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REVIEW ARTICLE

Female Sexual Dysfunction in Aswan Governorate prevalence

Nourhan Magdi Ali Mohamed*, Hani Ahmed Farouk Hassanein, Ahmed Hares El-Sayed Abd Allah, Mohamed Salah El-Din Fahmy Sayed

Department of Obstetrics & Gynecology, Faculty of Medicine, Aswan University

ABSTRACT

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***Corresponding author:** Nourhan Magdi Ali Mohamed
Mobile:01142048216
E-mail:nourm77777@Gmail.com

Dysfunction can appear at any of these stages. Furthermore, pain can be experienced by both female and male during the sexual act. These stages are utilized by both DSM-IV-TR and ICD-10 to categorize sexual dysfunction. A spectrum of illnesses known as hypoactive sexual desire disorder (HSDD) cause personal distress as a result of a persistent or recurring deficiency (or absence) of sexual thoughts and a lack of receptivity to sexual activity. Sexual arousal disorder is characterized by a persistent inability to achieve or sustain effective sexual excitation, resulting in personal distress. Sexual arousal disorder can appear as a reduction in subjective excitation, somatic responses, or genital lubrication/swelling. Sexual arousal disorder can also result from clitoral sensation and inefficient labial, engorgement, and a lack of vaginal smooth muscle relaxation. The most common causes of primary orgasmic disorder are emotional trauma or sexual assault. Secondary orgasmic disorder is frequently precipitated by hormonal deficiencies, surgical trauma, or medications. There are 2 critical components to the apparition mechanism of a female orgasm disorder: hyper-intention and hyper-attention.

INTRODUCTION

Female sexual dysfunction (FSD) is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) as "any sexual complaint or problem that causes marked distress or interpersonal difficulty and is the result of disorders of arousal, sexual pain, orgasm, or desire. “Four For a condition to be classified as a dysfunction, it must be present for a minimum of six months and cause substantial distress for a minimum of seventy-five percent of the time (1).
The occurrence of female sexual dysfunction varies between various populations, age groups, and countries, with a range of twenty-four to sixty-three percent, as indicated by epidemiological research. The most prevalent sexual problem is a lack of interest in sex, which is followed by the inability to experience orgasm and excruciating intercourse. Female sexual dysfunction is defined using a variety of criteria in various research, which makes it challenging to determine the actual occurrence. Nevertheless, just twenty-one percent of females who experienced sexual issues asked for help (2).

There is a wide variety of reasons and etiologies that can contribute to female sexual dysfunction. This dysfunction is a result of a complex interaction between psychosocial and biological factors, including factors such as level of education, partner-relationship and age (3).
This study aimed to assess prevalence of FSD in Aswan governorate, and associated risk factors and deferent types of FSD and the commonest type in our community.

Anatomy of Female Pelvis

Perineum, the boundaries of this diamond-shaped region are identical to those of the bony pelvic outlet. The pubic symphysis is located anteriorly, the ischiopubic rami and ischial tuberosities are located anterolaterally, the sacrotuberous ligaments are located posterolaterally, and the coccyx is located posteriorly (4).
Vulva, the vulva encompasses all structures that are externally visible in the urogenital triangle. The following are the following: the labia majora, labia minora, clitoris, mons pubis, vestibule, urethral opening, greater vestibular (Bartholin) glands, hymen, minor, paraurethral glands and vestibular glands, Labia majora are typically between seven and eight centimeters in length, between two and three centimeters in width, and between 1 and 1.5 centimeters in thickness. The round ligaments terminate at their upper borders, and they are directly continuous with the mons pubis in the superior direction. The clitoris is composed of a corpus or body, 2 crura, and a glans, and its length rarely exceeds two centimeters.
The paired dorsal nerves of the clitoris are corresponding to the prominent nerve bundles. Two corpora cavernosa are present in the clitoral body. Each corpus cavernosum forms a long, narrow crus by diverging laterally from the clitoral body. (5).
Vestibule, in adult female, the vestibule is a region that is formed like an almond and is surrounded by the Hart line laterally. The vestibule is typically perforated by six openings: the vagina, 2 greater vestibular (Bartholin) gland ducts, the ducts of the 2 largest paraurethral glands and the urethra, the Skene glands. The vestibular fossa is the name given to the posterior region of the vestibule that is located between the fourchette and the vaginal orifice or opening (5).
Vagina and Hymen, in mature females, the hymen is a thin membrane that forms an annular or crescent shape and covers the vaginal opening in completely or in a significant portion of it. Hymens are primarily composed of collagen, elastic fibers, and fine vessels. Nerve fibers are few and concentrated toward the base of the nerve. The stratified squamous epithelium that is not keratinized covers the outer and inner surfaces of the hymeneal glands. A muscular conduit that continues to the uterus and is interposed lengthwise between the rectum and the bladder, the vagina is located proximal to the hymen. The total length of the vaginal canal is between nine and ten centimeters. The vesicovaginal septum is a connective tissue that allows the vagina to be isolated from the bladder and the urethra from the anterior perspective. In the posterior region, the rectovaginal septum is formed by the combination of tissues that are comparable to those found between the lower portion of the vagina and the rectum. In addition to being referred to as the cul-de-sac or the pouch of Douglas, the rectouterine pouch is the structure that divides the top fourth of the vagina from the rectum (6).

