (cysts/polyps/fibroids)	49 (8%)
Postmenopausal bleeding	43 (7%)
Insertion/removal of coils	24 (4%)
Sterilization request	27 (4%)
Female sexual dysfunction	22 (3%)
Amenorrhea	11 (2%)
Postcoital bleeding	12 (2%)
Abnormal discharge	14 (2%)
Infertility	5 (1%)
Others	46 (7%)

A total number of 290 (24%) questionnaires included the question on "bother": 116 (40%) gynecology patients and 174 (60%) urogynecology patients. Of these, 106 (37%) women had one or more sexual complaints. Forty-eight (45%) found one of their sexual complaints bothersome, 30 (28%) said it was not bothersome, and 28 (26%) did not answer this question. There was no difference in patient characteristics between those who found their sexual complaints bothersome and those who found them not to be bothersome other than the presence of chronic rheumatic diseases (0% and 10%, respectively; $p=0.025$); however, the numbers were small.

Discussion

By using a simple and quick tool to screen for sexual problems in a clinical setting, we demonstrated that sexual complaints are highly prevalent in women attending gynecology and urogynecology clinics. Although these three simple questions have previously been used as an interview-based screening tool [14,16], we did not find any publications which describe it being used as part of a written questionnaire (PubMed search, until August 2010, keywords (female) sexual (dys)function, prevalence, questionnaire). Plouffe [14] showed that 45% of women admitted to a gynecology ward on an elective basis had a sexual complaint. Following its primary publication by Plouffe [14], Walters et al. used the screening tool in women with urinary incontinence [16]. They found that 35% of women with detrusor instability and 32% of women with genuine stress incontinence admitted to having sexual problems. We were able to identify sexual complaints in 37% of women visiting outpatient gynecology and urogynecology clinics. Furthermore, we found that less than one in five women overtly presented with these concerns, demonstrating that screening for sexual problems increases

Table 4 Differences in characteristics between patients presenting with gynecological complaints and those with urogynecological complaints in *N* (%)

	Gynecology, *N*=641	Urogynecology, *N*=553	*p*-value
Age[a]	40.7 (12.8)	54.5 (15.9)	<0.001
Parity[a]	1.65 (1.4)	2.38 (1.5)	<0.001
Diabetes	22 (3.4%)	44 (8.0%)	0.001
Hypertension	61 (9.5%)	150 (27.1%)	<0.001
Previous hysterectomy	19 (3.0%)	112 (20.3%)	<0.001
Previous vaginal repair	9 (1.4%)	50 (9.0%)	<0.001
Previous incontinence surgery	9 (1.4%)	43 (7.8%)	<0.001
Cardio-vascular disease	10 (1.6%)	52 (9.4%)	<0.001
Chronic rheumatic disease	21 (3.3%)	53 (9.6%)	<0.001
Psychiatric diseases	50 (7.8%)	68 (12.3%)	0.009
Smoking	129 (21.9%)	67 (13.7%)	0.001
HRT use	23 (4%)	41 (7%)	0.003

[a] Presented as mean (SD)

our ability to detect them without it being time consuming. A similar result was found in a study by Bachmann et al. [17] who screened women seeking gynecological evaluation by asking them two questions on their sexual functioning during history taking. Although they found a lower prevalence of 19% reporting sexual problems, only 17% of these overtly complained. Using a standard questionnaire for all new patients that includes questions on sexuality indicates to the patient that a sexual history forms part of a routine gynecological assessment. This may help put patients at ease and make them more comfortable to express their concerns.

Women with urogynecology complaints were more likely to suffer from sexual problems. Although there was no difference in dyspareunia, "other sexual problems" were more common. A higher percentage of women with gynecology complaints (31%) compared to those presenting with urogynecology complaints (22%) presented with dyspareunia. However, a multivariate analysis showed that this difference was not caused by the type of complaint per se but by the fact that women with gynecology complaints were more likely to be sexually active and were of younger age.

Interestingly, women under the age of 60 were more likely to suffer from sexual complaints. This is in contrast to previous literature. It is generally accepted that following menopause sexual desire is decreased. A previous large population-based study conducted in the USA showed that sexual problems, including low desire, arousal, and orgasm, were more common in women aged over 65, but sexually related personal distress was lowest in this age category [18]. Our screening questions did not include specific questions inquiring about desire, arousal, and orgasm. It is possible that sexually inactive women would not mention sexual complaints that do not create personal distress, like low desire and low arousal, if not specifically asked about these. Most sexually inactive women will be of older age and therefore self-reported sexual problems would be lower in this category.

