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LETTER TO EDITOR

Sexual dysfunction: Time for a multidisciplinary approach?

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Summary ***Sexual health impairment is one of the most important issues worldwide, with an increasing number of men and women affected. Specifically in male sexual dysfunction (SD), several risk factors were established such as atherosclerosis, hypertension, diabetes mellitus, smoking or obesity. The co-presence of more than one of risk factors identifies a condition, defined as the metabolic syndrome (MetS), related directly to the SD. However, not all the physicians involved in the MetS management routinely discussed the sexual impairment, increasing the bothering feelings of patients. Furthermore, the lack of knowledge, insufficient time, lack of attention, ambiguities about responsibility, insufficient training and experience, shared among physicians, regarding the communication and treatment of sexual dysfunction, are all reported factors involved in undervaluation of SD. The current paper represents a warning to the experts, with the aim of increasing the awareness of SD among clinicians and to promote the education, training and collaboration with sex therapists, through a multidisciplinary team, that can lead to a holistic approach in SD assessment and treatment.***

KEY WORDS: *Erectile dysfunction; MetS; Libido; Sexual health.*

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To the Editor,

*Sexual dysfunctio*n (SD) includes *erectile dysfunction* (ED) defined as the persistent inability to attain and/or maintain penile erection sufficient to permit satisfactory sexual performance, ejaculation disorders, orgasmic dysfunctions, and disorders of sexual interest/desire (1). Sexual health is an important aspect of our patients' lives, with a high impact on patients and partners quality of life and SD represents one of the most important problems worldwide, affecting a growing number of men and women (2-8). Several risk factors have been identified in *male sexual dysfunction* (MSD) such as atherosclerosis, hypertension, hyperlipidemia, diabetes mellitus, smoking, obesity, sedentary lifestyle, chronic alcohol use, benign prostate hyperplasia (9). In most of patients diagnosed with SD there is a concomitant presence of more than one risk factor.

The *metabolic syndrome* (MetS) also known as syndrome X and insulin resistance syndrome, is the term that consists of a cluster of disease states abdominal obesity, atherogenic dyslipidemia, raised blood pressure, insulin resistance ± glucose intolerance, proinflammatory state, and prothrombotic state (10). MetS may cause ED through multiple mechanisms. All components of MetS are frequently found in the obese population. Abdominal obesity promotes insulin resistance that is associated with hyperinsulinemia and hyperglycemia. Furthermore, several diseases and medical or surgical treatments such as radical pelvic surgery can significantly affect sexual health (11). Collaboration between different specialists can be useful in some patients with many risk factors as well as chronic disease and multiple drugs treatments when the conventional treatments are not effective alone. Despite this, previous published studies reported that most specialists do not address sexual problems during routine visits. *Nicolai et al.* reported that in a setting of patients with cardiovascular disease sexual dysfunction is not routinely discussed in the cardiology practice (12). MSD in particular ED shares the same risk factors of coronary artery disease. In fact, several studies have suggested that chronic inflammation and circulating inflammatory markers affect systemic endothelial function. Chronic inflammation may, therefore, represent a link between ED and *cardiovascular diseases* (CVD) (13). According to *Montorsi et al.* in patients with *coronary artery disease* (CAD), ED comes before CAD in the majority by an average of 2 up to 3 years (14). ED onset and severity are associated with increased expression of markers of inflammation. Markers and mediators such as *C-reactive protein* (CRP), intercellular adhesion molecule 1, interleukin (IL)-6, IL-10, IL-1β, and *tumor necrosis factor alpha* (TNF-α) were found to be expressed at higher levels in patients with ED (15). Furthermore, several cardiovascular drugs as well as diuretics, and β-blockers may negatively affect sexual function (16). This lack of information is against several cardiological consensus which recommended to assess SD in patients with cardiovascular risk factors and disease. *Perez-Garcia LF et al.* in a systematic review of the literature reported that male patients with rheumatic diseases have higher rates of SD, which also

seems to occur at a younger age compared to healthy controls. Most of these patients remain undiagnosed and uninformed about SD due to lack of specialists investigation (17). *Van Ek et al.* reported some findings in patients suffering from *chronic kidney disease* (CKD). In fact, Dutch nephrologists do not discuss sexual function routinely with their patients, despite a high incidence of SD both in men and women (18). In fact, men suffering from CKD reported ED, reduced libido and difficulty in reaching an orgasm, while female patients reported impaired vaginal lubrication, loss of arousal and desire, dysmenorrhea, and difficulty in reaching an orgasm. In patients undergoing renal dialysis there is a higher rate of SD, around 65% for men and 70% for women respectively. In neurosurgical and gastroenterological setting there are similar results: *Korse et al.* reported that 72% of *Dutch Neurosurgery* do not counsel patients about sexual dysfunction (19); *Romano et al.* reported that Italian gastroenterologist never/infrequently investigated SD with their patients and, similarly, most patients never discussed SD during the visit (20-22).
Our findings show that despite sexuality is an important aspect of holistic care, it is not addressed in the healthcare system. Physician should therefore investigate medical and sexual history. Given the personal and social implications of sexual dysfunction it is not an easy task. Hence, expert-guided, validated and standardized sexual inventories, structured interviews and self-reported questionnaires (for example IIEF-5 for ED) can help both inexperienced and seasoned clinicians to address sexual health and related conditions. The lack of knowledge, insufficient time, lack of attention, ambiguities about responsibility, insufficient training and experience regarding the communication and treatment of sexual dysfunction, are the most reported factors involved in undervaluation of SD. To avoid this, first it is necessary: an appropriate knowledge of SD, education, training and collaboration with sex therapists. It could be useful to create appropriate courses, and partnership through a multidisciplinary team of healthcare, that can lead to a holistic approach in assessment and treatment.

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