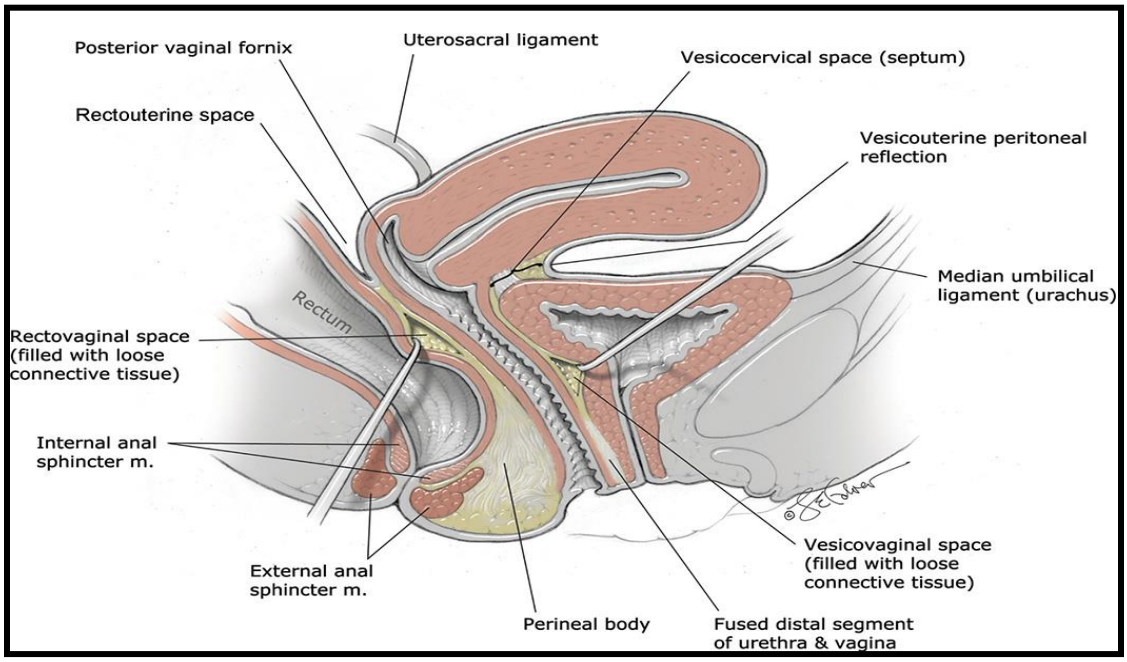

Figure (1): Vagina and surrounding anatomy.

The vaginal lumen typically has contact walls, but after birth-related trauma, stratified epithelium may be embedded beneath the surface, causing degenerated cells to shed. This can result in epidermal inclusion cysts filled with debris. The vagina has abundant vascular supply, with the proximal portion supplied by the cervical and vaginal arteries.

