Human sexuality in physical and mental illnesses and disabilities

Sha'ked, Ami

Published by Indiana University Press

Sha'ked, Ami.

Human sexuality in physical and mental illnesses and disabilities.

Project MUSE. muse.jhu.edu/book/113364.

For additional information about this book
https://muse.jhu.edu/book/113364

For content related to this chapter
https://muse.jhu.edu/related_content?type=book&id=3628868
Chapter Three

Genitourinary Conditions

Urologic Illness / Gynecologic Diseases

Various genital anomalies in the male and their effect on sexual functioning are discussed in this article, with some suggestions for corrective surgery and treatment. The author suggests that "many hypospadias, epispadias, and associated anomalies can be corrected if well established surgical techniques are employed at the most opportune time." He adds that congenital urethral defects will not impair sexual functioning if an adequate reconstruction surgery is conducted.


The purpose of this study was to assess the effect of open perineal prostatic biopsy on sexual potency of patients (n=24). Results show that there were no changes in potency in one-third of the patients, while 37 percent reported diminution of potency after perineal biopsy, and 29 percent had complete loss of potency. The average age of those who suffered complete loss was 64.4 years, whereas the average age of those whose potency was unchanged was 53.7 years. Other results and conclusions are presented.


The relationship between prostatitis and sexual function is the main topic discussed in this article. Also presented are some ideas for accurate diagnosis and treatment of the condition.

According to the authors, the belief that urologic disease implies termination of sexual activity is in most cases unfounded. This paper discusses the psychosexual implications of urologic disease and the effects of urologic surgery on sexual functioning. It is concluded that most urologic conditions, whether medical or surgical in nature, usually do not result in permanent sexual dysfunction.


The relationship between infrequent sexual activity or inadequate sexual gratification and benign prostatic hyperplasia is examined and discussed. The author could not find a one-to-one correlation between benign prostatic hyperplasia and sexual functioning in aging men.


Sexual dysfunction is one of the long-term hazards of fractured pelvis and ruptured urethra. Subjects in this study were 35 male patients who were admitted to Sydney Hospital with fractured pelvis and ruptured urethra and who were available for follow-up examination over a period of three years or longer. Impotence was found in 13 patients (37 percent). Of the 26 patients who sustained a complete rupture of the membranous urethra, 11 were impotent (42 percent). Only 5 of the 35 patients fathered children after injury. The author indicates that the cause of impotence in these patients seems to be an interference with neural control. Damage with thrombosis of the dorsal and deep arteries of the penis in the region of the perineal membrane may also be responsible for impotence in some patients who had experienced ejaculation without erection.


Elephantiasis of the male genitalia is a physically, psychosocially, and sexually debilitating disease. These aspects of the disease are discussed, as are its etiology and treatment. Sexual rehabilitation usually follows treatment in otherwise well-motivated and adjusted patients.

Various urologic factors and diseases affecting sexual potency are presented. The medical conditions that may cause impotency and difficulties in ejaculation include diseases of the nerve or blood supply, prostatic and urethral disease, and diabetes. Also discussed are the effects of surgery and of drug treatment on sexual functioning in male patients.


Physiologic and psychogenic considerations associated with sexual difficulties following urologic surgery are discussed, and specific suggestions for treatment and counseling are presented.


The clinical presentation of Peyronie’s disease includes tumors in the corpora cavernosa, associated with curved and painful penile erections. The physical, sexual, and treatment aspects of this disease are discussed. It was found that painful erections are present in 56 percent to 64 percent of patients. This complaint is more prevalent in younger patients.


The authors discuss the relationship between benign prostatic hyperplasia and associated alteration in sexual functioning and activity. Reduced sexual libido in older patients seems to complicate the evaluation of sexual potency following surgery. However, there is evidence that prostatectomy is associated with a decrease or loss of sexual potency. The authors state that “the consensus of opinion is that perineal prostatectomy will cause impotence in 30–40 per cent of patients, suprapubic and retropubic prostatectomy in 15–20 per cent of patients, and transurethral prostatectomy in 5–40 per cent of patients.” Also discussed are the physiology of erection and the treatment of impotence.

In this article the author discusses several types of urologic surgery and their effects on sexual functioning in the male. While some surgical procedures result in impotence and/or sterility in the male, psychogenic causes account for a significant amount of postoperative impotence. The urologic procedures discussed are total and partial penectomy, prostatectomy for malignant and benign tumors, and vasectomy. Regardless of the urologic surgery it is vital for the physician to explain the procedure adequately to the patient and his wife. Since many urologic surgeries threaten the male's body image and sexuality, adequate psychological preparation for the patient and his wife is also necessary. The attitude of the physician toward the patient and his surgery can influence the outcome of the surgery. If the physician takes the time to explain thoroughly the possible and/or inevitable effects of the surgery to the patient and his wife, much can be done to prevent psychogenic impotence.


Urogenital conditions affecting male and female patients and their impact on sexual intercourse are discussed in this brief communication. Also presented are suggestions for therapy and office counseling by a physician. Specific urogenital problems presented include infectious urethritis, herpes, traumatic urethritis, prostatitis, anatomical deformities, and vaginitis.


The author defines Peyronie's disease as "a plaque-like fibrous induration of the penis accompanied by a painful erection and eventual chordee." The pathology, symptoms, clinical course, and medical and surgical treatment of the condition are discussed in this paper.


Urologic conditions affecting sexual responsivity and enjoyment are discussed in light of a case report that illustrates the difficulties involved.


The author discusses sexual difficulties and dysfunctions associated with urethral stricture, a narrowing and hardening of a portion of the
Genitourinary Conditions

urinary canal. This condition occurs mostly in men. Also presented is a case study to illustrate the sexual complications of this condition. Suggestions for treatment are given.


