

# DOWNLOAD PDF INTRODUCTION : NEW DEVELOPMENTS IN THE AREA OF SEXUAL DYSFUNCTION(S R. BALON

## Chapter 1 : CiteSeerX " Introduction: New Developments in the Area of Sexual Dysfunction(s)

*Introduction: new developments in the area of sexual dysfunction(s). Balon, R. Update on diagnoses of sexual dysfunctions: controversies surrounding the proposed revisions of existing diagnostic.*

This article has been cited by other articles in PMC. Psychosexual problems are very common presentation, be it with psychiatric or physical illness but there are very few studies available on psychosexual disorders especially in the Indian context. Indian society is deeply ingrained in customs and several misconceptions, myths, prejudices, and social taboos are attached to sex which makes it further very difficult to tackle. The aim of this current study was to descriptively analyze the nature of sexual disorders in a tertiary care center. The current retrospective chart review included consecutive subjects seeking treatment for their psychosexual problems at the Sexual Clinic, Department of Psychiatry, Dr. Ram Manohar Hospital, New Delhi between and

This study observed erectile dysfunction ED DS was the major complaint among younger and unmarried individuals. We observed more married individuals seeking treatment for sexual disorders. These findings provide important information on a relatively under-researched area. It is even more difficult in developing countries like India. The problems are intensified by ill-advice from co-workers, friends, elders, and popular cheap literature on sex which heightens the fears, guilt, shame, and anxiety over the problem. Individuals then finally may turn up to hospitals for treatment seeking. As literature lacks large-scale epidemiologic data on sexual disorders, smaller studies should be integrated to obtain population estimates regarding the prevalence of sexual disorders. We aimed to add to the existing data, the prevalence of sexual problems in patients coming to sexual clinic in a tertiary care center. Ram Manohar Hospital, New Delhi. Data were collected retrospectively from case notes. The chart analysis of all consecutive subjects between and was carried out. Performa was prepared for the study which included demographic information including age, marital status, occupation, employment, socio-economic status, educational status, religion, catchment area, type of family, and their family background. Detailed family history of any substance use and psychiatric illness was elicited. Information was sought regarding the exact nature and duration of onset of the problem, associated problems in different phases of sexual response cycle, and presence of any performance anxiety. History regarding substance abuse was extracted along with detailed evaluation of any recent or ongoing stressor, past and presenting psychiatric illness including any personality traits or disorder, and co-morbid physical ailments. History of any indigenous medicines taken by these patients for the treatment of their psychosexual problem was assessed along with the prior types of consultations for the psychosexual problems. The diagnosis as assessed by the treating psychiatrist using standard definitions and criteria in accordance to international classification of diseases version 10 were evaluated. The data were imputed and analyzed using SPSS, version

Table 1 represents the socio-demographic data obtained. More than two-thirds were married with the majority belonging to Hindu religion Table 1 Open in a separate window Clinical parameters There was no family history of any substance abuse or dependence. A family history of psychiatric illness was present in only two subjects: Depression in one and psychosis in other. Almost half of the patients had taken prior consultation with a physician. As shown in Table 2 , about two-thirds of the subjects were having one or the other stressors in their life. None of the subjects are found to be suffering from any kind of personality disorder. Psychiatric illness apart from the sexual problems was observed in Most of the subjects were suffering from depression Two subjects were suffering from epilepsy. The severity of psychiatric illness was not written. Very few subjects were suffering from psychiatric illness prior to their substance use. Most of the subjects were not having any co-morbid physical illness. Table 2 Open in a separate window Of the various psychosexual disorders observed in our study, erectile dysfunction ED was most commonly reported Among the subjects having more than one psychosexual disorder, ED with PME was most commonly reported Sexual dysfunction and substance use A history of current use of substance was reported in Current use of substance meant use of any substance within 1 month of presenting to the psychiatric Out Patient Clinic to denote active use of

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substance. The substance commonly reported was alcohol Nicotine use was reported by 6.