Perineal Body, This fibromuscular pyramidal mass lies in the midline at the junction between the urogenital and anal triangles Clinically, it measures 3.5 to 5 cm in nulliparas from the posterior midline hymen to the mid-anal opening, which are standard pelvic organ prolapse-quantification (POP-Q) landmarks (7).

Urogenital Triangle

Superficial Space, the pubic rami, the ischial tuberosities, and the transverse perineal muscles surround the urogenital triangle, which is a complicated structure that is split into superficial and deep regions by a dense fibrous membrane that connects the ischiopubic rami and the vagina. The female urethra, which is approximately three to four centimeters in length and originates within the bladder trigone perineal body and pubis arcuate ligament, is located in Deep Space, which defines the space that is either above or below the perineal membrane. A portion of the urethra, the vagina, the branches of the internal pudendal artery, and the muscles of the urethra are included in it. At the urethrovesical junction, the urethra has a transitional epithelium, which transitions to pseudostratified columnar and nonkeratinized stratified squamous epithelium distally. The urethra is composed of the distal two-thirds that are connected with the anterior vaginal wall (8).

Pelvic Diaphragm

The coccygeus and levator ani muscles are the muscle groups that make up the pelvic diaphragm, which is a broad muscular floor that provides support for the pelvic viscera. The pubococcygeus, puborectalis, and iliococcygeus muscles are also present in this structure. The pubovisceral muscle, also referred to as the pubococcygeus, is further differentiated into the pubovaginalis,

puboperinealis, and puboanalis muscles. The levator ani muscle or its innervation can be damaged in vaginal birth. It has been suggested that levator ani trauma could put females at a greater risk of developing pelvic organ prolapse in the future. The current research efforts are aimed at reducing the severity of these injuries because of the adverse impact they have on the sexual lives of women (9).

Physiology of Female Sexual Response

When touched, the clitoris and the penis initially bring the most pleasure; however, the capacity of the central nervous system to bring pleasure activates a wide range of regions in the brain and the brainstem. These regions include the limbic system, the temporal cortex, the insula, the basal ganglia, the nucleus accumbens, the superior parietal cortex, the dorsolateral prefrontal cortex, and the cerebellum. Both spontaneous orgasms and self-stimulation are accompanied by activity in these regions, as demonstrated by neuroimaging techniques (10).

Neurophysiology Influences on FSD

The sexual response cycle is a universal pattern that represents the way in which the brain and other sex organs react to sexual stimuli. The sexual response is a fundamental physiological condition that is present in all species. It is affected by cultural settings and needs dynamic adaptation. In the nervous system, neural structures are responsible for the experiences and processing of sensory information, which in turn triggers motor and autonomic responses. Variations in sexual attitude between women and men may be attributed to dimorphic hormonal profiles and anatomical substrates. Despite the fact that neuroimaging research has yielded new insights into sexual behavior, there are still some aspects that have not been resolved (11).

Human Sexual Response Cycle

(HSRC). This 4-phase paradigm comprises of plateau, resolution, orgasm, and excitement in both women and men. Even though it indicated simply the physiology of sexual reaction among participants in lab experiment, the HSRC became the prototype for normal sexual response. It became crucial to the development thereafter of the management and diagnosis of sexual dysfunction. The phases of excitation, plateau, orgasm, and resolution are the successive phases that make up the physiological responses that occur during sexual stimulation, as stated by Masters and Johnson (12).

sexual excitement and desire are described as the existence of sexual thoughts, fantasies, and motives to engage in sexual action in response to relevant internal and external cause. This definition is applicable to both men and women. In addition, it is impacted by a wide range of elements, including attitudes, the availability of opportunities and/or partners, overall mood, and health. As a result of any erotic physical or mental stimulation that leads to sexual arousal, the body will prepare for coitus during the excitement phase. An erection, which is a reflexogenic process driven by sensory signals, brings about the beginning of sexual arousal in men. Penile hemodynamics during an erection are defined by the tumescence of cavernous bodies due to vasodilatation. On the other hand, penis detumescence is controlled by the pelvic, cavernous, and pudenda nerves of the sympathetic nervous system. Erection is dependent on control from the supraspinal and the spinal region in response to inputs from the senses of touch, vision, imagination, and smell. Sexual arousal is phasic with the menstrual cycle in female, and the autonomic nervous system regulates clitoris hemodynamics. Mucus and vaginal discharge are both produced by the bartholin glands, which are responsible for making sexual activity more comfortable (13).

