

Female sexual dysfunction: low desire, arousal and pain with sex

Female sexual function is not one switch: desire, arousal, lubrication, comfort, sensation, orgasm, pelvic-floor coordination and emotional safety can each change for different reasons. The first step is to identify which part changed and when, and treatment should match that pattern rather than assume every concern is hormonal, psychological or simply aging.



Figure 34.1. Female Sexual Function Is Not One Switch. Desire, arousal, lubrication and tissue comfort, sensation and orgasm, pelvic-floor coordination, and urinary or whole-body factors can change for different reasons. Identify the limiting step and match treatment to its cause.

Key points

- "Low libido" often does not describe the problem; pain, arousal, orgasm or bladder symptoms may be the real limit.
- Desire and arousal are related but not identical, and responsive desire can be normal.
- Pain at the vaginal opening and deep pelvic pain usually have different mechanisms.
- A guarding pelvic floor may need relaxation and coordination, not routine strengthening.
- Medications, sleep, mood, vascular health and diabetes belong in the review; that does not make a symptom "all in your head."
- Prescription options for low desire, including off-label testosterone after menopause, have narrow, specific roles.

Get prompt care if you notice

- Abnormal bleeding
- A visible lesion or new mass
- Significant discharge or fever
- Unexplained, progressive pain

Questions to ask your urologist

- Which part of my sexual function seems to be changing: desire, arousal, comfort, orgasm or something else?
- How might tissue health, pelvic-floor tension, urinary symptoms or my medications be contributing?
- Which examination or referral would change the plan?
- Would pelvic-floor therapy focused on relaxation help me?
- If low desire itself is distressing, which treatments fit my diagnosis, and what would prompt us to stop or change them?

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