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## Chapter 2 : sexual dysfunction | Download eBook PDF/EPUB

*Introduction: New Developments in the Area of Sexual Dysfunction(s) {Balon\_introduction:new, author = {Richard Balon} New Developments in the Area of Sexual.*

This article has been cited by other articles in PMC. Abstract Objective Several studies have reported that Clomipramine has the ability to suppress male rat sexual behavior. Hence this study was undertaken to investigate the effect of Amantadine, a dopamine agonists on the Clomipramine induced sexual dysfunction. The male rats were randomly divided into four groups of 12 male rats each. Group I served as controls. The sexual behavior of the male rats was observed to determine the following parameters: As well as the sexual behavior; serum testosterone and histopathology of the testes were also investigated in this study. Results The results indicate that Amantadine in all aspects failed to antagonize Clomipramine induced sexual dysfunction in male rats. Testicular damage and decline in testosterone levels continued in the presence of Amantadine. Conclusion Overall, the results suggest that Amantadine could not be a safe antidote to antagonize Clomipramine induced sexual dysfunction. Clomipramine, Amantadine, Male rat sexual dysfunction, Testosterone, Testes Introduction The sexual act involves central as well as peripheral mechanisms. It is well established that noradrenaline, 2, 3 serotonin, 4, 5 and dopamine are involved in the central mechanisms. Clomipramine Clmp is a tricyclic antidepressant, which has demonstrated efficacy in depression, obsessive compulsive disorder OCD and panic disorder. Clomipramine is the imipramine analogue of chlorpromazine. Due to its action against anxiety disorders and panic attacks, it is the only drug with 2 entries in the essential drugs list of the World Health Organization WHO. With regards to compulsive disorders, it is now the "gold standard" of therapy against which other drugs are measured. Case reports and open trials have suggested that Yohimbine, 19 Bupropion, 20 Cyproheptadine, 21 and Amantadine, 22, 23 may be effective in the antidepressant induced sexual dysfunction. Hence, the present study was conducted to find out whether dopamine agonists such as Amantadine can antagonize the Clomipramine induced sexual dysfunction in male rats. Amantadine acts by increasing dopamine levels centrally, increasing dopamine release, inhibiting amine uptake, or through direct action on dopamine receptors. The rats were 4 months old. The males weighed around gm each and females weighed gm each. They were fed on commercial pellet feed and water was available ad libitum. The study was approved by the Institutional Ethical Committee prior to commencement. All the animal studies were carried out after 7 PM in the animal house of Sri K. V College of Pharmacy, Chickballapur. The sexual behavior of the male rats was studied as explained elsewhere, 26 the copulatory behavior of the male rat was characterized by a series of mounts with or without vaginal intromission from the rear of the female approximately once in every 30 to sec, that eventually culminates in ejaculation. The females responded to each mount with a lordosis response, namely; a dorsoflexion of the spine and deflexion of the tail to one side allowing vaginal access for the male. Intromission patterns can be distinguished behaviorally from mounts with penetration by the presence of deep thrust and springing dismount. An intromission was identified when the male mounted and achieved insertion of the penis into the female as marked by deeper than normal thrust usually followed by abrupt movement away from the female, urgent front leg movements and grooming. Ejaculation was marked by a more profound thrust than that of regular intromission and was followed not by movement away from the female, but by sudden limpness and immobility until the female moves away. After ejaculation and immobility, the male was engaged in the long period of grooming min post ejaculation pause. The number of intromissions and latency to ejaculate at first decreases and then subsequently increases with increasing number of ejaculations. The following parameters were recorded: Using these measures the following parameters were computed: Half of the animals in each group were sacrificed on 30th day and the remaining on 60th day for blood sample collection and for histopathological examination of the testes. Blood was collected through the cardiac puncture using a 16 no. The sections were examined under high power microscope. The evaluation of the cell population was based on

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the calculation made for each type of developing sperm cells per cross section of ten randomly selected seminiferous tubules. However, in 2TD group, suppression of libido was observed on 60th day. Hence Amantadine failed to antagonize the effect of Clomipramine on sexual behavior. All the latencies for example mount latency, intromission latency and ejaculation latency were increased significantly compared to the controls. The results also conveyed a decrease in the number of intromissions and an increase in the number of mounts, thus leading to a decrease in the copulatory efficiency. Post ejaculation pause was also increased when compared to controls. Table 1 Table 1 Effect of chronic oral administration of Amantadine and Clomipramine on sexual behavior parameters of male rats.