Plateau phase: During the plateau phase, blood flow, heart rate, and breathing increase due to various factors. This leads to vasocongestion, causing sexual flush, which usually disappears

after orgasm. Females experience an orgasmic platform, while males release pre-seminal fluid containing healthy sperm cells. making penile withdrawal an ineffective form of birth control. Orgasm: Euphoria, rapid contractions of the lower pelvic muscles, and an elevated heart rate are all characteristics of the period of an orgasm that is considered to be the most enjoyable. When neuromuscular tension is relieved, the hormone oxytocin floods the bloodstream, which makes it easier for people to form emotional bonds with one another. Despite the fact that ejaculation is temporally related to rhythmic muscular contractions, these two physiological processes are physically distinct from one another (14). Resolution: It is an adaptive response that supports reproductive and social ends, and sexual inhibition is one of such responses. Inducing it can be accomplished by the use of non-reward suppressing desire components. FSD can be caused by a variety of neurologic conditions, including illnesses of the central or peripheral nervous system as well as spinal cord injury (SCI), and it can affect both men and women. It is necessary for a female to have intact sacral reflex arc and upper motor neurons in order for her to get an orgasmic experience and experience sexual desire. The severity and location of the injury both have a role in determining the impact of a spinal cord injury. Females who have sustained spinal cord injuries and lower motor neuron lesions are less probable to experience orgasm compared to those who do not have such injuries. There is also the possibility of FSD occurring following significant pelvic surgeries, such as gynecologic, urologic, and colorectal procedures that were carried out for a variety of benign and malignant disorders found in the pelvic region (15)

Neurobiology of sexual function

Over the past ten years, there has been a growing focus on the neurobiology of sexual function in research. This section serves to demonstrate the significance of the most critical neurotransmitter and endocrine factors in sexual function (16).

Serotonin

Enterochromaffin cells contain between eighty and ninety percent of the human body's total serotonin, a monoamine neurotransmitter, which is predominantly located in the gastrointestinal tract. Regulating appetite, muscle contraction, sleep, mood, and cognitive functions as learning and memory, the remaining serotonin is synthesized in serotonergic neurons in the central nervous system. Vasoconstriction and vasodilatation are induced by serotonin receptors in the body's periphery, which act on the smooth muscles of genitals and sexual organs. SSRI antidepressants impair ejaculatory and organasmic function, and serotonin has an inhibitory impact on sexual function in the central nervous system. The urethrogenital reflex and reflexive erections are disinhibited by experimental lesions of nPG1 in the spinal cord, which confirms the inhibitory role of serotonin in sexuality. These receptors have been reorganized into seven families due to their high heterogeneity (17).

Dopamine

Dopamine is essential for human sexuality, as it facilitates the motor aspects of copulation but does not contribute to motivation for sexual activity. It promotes men sexual behavior by acting in the MPOA. Cocaine is an "aphrodisiac" that enhances sexual desire, performance, and sensation perception by increasing dopamine activity if utilized acutely. The disruption of the dopaminergic system is the cause of sexual disorders in chronic cocaine users (18).

Norepinephrine

Norepinephrine (NE) is a stress hormone that is secreted from the adrenal medulla and has an impact on the brain and body. It induces the fight or flight response, elevates the heart rate, and enhances the passage of blood to the muscles. It influences reward systems, alertness, and arousal. An erection can be induced by A1-adrenergic receptors in human penile tissue. Male

sexual function is significantly influenced by monoamines, which act on NE receptors. Antidepressants that are more recent have less adverse effects. Interestingly, the administration of the α2 antagonist (yohimbine) may reverse the sexual inhibition that occurs after sexual exhaustion in men rodents and stimulate penile erection through autonomic activation (19).

