Medication in the integrated treatment method of sexual dysfunctions

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INTRODUCTION

The authors agree with integration between bio-drugs (hormones, pro-erectogenic vasoactive drugs) and psychotherapy in treating sexual dysfunctions as currently widespread practice (bi-integration), but they support the use of a triple integration as a further therapeutic interaction between bio-drugs, psychotherapy and psychiatric medications.

The latter, which have so far been rarely used in sexology, may be decisive in treating psychogenic sexual disorders. Moreover, they often prove to be extremely useful even also in those conditions of prevalently organic aetiology.

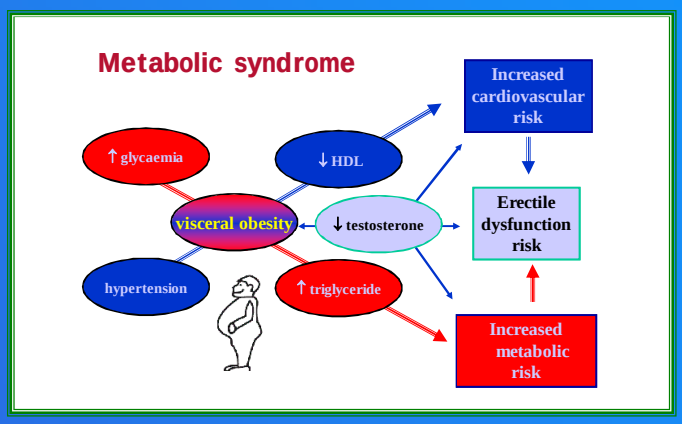
AIMS

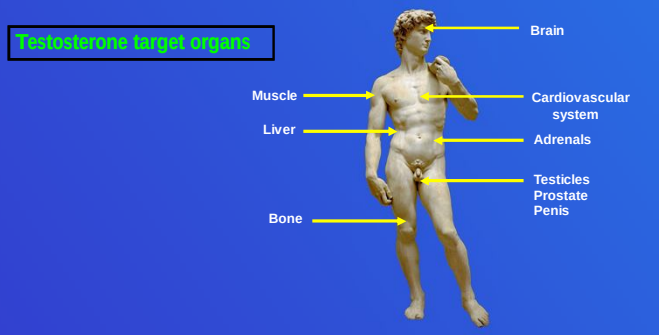
The aims of this paper are:
✓to evaluate the integration between bio-drugs and psychotherapy in treating sexual dysfunctions
✓ to support the use of a triple integration as a further therapeutic interaction between bio-drugs, psychotherapy and psychiatric medications when the latter may be effective from a sexual point of view, too.

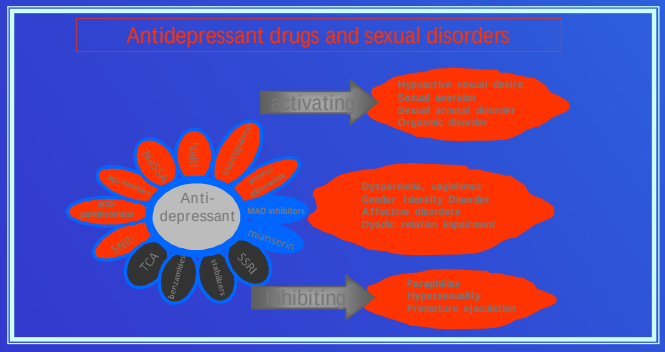
KEY EVIDENCE

Antidepressant drugs act on phobic and depressive factors, anxiolytic drugs on anxiety, neuroleptic medications on aggressive or delirious symptoms, which may be present in organic sexual disorders.

Noteworthy, antidepressant drugs may have both inhibitory or activating effects on sexuality.







CASE REPORT

Patient's history

A 60 year old patient had attended the andrologist's for organic erectile dysfunction (metabolic syndrome and hypogonadism, smoker).

Metabolic profile: fasting glucose 120 mg/dl (range 70-100), *glucose after 120' OGTT 240 mg/dl* (< 140), *HbA1c 7.1%*, total cholesterol 270 mg/dl, cholesterol HDL 30 mg/dl (> 40 mg/dl), triglyceride 263 mg/dl (<150), *non – HDL cholesterol 240 mg/dl*).

Hormonal status: *total testosterone 1.9 ng/ml* (range 3-10), LH 7.8 mU/ml (range 1.5-7), PRL 4 ng/ml (range 2-12), TSH 1.4 mUI/l (range 0.25-3.50).

Treatment

Initially the *andrologist-endocrinologist* treated the patient with a diet, increased physical exercise, testosterone replacement therapy, and pro-erectogenic medication when needed.

A *psycho-sexologist* also assisted the patient with sexual therapy for psychic and relational distress relapses. During couple sex therapy a state of low mood emerged which interfered with the recovery of sexual pleasure.

A good success was achieved by integration with Bupropione 150 mg/die prescribed by a *psychiatrist* trained in sexology.

CONCLUSION

Successful treatment of this patient was obtained by the collaboration among the andrologist (who treated hypogonadism and metabolic syndrome), the psychosexologist (who allowed to recover the dyadic interaction), and the psychiatrist.

Co-treatment with psychiatric medications has to be managed by psychiatrists with training in sexology and who are skilled in the receptor spectrum at the single molecule level in order to avoid inhibitor side effects and to encourage those which activate sexuality.

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