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## Chapter 3 : - NLM Catalog Result

*Richard balon introduction new developments in the area of sexual dysfunction s free sample chapter, pdf 93 kb zvi zemishlany, abraham calendrierdelascience.com boys were looking at it when the Chink happened along, and one of them, in a joke, threw it at calendrierdelascience.com next sexual disorders pdf thing is, what were you doing tonight, as I see that both you and.*

The authors declare that they have no disclosures. The author s declared that no grants were involved in supporting this work. This is an open access article distributed under the terms of the Creative Commons Attribution Licence , which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. Patel CK and Bennett N. Advances in the treatment of erectile dysfunction: FResearch , 5 F Faculty Rev: ED risk is increased with comorbid conditions such as type II diabetes mellitus DM , obesity, cardiovascular disease, hypertension, and dyslipidemia 4. Interestingly, recent studies have confirmed that ED can serve as a predictor for future cardiovascular disease. ED is well recognized to adversely affect quality of life, decrease work productivity, and increase healthcare costs. Needless to say, ED is a significant health condition that affects the individual patient and healthcare system as a whole. As such, effective treatment for this condition is paramount. Currently, there are several treatment options for patients with ED, both non-invasive and invasive. These remain the first-line therapy for ED. Sildenafil and vardenafil have similar half-lives of 4 hours, while tadalafil has the longest Vardenafil should be used with caution in patients with prolonged QT interval. Second-line therapies include intracavernosal injections with vasogenic agents. An alternative second-line therapy consists of intraurethral prostaglandin E1 pellets and vacuum erection devices. These options are invasive, which can be troublesome for patients, and also have side effect profiles. Finally, the most invasive treatment of ED consists of insertion of a penile prosthesis. Even though there are many treatment options for ED currently, there are still patients who do not respond to or cannot tolerate the above therapies. The focus of this article will not be on the current therapies but rather newer medications and procedures that are currently under investigation in both preclinical and clinical settings for the treatment of ED. Non PDE5-I oral agents Newer pharmacological treatments are focused on targeting alternative pathways in the erectile process, both centrally and peripherally. Dopamine operates in the brain as a neurotransmitter and in the periphery it functions like a local messenger. Apomorphine Uprima is a dopaminergic agent activating dopamine receptors D1 and D2 at a central level within the paraventricular nucleus of the brain. This medication was first introduced in by Lal and colleagues 7 and has been studied extensively since its debut. In the first phase III parallel arm cross-over double-blind study of ED patients, erections occurred rapidly 10â€”25 minutes and in This drug achieved regulatory approval in Europe in early , but its use has not been authorized in the United States because of hypotension side effects. Along this same pathway, two dopamine agonists ABT and ABT selected for the D4 receptor are currently being studied in pre-clinical trials and demonstrated physiologic erections in in vivo rat models without the side effects seen with other dopaminergic agents 9. Melanocortins are involved in many processes, and their role in controlling sexual function was first reported in the s They are linked to the induction of penile erection and the regulation of sexual behavior Two well-studied melanocortin receptor agonists are melanotan II and bremelanotide. Side effects reported with melanotan II include nausea, yawning, and a delayed onset of erection approximately 2 hours. This in turn led to the development of bremelanotide, which can be administered intranasally and has a quicker onset of action. Intranasal forms of bremelanotide have also shown side effects of nausea and hypertension, and this has led to the development of subcutaneous forms of this therapy. Combination therapy of a subcutaneous melanocortin analogue PT with sildenafil has been shown to enhance erectile response in a small sample of patients Soluble guanylate cyclase stimulators and activators. In some patients, especially post-prostatectomy and DM patients, this pathway is disturbed because of varying amounts of nerve damage 15 and the effectiveness of PDE5-Is is reduced significantly. There are two types of