Sex hormones

Sex hormones play a crucial role in sex-specific behaviors and neural circuit development, with men behaviors requiring both estrogen and testosterone. Testosterone activates androgen receptors in the brain, converting into estrogen during brain development. Sexual hormones integrate autonomic and somatic sexual systems and contribute to sexual arousal. Adult males require lower testosterone levels for sexual interest and activity, while reduced levels of testosterone in females are linked to female sexual arousal disorder and reduced sexual desire in hypoactive sexual disorder. Estrogen is essential for sexual function and lubrication, preventing vaginitis and insertional dyspareunia. Low estradiol levels can lead to vaginal dryness, pain, and reduced coital activity. Combining estrogen and androgen therapy may alleviate sexual dysfunction in postmenopausal women, influenced by psychological, neurovascular, and hormonal factors (20).

Female sexual dysfunction following pelvic surgeries

Sympathetic fibers originate from the hypogastric plexus, while parasympathetic fibers originate from the sacral roots, and they are essential for the proper functioning of the pelvic organs. They provide a significant autonomic supply to the pelvic organs. Hysterectomy, cystectomy, and rectal excisions are among the most frequently performed pelvic operations, which are performed to treat a variety of illnesses. Injury to the autonomic pelvic Fertility and Sterility 1275 nerves is frequently associated with genitourinary dysfunction. The most frequently performed surgical procedure on females is the hysterectomy (21).

Epidemiology of Female Sexual Dysfunction

Sexual health is crucial for overall well-being, but it's a complex concept involving organic, hormonal, emotional, social, and cultural factors. Prevalence varies between 20% and 69%, with female sexual dysfunction occurrence varing from 43% to 69% in the USA and 46-73% in African countries. Age-related factors, such as decreased sexual interest, psychological issues, and intimate-relationship problems, can also impact sexual desire. Mental health issues can coexist with sexual issues (22).

Female genital mutilation (FGM) effect on female sexuality

Although there are numerous factors that influence female sexual dysfunction, one of the most intriguing topics that has been the subject of numerous research, particularly in Africa and Arab or Islamic countries, is female genital mutilation (FGM). This issue is of paramount importance, as evidenced by the strong statistical trend between circumcised and non-circumcised women on the total score of the FSDI. The influence of chronic illness on the sexuality of females is usually significantly greater. Female sexual dysfunction SD was found to be two times more prevalent among females who had experienced medical conditions, according to research carried out in Turkey. In females with diabetes and hypertension, sexual problems and limitations have been observed (23).

Infertility and female sexuality

Infertility significantly impacts intimacy, with forty-three to ninety percent of females experiencing sexual dysfunction. It can either cause or intensify sexual problems, with psychological stress potentially preventing their occurrence (24).

Hormonal Contraceptives Sexual Effects

Some females who utilize hormonal contraceptive methods might notice a loss of sexual enjoyment at the outset, which could serve as a deterrent to their utilize. This may result in an increased susceptibility to unintended pregnancy. Hormonal contraceptive methods have been the subject of fewer investigations on sexual function than combined oral contraceptives (COCs). A reduction in the thickness of the labia minora and vulvovaginitis have been associated with cocs. Hormonal contraception has been associated with adverse effects on female sexuality, including infrequent intercourse, orgasm, arousal, pleasure, reduced sexual desire, sexual thoughts, , pleasure and interest (25).

Risk Factors for Sexual Dysfunction

There are a number of factors that might have an effect on sexual performance. These factors include medical conditions, drugs, age, menopausal status, and environmental factors. Gynecologic disorders have the potential to alter sexual function throughout pregnancy and postpartum. This is assumed to be caused by a combination of factors, and it affects forty to eighty percent of women after giving birth. There does not appear to be any correlation between the mode of delivery and sexual health following delivery, despite the fact that outcomes have been varied (26).

Gynecologic conditions and surgery effect

Sexual health and sexual dysfunction can also be influenced by gynecologic conditions, such as endometriosis, pelvic organ prolapse, and gynecologic malignancies. The majority of research have demonstrated that hysterectomy results in an enhancement in sexual functioning, particularly for condition that are benign. The importance of before surgery counseling on the effects of hysterectomy on sexual health is emphasized, and it is emphasized that mental health is the most significant risk factor for sexual dysfunction. Benzodiazepines, selective serotonin reuptake inhibitors (SSRIs), and mood stabilizers are among the pharmaceuticals that are utilized for the management of these disorders. Unfortunately, these drugs are known to have a negative impact on sexual arousal and the capacity to attain orgasm (27).

