Although male sexual function has long been an integral part of Urology, female responses are only now being studied in depth.

A National Health and Social Life Survey in the USA in 1999 ([1]), showed that female sexual dysfunction is more common than male (31% in men between 18 and 59 years of age, compared with 43% in women).

There are however, few reliable diagnostic tools.

A study of 60 women with sexual dysfunction ([2]) showed that 67% had poor arousal, 92% problems with orgasm and 67% had pain on intercourse.

Masters and Johnson identified 4 main phases of sexual response in women: excitement, plateau, orgasm and resolution. Kaplan, in 1979 proposed a 3 phase model: desire, arousal, orgasm.

In 1998, a consensus panel created a new classification system of sexual dysfunction:

- **Hypoactive sexual desire disorder**: persistent/recurring lack of sexual desire, including fantasies/thoughts and/or receptivity to sexual activity, which causes personal distress. This may result form psychological factors or be secondary to physical causes such as hormone deficiencies or medical/surgical intervention.
- **Sexual aversion disorder:** persistent/recurring phobic aversion to and avoidance of sexual contact, causing personal distress. This is generally a psychologically or emotionally based problem resulting from events such as rape, childhood sexual abuse etc.
- **sexual arousal disorder:** persistent/recurrent inability to attain or maintain sufficient sexual excitement, causing personal distress. This may manifest as lack of subjective excitement or lack of genital or other physical response. These include lack of/diminished vaginal lubrication, reduced clitoral/labial sensation/engorgement or lack of vaginal smooth

muscle relaxation (vaginismus) Whilst these problems may be secondary to psychological factors, there may well be a physical basis such as spinal problems/previous pelvic surgery/ medication (see below).

- **Orgasmic disorder:** persistent/recurrent difficulty/delay/absence of orgasm following sufficient sexual arousal and stimulation, causing personal distress. This can be primary (never achieved orgasm) or secondary (after surgery/trauma/hormone deficiencies etc.)
- **Sexual pain disorder: Dyspareunia:** recurrent/persistent genital pain associated with intercourse: this may be superficial: felt in the outer part of the vagina or the labia, or deep felt internally on full penetration and may cause pain in the pelvic area. Physical causes such as infection (deep/superfical dyspareunia) and ovarian cyst (deep dyspareunia) should be excluded. **Vaginismus:** recurrent/persistent involuntary spasm of the muscles of the outer third of the vagina, interfering with penetration. This often follows painful episodes of intercourse, or may result from psychological distress.

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[1] Laumann EO, Paik A, Rosen RC *JAMA* 1999; 281 (6) :537-544 Sexual dysfunction in the United States: prevalence and predictors.

[2] Berman JR, Goldstein I reported at the American Urological Association 95th. Annual Meeting, April 2000, Atlanta, Georgia. Abstract 1067. Gender differences in sexual arousal responses: implications for qualitative variations in genital engorgement.