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compounds that can stimulate sGC: Heme-dependent sGC stimulator functionality depends on the reduced prosthetic heme moiety in the sGC enzyme and synergistic enzyme activation when administered with NO. The activation of sGC by heme-independent activators functions after oxidation or removal of the prosthetic heme group of sGC, highlighting a previously unknown mechanism of enzyme activation. A study using an in vivo model using human corpora cavernosal tissue from 16 PDE5-I non-responders found that combination of sGC stimulator and vardenafil enhanced relaxation of the corpora cavernosa. In this study, human corpora cavernosal tissues were harvested after consent from individuals undergoing penile prosthesis implantation and potent patients undergoing transurethral surgery. As mentioned above, endothelial-derived NO plays a critical role in the relaxation of corporal tissue and this pathway is impaired in diabetic patients, which leads to poor erectile function. Phosphorylation of myosin light chain kinase regulates the contraction of smooth muscle in the corpora and dephosphorylation is mediated by smooth muscle myosin phosphatase enzyme. Two inhibitors of this Rho-kinase, fasudil and Y, were the first to be studied in rat models, and it was found that relaxation of the corpora was not impaired when subjects were given these medications. SAR is a more recently developed Rho-kinase inhibitor and has shown promising results in one study when compared to placebo and sildenafil. In this phase II clinical trial, a single dose of SAR was used to assess the increased duration of rigidity of erection. Topical therapy Topical therapies are a promising alternative to the current second-line therapies, as they can be safe and easy to use and do not require intraurethral or intracavernosal instrumentation. One of the leading candidates for this type of administration is a medication termed Topiglan. It consists of prostaglandin E1 alprostadil combined with SEPA soft enhancer of percutaneous absorption. Topical alprostadil has been studied in cats and humans and has been shown to induce erectile responses with minimal side effects. The benefit of this topical therapy is maximized when used as part of a combination regimen such as those including PDE5-Is. This medication has been approved in Canada. Another topical therapy being investigated is topical sildenafil, currently in phase IIa and actively recruiting study participants. Limitations of this therapy include variable penetration based on individual penile tissue characteristics as well as reported allergic skin reactions. Low-intensity shockwave therapy Extracorporeal low-intensity shockwave therapy LIST to the penis has recently emerged as a novel and promising treatment modality for ED. LIST has been previously used to treat a wide variety of urological and non-urological conditions. The mechanism of action for this treatment consists of sending acoustic waves that generate pressure impulses, which can treat patients with kidney stones, tendinitis, and peripheral vascular disease. For the treatment of ED<sup>24</sup>, it is hypothesized that LIST causes cell membrane microtrauma and mechanical stress, which causes an upregulation of angiogenic factors such as vascular endothelial growth factor VEGF, NO synthase, and von Willebrand factor, which increase angiogenesis and vascularization of tissues. As such, it is postulated that LIST increases blood flow and endothelial function and results in improvement in erectile function. Data from initial human trials are promising but are still in the investigational stage. Gruenewald<sup>25</sup> and colleagues performed an open-label, prospective study on patients with severe ED who previously failed PDE5-I therapy. In this group of 29 patients, LIST treatments were administered twice per week for 3 weeks. There was a 3. The same group of authors more recently published a randomized, double-blinded, sham-controlled study with 58 men. Significant improvements were again seen in components of the IIEF and penile hemodynamics. Even though there were no immediate adverse outcomes reported, the true long-term effects of this therapy are yet to be defined. Future studies with longer follow up will be necessary to see if the remodeling of the penile arterial system causes any long-term damage. Stem cell transplant Stem cell therapy is a new treatment option that offers the potential to reverse the underlying causes of ED and reduce patient reliance on the transitory effects of PDE5-I medications. Stem cell regenerative therapy is based on the rationale that stem cells can differentiate into a wide variety of cells including endothelial cells, Schwann cells, smooth muscle cells, and neurons. In ED research, three types of stem cells are commonly used: These can all differentiate into various cell types within the mesodermal germ line. It is hypothesized that multipotent stem cells have beneficial effects on damaged or diseased tissues by releasing various molecular mediators, which lead the host tissue to

