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# Prevalence of sexual dysfunction in new heterosexual attenders at a central London genitourinary medicine clinic in 1998

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**Objective:** To determine the prevalence of sexual dysfunction and dissatisfaction (SD) among new heterosexual attendees at a central London genitourinary medicine (GUM) clinic.

**Methods:** Consecutive new attendees seen by a single clinician were asked a probe question about SD in the previous year. A clinical interview followed a positive response to the probe question. Demographic information was obtained using standard clinic forms.

**Results:** 37% of 103 men and 20% of 100 women participants gave positive responses, and 24% of the men and 12% of the women wanted treatment for their problems.

**Conclusions:** Our results indicate a relatively high rate of SD in new GUM clinic attendees that is not currently being detected or managed. SD may lead to psychological problems, which can be reversed with appropriate treatment. The financial implications of such treatment are discussed.

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Keywords: genitourinary medicine clinic; sexual dysfunction; London

## Introduction

Genitourinary medicine (GUM) clinics in the United Kingdom traditionally treat sexually transmitted infections (STI), but are increasingly also taking on the role of managing patients with sexual dysfunction (SD), often as secondary or tertiary referrals.<sup>1</sup> However, it is uncertain what proportion of patients attending “walk-in” GUM clinics also have SD. SD can lead to decreased quality of life and overt psychiatric illness,<sup>2–4</sup> although evidence suggests that treatment improves both quality of life and psychological state.<sup>5</sup> A previous study from our unit suggested that 24% of men and 9% of woman seen in a walk-in GUM clinic in London in 1996 suffered from significant SD.<sup>6</sup> In that study SD was measured using a self administered questionnaire—the Golombok Rust Inventory of Sexual Satisfaction (GRISS).<sup>7</sup> As the GRISS was validated for heterosexual couples, the derived rates in that study were for that population only.

In this present study we aimed to validate our previous study, our hypothesis being that there are indeed high rates of SD in patients presenting to our clinic. Our current method of assessment for SD was by screening patients with a standardised “probe question” followed by a clinical interview.

## Methods

The study sample consisted of new attendees at the Jefferiss Wing walk-in GUM clinic at St Mary’s Hospital, Paddington. Consecutive heterosexual patients over the age of 17 seen by a single clinician (DG) were invited to participate in the study. Three men and four women were excluded from the study because of poor English, leaving 100 women and 103 men who took part. No patient refused to see DG or to take part in the study. All patients were asked a probe question, “Have you been dissatisfied

with your sex life, or have you had any sexual problems over the last year?” Cases who answered “yes” to this question underwent a clinical interview (by DG) to obtain details of the exact nature of the sexual problem. Demographic details were obtained from all patients using standard clinic forms. The KC60 classification was used to record STI diagnoses for participants. Data from this study were compared with the total attendances at the Jefferiss Wing for 1998. The hospital’s ethics committee gave approval for this study.

The statistical software package STATA 5.0 (Stata Corp, College Station, TX, USA) was used for all analyses. Differences in the distributions of different groups across continuous variables were assessed using the Mann–Whitney (MW) Z. Heterogeneity in distributions of different groups across categorical variables was assessed using the  $\chi^2$  test. Exact binomial confidence intervals were calculated for proportions. All p values refer to the  $\chi^2$  test unless otherwise stated.

## Results

Table 1 depicts the characteristics of the study sample (n=203) and all new heterosexual attenders at the Jefferiss Wing in 1998 (n=9183). There were no statistical differences between the sample and all new attenders in terms of ethnic group or marital status. However, there were proportionally fewer females in the study sample than in the clinic population, and the median age of the study sample was slightly older than that for the clinic population (30 years *v* 27 years,  $p<0.01$ ). The proportions of KC60 diagnoses were similar for both groups.

Similar percentages of males and females were recruited to this study and the previous 1996 study ( $\chi^2$  1 df =0.01,  $p=0.92$ ). However, the populations differed in terms of ethnicity

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Table 1 Characteristics of the study sample and the clinic population in 1998