It has been demonstrated through research that emotional distress and dissatisfaction are associated to sexual dysfunction, which in turn causes patients to experience distress. A history of sexual abuse or assault, whether it occurred during childhood or adulthood, is associated with a higher possibility of sexual dysfunction, which can manifest as dyspareunia, issues with interest, arousal, or orgasm, or avoidance of sexual activity. It is essential to have a history of trauma in order to gain an understanding of the underlying causes of sexual dysfunction, despite the fact that the rates are greater among females who have experienced abuse (28)

Management

The diagnosis of female sexual problems

The classification in addition to mangement of female sexual problems have undergone modifications in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Involutional melancholia, frigidity, dyspareunia, and psychosexual dysfunctions were all items that were added in the DSM beginning in the year 1952. The term "sexual dysfunctions and hypoactive sexual desire disorder" was utilized to refer to these disorders in the year 1987. With the exception of the removal of sexual aversion in 2013, the DSM-IV, IV, TR, and DSM-5 editions did not undergo any significant alterations Genito-pelvic pain/penetration disorder (GPPPD) has taken the place of dyspareunia and vaginismus, and female sexual interest/arousal disorder (SIAD) has taken the place of male sexual dysfunctions. In the case of men sexual dysfunctions, there was no collapse of a similar nature. In 1952, the 1st edition of the Diagnostic and

Statistical Manual of Mental Disorders has been published, and in 1980, psychosexual dysfunctions were formally included in the DSM-III (28).

The Female Sexual Function Index (FSFI)

A 19-item self-administered questionnaire evaluates sexual function domains over the last 4 weeks, with 0 scores indicating no intercourse. Answers are rated on a five-point scale, with domain scores determined by adding individual items and multiplying by domain factors (29).

Treatment

A novel paradigm for the management of sexual dysfunctions in both males and females has been developed, with a focus on psychodynamic management. The objective of this paradigm was to comprehend the psychological underpinnings of sexual difficulties by means of long-term, insight-oriented psychotherapy. The model has been depended on the duplication of qualifications between co-therapists, with one being a medical professional and the other a mental health professional, and the character of female sexual experience. The remainder of the program continues to serve as the foundation for contemporary sex therapy practice, despite the fact that dual-sex therapy teams were costly and scheduling could be cumbersome. The origin of sexual dysfunctions was attributed to sex-negative psychosocial expectations, with ten percent of the etiology being organic and ninety percent being psychogenic. Sexual treatment was designed to remove any obstructions that could potentially disrupt sexual activity, thereby enabling the resumption of normal sexual function. Women with vaginismus, a complex condition marked by a history of trauma in the genital area, childhood sexual abuse, and upbringing in sex-negative environments with minimal or no sex education, are especially well-served by the model. The optimal constellation for the development of vaginismus is often established when women are informed that penetration will be painful. The behavioral treatment protocol for vaginismus developed by Masters and Johnson was entirely successful in instructing women on how to open and close their vaginal muscles autonomously. Intrapsychic investigation or management were not required, except in rare, recalcitrant cases (30).

Recent treatment and future directions

Healthcare professionals are undergoing a transformation in their clinical orientation and training within the field of sexual medicine. New directions involve cosmetic procedures such as laser management and labiaplasty, which are designed to establish a more symmetrical labia minora and refine vaginal tissues. Some therapists are reintroducing sensate concentration exercises to new generations, while others are integrating sexual management with systemic psychotherapy models to deal with the relational aspects of sexual difficulties. Therapists continue to prioritize normative performance standards, regardless of the potential advantages of mindfulness techniques. This underscores the persistent discrepancy in the clinical orientation and training of healthcare professionals (31).

Nonmedical treatment for female sexual dysfunction

To improve sexual intimacy, it's recommended to engage in regular conversations, maintain healthy lifestyles, and seek counseling. Therapy can teach women to enhance their sexual response, improve intimacy, and recommend reading materials or couples exercises (32).