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initiate a regenerative or healing response to diseased or injured tissue responsible for ED. The majority of published studies are based on animal models, but there has been one reported case series of seven men from Korea. In this study, all diabetic patients, with ages ranging from 57 to 87, were treated with an intracavernosal injection of 15 million allogeneic umbilical cord blood stem cells. Morning erection was regained in six out of the seven men at 6 months from time of injection. With concomitant use of sildenafil, all of these men were able to obtain vaginal penetration. No adverse events were reported. At 6 months, significant improvements of intercourse satisfaction and erectile function were noted in these patients. These results were preliminary and need to be confirmed in phase II trials. Stem cell transplant therapy is a new frontier in medicine. Larger controlled studies are needed to show any potential benefit at the human level, and further investigation is paramount. Gene therapy Gene therapy is a potential therapeutic option that is another area of investigation for the treatment of ED. Genetic material can be easily injected into the penis, which is advantageous as this direct injection avoids potential systemic complications. Furthermore, the effects of gene therapy are more prolonged in the penis because of a slow turnover rate of the tunica albuginea. In the first human trial, Melman et al. No adverse events were noted in the 11 patients who received this therapy. Patients given the two highest doses of hMaxi-K had apparent sustained improvements in erectile function as indicated by improved IIEF domain scores over the length of the study. This was a small study, but the encouraging safety profiles and effectiveness provide evidence that gene therapy is a viable option for the future. The role of stem cell regenerative therapy, in conjunction with gene therapy, will be heavily researched for the treatment of ED in the coming years. Conclusion PDE5-Is have been the cornerstone of ED therapy and because of their effectiveness, the incentive to develop newer drugs has been lacking. Over the past decade, however, we have gained more insight into the molecular and physiologic pathways involving normal erections. This has allowed for the development of new pharmacotherapies for the treatment of ED, especially for patients who are PDE5-I non-responders. Topical alprostadil, shockwave lithotripsy, and stem cell transplants represent innovative treatments and show promise for the next decade. In the future, the treatment of ED will be based on the specific etiologies causing ED, and treatment protocols will be tailored to the particular needs of each individual patient. Personalized medicine is the future of medicine and will indeed be an important component of ED treatment in the years to come.

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### Chapter 4 : Sexual dysfunction - Wikipedia

*Contents: Introduction: new developments in the area of sexual dysfunction(s) / R. Balon -- Clinical and research evaluations of sexual dysfunctions / L.R. Derogatis -- Management of hypoactive sexual desire disorder / R.T. Segraves -- Erectile dysfunction / K. Wylie -- Recent advances in the classification, neurobiology, and treatment of.*