In order to decide when clinical intervention is necessary, one should assess the "personal distress" caused by the sexual problem. This is in accordance with the definition of FSD by the International Consensus Development Conference on FSD, which considers

Table 5 Results of sexual screening questions, presented as *n* (%) with 95% confidence interval, compared between gynecology and urogynecology patients

	Gynecology, *N*=641	Urogynecology, *N*=553	*p*-value[a]
Sexually active	467 [73% (69–76)]	272 [49% (45–53)]	< 0.001
Any sexual complaint	226 [35% (32–39)]	211 [38% (34–42)]	0.30
Dyspareunia	199 [31% (28–35)]	121 [22%(19–26)]	< 0.001
Other sexual problems	60 [9% (7–12)]	142 [26% (22–29)]	< 0.001
Volunteered sexual complaint	46 [20% (16–26)][b]	29 [14% (10–19)][b]	0.07

[a] Difference between gynecology and urogynecology patients using chi-square Test

[b] As a percentage of women with any sexual complaint

a sexual problem as dysfunction only when it causes personal distress [19]. This is an important consideration in order to prevent excessive medication and over-treatment of a sexual problem based on what society believes is normal. By introducing a fourth question ("Are any of your sexual problems bothersome?"), we showed that only 45% of the women with sexual complaints actually found them to be bothersome. The previous prevalence estimates of sexual dysfunction might have over-estimated FSD by not including the distress factor into the definition of sexual dysfunction. This is supported by the findings of a previous study in which only 28% of sexual problems in a general female population were associated with distress [18].

A limitation of our study is that, first, we did not use a validated questionnaire to assess sexual problems. However, the aim of our study was to use a simple and quick screening tool and, to the best of our knowledge, there is currently no validated screening tool for FSD available. Furthermore, our screening questionnaire was not designed to differentiate between the different domains of sexual dysfunction. We decided to use this screening questionnaire over others [17,20,21] as this questionnaire, although not validated, has been shown to be as effective as a detailed enquiry in detecting sexual problems [14]. If, by answering the screening questions, a woman admits to having sexual problems, a validated condition-specific questionnaire like the Pelvic Organ Prolapse–Urinary Incontinence Sexual Function Questionnaire [22] could be administered to urogynecology patients and a general validated questionnaire like the Female Sexual Function Index [23] could be administered to gynecology patients. Secondly, our results could have been affected by the fact that there was limited privacy, as women completed this questionnaire in the waiting area and not in a private room. This could result in less women admitting to sexual problems. The fact that there was no specific definition of the time period in which sexual problems were measured (for example, over the last month/year) as well as the fact that both sexually active and inactive women were included could be reasons for the lower prevalence of sexual problems found in the present study compared to that recently reported in women seeking (uro)gynecological care [6,7].

We feel that the results of this study are generalizable to women attending other gynecology outpatient clinics in secondary care settings. Results are expected to be different in women presenting with gynecology problems to a primary care setting where the severity of complaints may be different.

Sexual problems in the gynecology clinic: are we making a mountain out of a molehill? This study shows that although sexual complaints are common amongst women presenting to gynecology and urogynecology clinics, by enquiring about bother with this four-question screening tool, we have identified that nearly half of women with sexual problems do not find them bothersome. This is highly relevant because, by definition, sexual problems cannot be classified as FSD unless they cause distress. Previous prevalence estimates of sexual dysfunction might have over-estimated FSD, making a mountain out of a molehill.

However, this study does highlight that the vast majority of women experiencing sexual problems only volunteer symptoms when asked directly. By using a simple and quick screening tool, sexual problems were five times more likely to be identified by the physician. As urogynecology complaints were independently associated with sexual problems, this screening tool could be included as part of the initial evaluation of these patients.

Acknowledgements The authors would like to thank Dr. Farah Lone for her help with collecting the data.

Funding Anne-Marie Roos was funded by the Mayday Charity Childbirth Fund.

Conflicts of interest None.

Appendix

Mayday Healthcare NHS
NHS Trust

GYNAECOLOGY CLINIC - HEALTH QUESTIONNAIRE

NAME:		**TODAY'S DATE: / /**
DATE OF BIRTH;	**AGE:**	**YOUR WORK?**
PLEASE STATE YOUR REASONS FOR COMING TO THE GYNAECOLOGY CLINIC TODAY		
IF YOUR PERIODS HAVE STOPPED (MENOPAUSE) PLEASE MOVE TO QUESTION 2		
1**. ABOUT YOUR PERIODS:** Date of last period; / /		Duration of periods…..days
Periods regular (every 28 to 32 days) **YES / NO**	Heavy periods? **YES / NO**	Any Clots? **YES / NO**
Any bleeding in between periods? **YES / NO**		Painful periods? **YES / NO**
2. **ARE YOU SEXUALLY ACTIVE? YES / NO**	If Not Active, State Reason	
Is Sex Painful? **YES / NO**	Do You Have Any Other Problem With Sex? **YES / NO**	
If Yes State Problems:		
Are Any Of Your Sexual Problems Bothersome? **YES / NO**	Do You Bleed During Sex? **YES / NO**	
DATE AND RESULT OF YOUR LAST CERVICAL SMEAR TEST? / / Normal / Abnormal		
WHAT TYPE OF CONTRACEPTION DO YOU OR YOUR PARTNER USE? (please circle) **PILL CONDOM COIL VASECTOMY STERILISATION OTHER** (please state)		
DO YOU HAVE CHILDREN? **YES / NO**	HOW MANY?	AGE OF OLDEST AGE OF YOUNGEST
HAVE YOU HAD ANY OPERATIONS (INCLUDING CAESAREANS) PREVIOUSLY? (date and type of operation)		
DO YOU SUFFER FROM ANY OTHER MEDICAL CONDITIONS? Please tell us what these are		
WHAT MEDICATIONS ARE YOU TAKING?		
ANY ALLERGIES?	HOW MANY CIGARETTES SMOKED PER DAY?	
ANY BLADDER PROBLEMS?	ANY BOWEL PROBLEMS?	
ANY FAMILY HISTORY OF CANCER? **YES / NO** IF YES, STATE CANCER TYPE AGE OF ONSET		
OTHER COMMENTS		
Weight ……..…. …kg	Height …..…….cm	BMI…….