Characteristic	Sample (%) (n=203)	Population (%) (n=9183)	p Value
Sex			
Female	100 (49.3)	5212 (56.8)	0.03
Male	103 (50.7)	3971 (43.2)	
Age			
Median (range)	30 (17–74)	27 (8–68)	MW<0.01
Ethnicity			
White	106 (54.1)	5141 (58.0)	0.47
Black	50 (25.5)	1878 (21.2)	
Asian	6 (3.1)	343 (3.9)	
Other	34 (17.3)	1504 (17.0)	
Marital status			
Single	127 (64.1)	6218 (68.9)	0.52
Married/cohabiting	54 (27.3)	2203 (24.4)	
Divorced/separated	16 (8.1)	575 (6.4)	
Widowed	1 (0.5)	35 (0.4)	
KC60 "diagnosis"*			
Gonorrhoea	3 (1.5)	200 (2.2)	0.52
Herpes	6 (3.0)	315 (3.4)	
Warts	18 (8.9)	653 (7.1)	
C4 category†	50 (24.6)	2289 (24.9)	
Vaginitis‡/balanitis	33 (16.3)	2080 (22.7)	
Scabies	3 (1.5)	98 (1.1)	
HIV testing	35 (17.2)	2661 (29.0)	
Other untreated conditions	37 (18.2)	1938 (21.1)	
Other treated conditions	41 (20.2)	1631 (17.8)	

Percentages add up to more than 100% as some patients had multiple "diagnoses."

\*Defined as all new heterosexual attenders at the Jefferiss Wing.

†C4 category includes non-specific urethritis, chlamydia, and complicated chlamydial disease.

‡Includes trichomoniasis, bacterial vaginosis, and candidiasis.

(75% white in 1996 *v* 54% white in 1998,  $\chi^2$  1 df = 18.3,  $p < 0.01$ ), marital status (81% single in 1996 *v* 64% single in 1998,  $\chi^2$  1 df = 14.8,  $p < 0.01$ ), and median age (27 years in 1996 *v* 30 years in 1998, MW Z = 3.0,  $p < 0.01$ ).

Just over a third of males (38/103, 37%, 95% CI 28%–47%) compared with a fifth of females (20/100, 20%, 95% CI 13%–29%) reported SD ( $p < 0.01$ ). "Caseness" was also associated with ethnicity, with an average of 26% (50/190, 95% CI 20%–33%) of white, black, and "other" participants being cases compared with 83% (5/6, 95% CI 36%–100%) in Asian participants ( $p < 0.01$ ). However, caseness was not associated with age, marital status, or KC60 diagnosis.

Among women reporting SD, 50% were diagnosed as having anorgasmia, 35% decreased sexual desire, 20% arousal problems, 10% dissatisfaction, and 50% other problems. For men, 42% were diagnosed with erectile dysfunction, 18% dissatisfaction, 13% premature ejaculation, 11% retarded ejaculation, 8% decreased sexual desire, and 16% other problems. Nine women and three men received more than one SD diagnosis.

Twenty four per cent of men (25/103, 95% CI 16%–34%) and 12% of women (12/100, 95% CI 6%–20%) in the total sample were "cases" and requested treatment for their problem. All the female cases presented to the clinic with problems other than SD compared with 71% of the men ( $p < 0.01$ ).

## Discussion

In this study 37% of men and 20% of women had SD. The sample was based on consecutive new attenders seen by one physician at a central London GUM clinic, and was representative of the wider clinic population in terms of ethnic group and marital status but not median age or sex. The lower proportion of females both in the study sample, and reporting sexual dysfunction,

could be due to new female patients, and particularly those with sexual difficulties, opting not to see the male physician (DG) (this is a standard option in our clinic).

The SD rates in this study appear to be higher than those in our 1996 study, where dysfunction was measured using the GRISS. However, the GRISS asks patients to assess their sexual functioning "recently"<sup>7</sup> whereas the probe question related to the previous year. Furthermore as discussed above, there were some differences in the sample populations of the two studies. None the less, the order of magnitude of the SD rates in our two studies is similar to other previous studies in both GUM clinics,<sup>8–10</sup> and the wider population, both in the United Kingdom<sup>11</sup> and the United States.<sup>12</sup>

Our results suggest that 24% of men and 12% of women attending a walk-in clinic for the first time have SD and would want treatment for this problem. These figures exclude referrals from other hospital departments (for example, diabetes clinics) and from general practitioners. These data have significant service and financial implications for GUM clinics. Currently our purchasers (and possibly most other GUM clinic purchasers in the United Kingdom) do not provide specific resources for patients with SD, although nearly half the UK GUM clinics recently surveyed already have dedicated SD clinics.<sup>1</sup>

It thus appears there is a relatively high rate of SD in new GUM clinic attendees that is not currently being detected or managed. Furthermore, SD has knock on implications in terms of consequent decreases in quality of life and depression. However these are preventable with appropriate treatment of the sexual problem.

*Contributors:* DG initiated this study, conducted all clinical interviews, and drafted the manuscript; AJ conducted the statistical analysis and interpretation and edited the manuscript; KS helped construct and initiate this study.

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