SHORT COMMUNICATION

Screening for sexual dysfunction – Against

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To 'screen' is to perform a mass examination of the population with the understanding that there will be a health benefit that outweighs the costs and inconvience. While sexual dysfunction is a common problem and treatment is often effective, it is a lifestyle condition and does not warrant the use of precious health care resourses to survey and treat the general Canadian population.

Key Words: *Lifestyle; Mass examination*

Contre le dépistage du dysfonctionnement sexuel

« Dépister » signifie procéder à un examen général de la population qui comporte des bienfaits pour la santé, supérieurs aux coûts et aux inconvénients qu'il engendre. Même si le dysfonctionnement sexuel constitue un problème fréquent et que le traitement se montre souvent efficace, il s'agit d'un trouble lié au mode de vie et il ne justifie pas l'utilisation de ressources rares et précieuses en santé pour examiner et traiter la population en général au Canada.

Of course, no one should ever screen for sexual dysfunction. In fact, there are very few things in medicine for which screening can be justified if one uses a proper definition. When we screen, we are subjecting a population who is feeling perfectly fine to a test (eg, Pap smear, prostate-specific antigen [PSA] or a sexual function questionnaire) and then a possible intervention to benefit the health of that population. If the stakes are high – for example, life or death, then certain costs or inconveniences can be justified to those who screen negatively and do not receive the intervention. For example, Pap smears dramatically lower the chance of dying from cervical cancer, so women endure the embarrassment and discomfort of having the test and our public medical insurance pays the costs. A few women will benefit dramatically and the rest of us share a small cost. Compared with other things doctors might screen for, including high blood pressure or cholesterol, hematuria and PSA (in some enlightened areas), how would screening for sexual dysfunction stand up?

Perhaps the first issue is whether the condition is common enough to warrant asking the question. There is little doubt that a huge number of men and women suffer from sexual dysfunction, particularly in the elderly population. There is no doubt that it is a widespread problem.

How much suffering does this problem cause? Treating high blood pressure can prevent a stroke. A screening urinalysis showing hematuria might lead to early diagnosis of an urothelial tumour. Screening for elevated cholesterol may eventually prevent a heart attack. Screening for sexual dysfunction may...well, we know that sexual activity can result in death (0.6% of sudden deaths), but death from a lack of sex (while often a part of sexual negotiations) is extraordinary in the scientific literature. Most of the conditions we screen for have catastrophic consequences if left untreated. Screening subjects healthy people to a possible intervention and the level of evidence showing that it is beneficial needs to be extremely high. Look at all the tip-toeing around the PSA issue – common sense leads virtually all family doctors to screen for prostate cancer, but PSA screening is not yet endorsed by any of the major urologic societies. So far, the definitive data showing that we change the natural history of the disease are thought to be insufficient.

Given that so many individuals have sexual dysfunction, could the cumulative suffering, albeit minor, add up to a whole that would justify screening? Perhaps, but this would assume that screening could identify those individuals with the problem and could offer them effective and inexpensive therapy. As far as male sexual dysfunction is concerned, most of those people with a problem can probably be identified by taking a simple history. Investigations are used less and less frequently, and most patients will go from identification of the problem to treatment in the same visit. If we looked at a hypothetical example that would best favour screening, we might think of a 60-year-old man in perfect health who, because of his age, has a greater than 50% chance of having erectile dysfunction (ED). At his annual doctor's visit, he admits after screening to having the problem. The best scenario I can imagine is that he is one of those 70% who respond to sildenafil citrate, he has no significant side effects and that his life is better for it. This man, however, did not come to the office asking for sildenafil. He may not want to talk about his sex life. He may be embarrassed about this prying into his personal affairs that have nothing to do with his medical care. Only 27% of men who have ED have tried sildenafil and maybe the rest want to be left alone. Many rewarding sexual encounters involve a partner and, unfortunately, treatment often tends to involve an individual and not a couple. Medicine cabinets are filled with sildenafil sample boxes that failed to ignite the flame in disinterested partners.

Screening is usually thrust upon a population based on a paternalistic decision. Most people do not weigh the pros and

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cons of each test in their yearly blood work; they just do what the doctor suggests. Because we, as doctors, make that decision, we are responsible for the costs. Lives saved (or penises raised) per dollar spent. Sildenafil (for example) is $15 per use – multiply that by the number of individuals who are at risk (more than 3 million in Canada) and the frequency of use (veterans are insured for eight tablets per month, which equals $120/month, or $1440/year) and the costs are enormous (billions). There may be costs to health as well as wealth. Sexual activity carries small cardiovascular risks, and when this activity wanders outside the conjugal relationship, the risk of both cardiovascular and financial catastrophe escalates quickly.

Sex is recreational, but it is also part of a healthy relationship. But let's not get too mushy. Kissing is part of a healthy relationship. Maybe we should screen for kissing. "Any blood in the stool? Loss of weight? Good kissing?" Sure, kissing can have certain risks – cold sores, mononucleosis and hygiene issues, but at least the public pot will not be coughing up to pay for more kissing when we live in a country without sufficient medical resources to look after basic health – 4.5 million Canadians have no family doctor. Treatment for sexual dysfunction should be for those who are motivated to seek treatment. We no longer live in a world that is sheltered from medical advances and patients are very aware of the treatments that are available. Let's not play up the 'relationship' up too much, either. Many men are not thinking about 'the relationship' and may not even want a relationship – they are seeking pleasure, pure and simple.

Screening affects whole populations, is expensive and deserves rigorous outcome analysis. In Canada, sexual dysfunction is common and often treatable (although rarely cured) but is a lifestyle condition and does not warrant screening. We cannot prove that it makes the population healthier.