References

1. Mercer CH, Fenton KA, Johnson AM et al (2003) Sexual function problems and help seeking behaviour in Britain: national probability sample survey. Br Med J 327:426–427
2. Novi JM, Jeronis S, Morgan MA, Arya LA (2005) Sexual function in women with pelvic organ prolapse compared to women without pelvic organ prolapse. J Urol 173:1669–1672
3. Sen I, Onaran M, Aksakal N et al (2006) The impact of urinary incontinence on female sexual function. Adv Ther 23:999–1008
4. Aslan G, Köseoğlu H, Sadik Ö, Gimen S, Cihan A, Esen A (2005) Sexual function in women with urinary incontinence. Int J Imp Research 17:248–251
5. Salonia A, Zanni G, Nappi RE et al (2004) Sexual dysfunction is common in women with lower urinary tract symptoms and urinary incontinence: results of a cross-sectional study. Eur Urology 45:642–648
6. Pauls RN, Segal JL, Silva WA, Kleeman SD, Karram MM (2006) Sexual function in patients presenting to a urogynecology practice. Int Urogynecol J 17:576–580
7. Geiss IM, Umek WH, Dungl A, Sam C, Riss P, Hanzal E (2003) Prevalence of female sexual dysfunction in gynaecologic and urogynecologic patients according to the international consensus classification. Urology 62:514–518
8. Moreira ED, Brock G, Glasser DB et al (2005) Help-seeking behaviour for sexual problems: the global study of sexual attitudes and behaviours. Int J Clin Pract 59:6–16
9. Shifren JL, Johannes CB, Monz BU, Russo PA, Bennett L, Rosen R (2009) Help-seeking behaviour of women with self-reported distressing sexual problems. J Women's Health 18:461–468
10. Berman L, Berman J, Felder S et al (2003) Seeking help for sexual function complaints: what gynecologists need to know about the female patient's experience. Fertil Steril 73:572–576
11. Gott M, Hinchliff S (2003) Barriers to seeking treatment for sexual problems in primary care: a qualitative study with older people. Fam Pract 20:690–695
12. Roos AM, Thakar R, Sultan AH, Scheer I (2009) Female sexual dysfunction: are urogynecologists ready for it? Int Urogynecol J 20:89–101
13. Kingsberg S, Althof SE (2009) Evaluation and treatment of female sexual disorders. Int Urogynecol J 20:S33–S43
14. Plouffe L Jr (1985) Screening for sexual problems through a simple questionnaire. Am J Obstet Gynecol 151:166–168
15. Palacios S, Castaño R, Grazziotin A (2009) Epidemiology of female sexual dysfunction. Maturitas 63:119–123
16. Walters MD, Taylor S, Schoenfeld LS (1990) Psychosexual study of women with detrusor instability. Obstet Gynecol 75:22–26
17. Bachmann GA, Leiblum SR, Grill J (1989) Brief sexual inquiry in gynecologic practice. Obstet Gynecol 73:425–427
18. Shifren JL, Monz BU, Russo PA, Segreti A, Johannes CB (2008) Sexual problems and distress in United States women. Prevalence and correlates. Obstet Gynecol 112:970–978
19. Basson R, Berman J, Burnett A et al (2000) Report of the international consensus development conference on female sexual dysfunction: definitions and classifications. J Urol 163:888–893
20. Kingsberg S (2004) Just ask! Talking to patients about sexual function. Sex Reprod Menopause 2:199–203
21. Nusbaum MRH, Hamilton CD (2002) The proactive sexual health history. Am Fam Physician 66:1705–1712
22. Rogers RG, Kammerer-Doak D, Villarreal A, Coates K, Qualls C (2001) A new instrument to measure sexual function in women with urinary incontinence or pelvic organ prolapse. Am J Obstet Gynecol 184:552–558
23. Rosen R, Brown C, Heiman J et al (2000) The Female Sexual Function Index (FSFI): a multidimensional self-report instrument for the assessment of female sexual function. J Sex Marital Ther 26:191–208