Sexual dysfunction disorders may be classified into four categories: Sexual desire disorders[ edit ] Main article: Hypoactive sexual desire disorder Sexual desire disorders or decreased libido are characterized by a lack or absence for some period of time of sexual desire or libido for sexual activity or of sexual fantasies. The condition ranges from a general lack of sexual desire to a lack of sexual desire for the current partner. The condition may have started after a period of normal sexual functioning or the person may always have had no or low sexual desire. The causes vary considerably, but include a possible decrease in the production of normal estrogen in women or testosterone in both men and women. Other causes may be aging, fatigue, pregnancy, medications such as the SSRIs or psychiatric conditions, such as depression and anxiety. While a number of causes for low sexual desire are often cited, only some of these have ever been the object of empirical research. Sexual arousal disorder Sexual arousal disorders were previously known as frigidity in women and impotence in men, though these have now been replaced with less judgmental terms. In men, there may be partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity. There may be physiological origins to these disorders, such as decreased blood flow or lack of vaginal lubrication. Chronic disease can also contribute, as well as the nature of the relationship between the partners. Additionally, the condition postorgasm illness syndrome POIS may cause symptoms when aroused, including adrenergic-type presentation; rapid breathing, paraesthesia, palpitations, headaches, aphasia, nausea, itchy eyes, fever, muscle pain and weakness and fatigue. From the onset of arousal, symptoms can persist for up to a week in patients. The aetiology of this condition is unknown, however it is believed to be a pathology of either the immune system or autonomic nervous systems. It is defined as a rare disease by the NIH but the prevalence is unknown. It is not thought to be psychiatric in nature, but it may present as anxiety relating to coital activities and thus may be incorrectly diagnosed as such. There is no known cure or treatment. Erectile dysfunction Erectile dysfunction or impotence is a sexual dysfunction characterized by the inability to develop or maintain an erection of the penis. There are various underlying causes, such as damage to the nervi erigentes which prevents or delays erection, or diabetes as well as cardiovascular disease, which simply decreases blood flow to the tissue in the penis, many of which are medically reversible. The causes of erectile dysfunction may be psychological or physical. Psychological erectile dysfunction can often be helped by almost anything that the patient believes in; there is a very strong placebo effect. Physical damage is much more severe. One leading physical cause of ED is continual or severe damage taken to the nervi erigentes. These nerves course beside the prostate arising from the sacral plexus and can be damaged in prostatic and colorectal surgeries. Diseases are also common causes of erectile dysfunction; especially in men. Diseases such as cardiovascular disease, multiple sclerosis, kidney failure, vascular disease and spinal cord injury are the source of erectile dysfunction. Folk remedies have long been advocated, with some being advertised widely since the s. The introduction of perhaps the first pharmacologically effective remedy for impotence, sildenafil trade name Viagra , in the s caused a wave of public attention, propelled in part by the news-worthiness of stories about it and heavy advertising. It is estimated that around 30 million men in the United States and million men worldwide suffer from erectile dysfunction. The Latin term impotentia coeundi describes simple inability to insert the penis into the vagina. It is now mostly replaced by more precise terms. Premature ejaculation Premature ejaculation is when ejaculation occurs before the partner achieves orgasm, or a mutually satisfactory length of time has passed during intercourse. There is no correct length of time for intercourse to last, but generally, premature ejaculation is thought to occur when ejaculation occurs in under two minutes from the time of the insertion of