Medical management for FSD

Addressing an underlying medical condition or hormonal alteration is frequently necessary for the successful management of sexual dysfunction. Possible remedies for female sexual dysfunction may involve the following:

Estrogen therapy

Vaginal moisturizers or lubricants may serve as the initial treatment for cases suffering from vulvovaginal atrophy or genitourinary syndrome of menopause. Vaginal estrogen is frequently utilized as a secondary treatment, with a modest initial dose to reduce systemic absorption. It is available in the form of estradiol tablets, conjugated estrogen cream, cream, or a ring. By enhancing vaginal tone, elasticity, blood flow, and lubrication, localized treatment with estrogen enhances sexual function. The risks of treatment with hormones may differ depending on the type, dose, age, health issues, and whether estrogen is administered alone or in conjunction with a progestin. Ospemifene, a selective estrogen receptor modulator, has the potential to alleviate discomfort during sexual intercourse in females who have vulvovaginal atrophy (33).

Androgen therapy

Both males and females possess testosterone, a hormone that plays a critical role in sexual function. The effects of intravaginal dehydroepiandrosterone (DHEA) on vulvovaginal atrophy have been the subject of research. dehydroepiandrosterone has been discovered to alleviate discomfort during sexual activity and enhance objective measures of vulvovaginal atrophy in a randomized trial. Vaginal discharge was the sole adverse effect, which has been observed by six percent of the participants. Androgen treatment for sexual dysfunction is a contentious issue. There are research that indicate a benefit for women who develop sexual dysfunction due to reduced testosterone levels, while others indicate little or no benefit (34).

Flibanserin (Addyi)

Flibanserin, which has been initially developed as an antidepressant, has been approved by the FDA as a management for reduced sexual desire in premenopausal females. It is the 1st pharmaceutical to be approved for hypoactive sexual desire disorder, and it functions as both a 5-HT1A agonist and 5-HT2A antagonist. In females who are experiencing low sexual desire and find it distressing, Addyi, a daily tablet, may increase sex drive. In 2019, a pooled analysis has been conducted to compare the efficacy of flibanserin one hundred milligrams once daily at bedtime to a placebo in premenopausal females with hypoactive sexual desire disorder. Flibanserin is well effective and tolerated, as confirmed by a recent safety evaluation. However, potential severe side effects involve fainting ,low blood pressure, fatigue, dizziness, nausea, and sleepiness, particularly when combined with alcohol (35).

Bremelanotide (Vyleesi)

Bremelanotide, a melanocortin-4 receptor agonist, has been approved by the FDA for the management of sexual interest and arousal dysfunction in females. It is administered subcutaneously for forty-five minutes prior to sexual activity and may be repeated once every twenty-four hours. It has been related to significant enhancements in the domains of arousal, orgasm, lubrication, and sexual gratification. Nevertheless, the majority of adverse effects are mild or moderate, with vertigo, facial flushing, and headaches being frequent. eighteen percent of participants discontinued therapy due to adverse effects (36).

Phosphodiesterase inhibitors.

Sildenafil citrate, a selective inhibitor of phosphodiesterase 5, has been demonstrated to enhance genital blood flow and clitoral and vaginal vasocongestion. It has been utilized to address female arousal dysfunction and sexual interest; however, its efficacy in managing female sexual dysfunction is inconsistent. Research has demonstrated that these medications are more effective in managing erectile dysfunction in men than in treating female sexual dysfunction. For certain women who are experiencing sexual dysfunction as a result of their use of selective serotonin reuptake inhibitors (SSRIs), a class of medications that are prescribed to treat depression, the administration of sildenafil citrate one hour prior to sexual intercourse may prove advantageous.

Nevertheless, the majority of adverse effects were mild or moderate, with vertigo, facial flushing, or headaches being the most prevalent (37).

Conclusion

The sample of Aswanian females in the study group is characterized by a high prevalence of female sexual problems. Female age, low socioeconomic status, parity, and duration of marriage were all significantly correlated with the occurrence of sexual dysfunction in females. The domains that were most significantly impacted were Lubrication and Satisfaction. Satisfaction was followed by issues of pain and desire.

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