Based on their clinical observations and experience, the authors stress that “many patients experience sexual difficulties as a result of genitourinary problems. In others, the inadequacy of their sexual experience may be one of the underlying causes of their urologic complaints.” In this paper, the authors discuss the relationships between urological symptoms and sexual dysfunctions in light of several case studies from their clinical practice.


The psychosocial and sexual development aspects of undescended testes are discussed in this paper, followed by a commentary by another authority. Based on their clinical experience and other findings, the authors conclude that the psychological factor is very important in the timing of therapy, and they advise that both testes be in the scrotum by the fifth birthday.


Because of their close relationship, any disturbance in the urinary system may affect sexual functioning. The impact of various urinary disorders on sexual function and behavior is examined in this paper.


Various organic disorders and diseases of the male’s genital organs and their effect on sexual function and behavior are presented and discussed. Specific abnormalities discussed include hypoplasia of the penis, hypospadias, epispadias, Peyronie’s disease, monorchism, anorchism, and other conditions.

Dyspareunia resulting from atrophic vaginitis often interferes with satisfactory sexual intercourse in menopausal women. This and other sexual dysfunctions and behavior associated with atrophic vaginitis are discussed in this paper in light of the author’s clinical experience. The prevention and treatment of this condition becomes clinically important after the menopause and after childbirth, especially with lactation. Low estrogen levels and thin vaginal epithelium are biologically normal in these two periods. The author stresses that “it is not unusual for a tiny dose of exogenous estrogen to help appreciably” in cases of dyspareunia associated with atrophic vaginitis. A commentary by two medical authorities follows this article.


Reflecting upon her extensive clinical experience, the author identifies and discusses the relationships between various gynecological problems and marital and sexual dysfunctions. She presents several clinical case reports to illustrate these relationships. Also outlined are the gynecologist’s responsibilities in alleviating marital and sexual problems associated with gynecological conditions.


The effects of gynecologic surgery on the patient’s sexual behavior and functioning is discussed in light of the nurse’s role and responsibility in alleviating the patient’s concerns and difficulties. The importance of preoperative counseling is stressed.


Follow-up study was conducted with 243 women who underwent various types of vaginal operations. Coital function before and after
operation was studied and compared. Apareunia and dyspareunia were commonly found in postoperative patients. Conclusions are presented in light of detailed results of this study.


Various coital problems and difficulties related primarily to abnormalities of the hymen are discussed in this paper. One of the main problems identified is hymenal dyspareunia, which can be relieved by appropriate medications, psychotherapy, or surgery.


The purpose of this study was to further examine the effects of gynecologic surgery on sexual function. The report was prepared after reviewing the records of 317 private patients who were seen over a period of one year. The study excluded women less than 16 years of age, single, widowed, or divorced women, those whose husbands were impotent, those in whom vaginal obliteration was necessary, and those in whom reconstructive surgery had been performed without genital excision. Results show that of the 317 women, 10 reported a decrease in their sexual reactions, 40 stated their sex life was better, and 267 found no change. Of the 10 who reported a decrease in sexual activity, 9 were found to have extraneous factors diminishing sexual capacity. The report hypothesized on the emotional stress of surgery and discussed the importance of preoperation screening and patient education. The author concludes that following gynecologic surgery alterations in sexual reactions are infrequent if the patient is stable and has been adequately prepared preoperatively as to what to expect. If physicians fail to instruct, the author predicts, a great many women will have emotional and sexual problems.


The author asserts that when dyspareunia is present and there is a retrodisplacement of the uterus the pain is, “in the majority of cases, due to other pelvic disorders rather than the retrodisplacement itself.” This article discusses various pelvic disorders associated with coital pain and presents some therapeutic modalities.

Amenorrhea is the pathological absence of menstruation in a woman who has previously experienced normal menstrual cycles. The psychological and sexual aspects of this condition are discussed.


Painful menstruation may reflect or contribute to sexual conflicts and difficulties. In this article, the author discusses the psychosexual aspects of dysmenorrhea, outlining the sexual problems, the effect of the condition on feminine self-image, and therapy.


The effect of obstetric trauma on sexual function and activity of women is examined and discussed. Some preventative measures are presented. The author concludes that "proper emotional preparation of the patient for labor during her prenatal course, along with prevention of obstetric trauma, is the best means of assuring satisfactory sex relations after the puerperium."


The effect of gynecologic illness and surgery on sexual function and activity is discussed. The author asserts that "sexual problems can be intertwined with gynecologic illness, can be influenced, can be ameliorated, can be exacerbated, and can be eradicated by such illness, but rarely does gynecologic illness of itself create a severe and lasting sexual problem." Several case histories are presented for illustration, and suggestions for management are made.


The complaint of change in a woman's sexual behavior pattern may be an indication of an underlying gynecologic illness. The relationship between gynecological disorders and sexual function and interest is discussed, and treatment and counseling modalities are presented.


Some women with uterine prolapse experience painful intercourse which may lead to alterations in sexual behavior. This and other sex-
ual aspects of this medical condition are discussed. The importance of preoperative counseling is stressed.


The psychosocial, developmental, and sexual aspects of various vaginal anomalies are discussed, along with suggestions for treatment and counseling.


The authors complain that “when a patient requires an exenterative procedure for carcinoma of the cervix, the surgeon seldom gives any thought to sexual activity of the patient.” They present a case report of a patient whose postoperative sexual activity was considered. The paper reports on the use of amniotic membrane to maintain a vaginal opening in a 54-year-old patient. The authors conclude that “it is possible that in the future more consideration to the production of an artificial vagina at the time of exenterative procedures may be undertaken.”