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the penis. SSRI antidepressants are a common pharmaceutical culprit, as they can delay orgasm or eliminate it entirely. A common physiological culprit of anorgasmia is menopause, where one in three women report problems obtaining an orgasm during sexual stimulation following menopause. Sexual pain disorders[ edit ] Sexual pain disorders affect women almost exclusively and are also known as dyspareunia painful intercourse or vaginismus an involuntary spasm of the muscles of the vaginal wall that interferes with intercourse. Dyspareunia may be caused by insufficient lubrication vaginal dryness in women. Poor lubrication may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause, pregnancy, or breastfeeding. Irritation from contraceptive creams and foams can also cause dryness, as can fear and anxiety about sex. It is unclear exactly what causes vaginismus, but it is thought that past sexual trauma such as rape or abuse may play a role. Another female sexual pain disorder is called vulvodynia or vulvar vestibulitis. In this condition, women experience burning pain during sex which seems to be related to problems with the skin in the vulvar and vaginal areas. The cause is unknown. Post-orgasmic diseases[ edit ] Post-orgasmic diseases cause symptoms shortly after orgasm or ejaculation. Post-coital tristesse PCT is a feeling of melancholy and anxiety after sexual intercourse that lasts for up to two hours. Sexual headaches occur in the skull and neck during sexual activity, including masturbation, arousal or orgasm. In men, postorgasmic illness syndrome POIS causes severe muscle pain throughout the body and other symptoms immediately following ejaculation. The symptoms last for up to a week. From the onset of orgasm, symptoms can persist for up to a week in patients. It is a culture-bound syndrome which causes anxious and dysphoric mood after sex, but is distinct from the low-mood and concentration problems acute aphasia seen in postorgasm illness syndrome. Pelvic floor dysfunction[ edit ] Pelvic floor dysfunction can be an underlying cause of sexual dysfunction in both women and men, and is treatable by physical therapy. Vascular disease is common in individuals who have diabetes, peripheral vascular disease, hypertension and those who smoke. Any time blood flow to the penis is impaired, erectile dysfunction is the end result. Hormone deficiency is a relatively rare cause of erectile dysfunction. In individuals with testicular failure like in Klinefelter syndrome, or those who have had radiation therapy, chemotherapy or childhood exposure to mumps virus, the testes may fail and not produce testosterone. Other hormonal causes of erectile failure include brain tumors, hyperthyroidism, hypothyroidism or disorders of the adrenal gland. The disease is characterized by thick fibrous bands in the penis which leads to a deformed-looking penis. Individuals who take drugs to lower blood pressure or use antipsychotics, antidepressants, sedatives, narcotics, antacids or alcohol can have problems with sexual function and loss of libido. This condition develops when blood gets trapped in the penis and is unable to drain out. If the condition is not promptly treated, it can lead to severe scarring and permanent loss of erectile function. The disorder occurs in young men and children. Individuals with sickle-cell disease and those who abuse certain medications can often develop this disorder. These may result from emotional or physical causes. Emotional factors include interpersonal or psychological problems, which can be the result of depression, sexual fears or guilt, past sexual trauma, and sexual disorders, [27] among others. Sexual dysfunction is especially common among people who have anxiety disorders. Ordinary anxiousness can obviously cause erectile dysfunction in men without psychiatric problems, but clinically diagnosable disorders such as panic disorder commonly cause avoidance of intercourse and premature ejaculation. Diseases such as diabetic neuropathy, multiple sclerosis, tumors, and, rarely, tertiary syphilis may also impact the activity, as could the failure of various organ systems such as the heart and lungs, endocrine disorders thyroid, pituitary, or adrenal gland problems, hormonal deficiencies low testosterone, other androgens, or estrogen and some birth defects. Pelvic floor dysfunction is also a physical and underlying cause of many sexual dysfunctions. This can be very distressing for the male partner, causing poor body image, and it can also be a major source of low desire for these men. If a woman has not been participating in sexual activity regularly in particular, activities involving vaginal penetration with her partner, if she does decide to engage in penetrative intercourse, she will not be able to immediately accommodate a penis without risking pain or injury. Not all cultures seek treatment; for example, a population of men living in Mexico often accept erectile dysfunction as a normal part of their maturing

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sexuality. Three social psychological theories include: Many women perceived sex as a chore as opposed to a pleasurable experience, and they tend to consider themselves sexually inadequate, which in turn does not motivate them to engage in sexual activity. A study has found that African American women are the most optimistic about menopausal life; Caucasian women are the most anxious, Asian women are the most inhibited about their symptoms, and Hispanic women are the most stoic. Since these women had sexual problems, their sexual lives with their partners became a burden without pleasure, and eventually, they may completely lose interest in sexual activity. Some of the women found it hard to be aroused mentally; however, some had physical problems. Several factors can affect female dysfunction, such as situations in which women do not trust their sex partners. The environment where sex occurs is crucial, since being in an extremely public or extremely private place may make some women feel uncomfortable. The most prevalent of female sexual dysfunctions that have been linked to menopause include lack of desire and libido; these are predominantly associated with hormonal physiology. Androgen depletion may also play a role, but currently this is less clear. Testosterone, along with its metabolite dihydrotestosterone, is extremely important to normal sexual functioning in men and women. Dihydrotestosterone is the most prevalent androgen in both men and women.

### Chapter 5 : A Descriptive Analysis of Patients Presenting to Psychosexual Clinic at a Tertiary Care Center

*Introduction: new developments in the area of sexual dysfunction(s) / R. Balon --Clinical and research evaluations of sexual dysfunctions / L.R. Derogatis --Management of hypoactive sexual desire disorder / R.T. Segraves --Erectile dysfunction / K. Wylie --Recent advances in the classification, neurobiology, and treatment of premature.*

### Chapter 6 : Advances in the treatment of erectile dysfunction: what's new and upcoming? - FResearch

*Introduction: New Developments in the Area of Sexual Dysfunction(s) February 2011. Advances in psychosomatic medicine  
New developments in the area of sexual dysfunction, e.g. epidemiology and.*