197 - Treatment of sexual dysfunction

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198 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 1 Treatment of sexual dysfunction Before attempting to treat sexual dysfunction, a thorough assessment is essential to determine the most likely cause. A large meta-analysis of 72 studies from 33 different countries found that for patients with schizophrenia spectrum disorders, concurrent antidepressant and mood stabiliser prescriptions were associated with lower rates of erection and ejaculation disorders.1 This suggests that treating a comorbid depression or mood disorder is an important strategy to improve sexual health. Assuming that psychiatric comorbidity or physical pathology (diabetes, hypertension, cardiovascular disease, etc.) has been excluded or treated (e.g. obesity),78 the following principles apply when considering the prescribing of antipsychotics: ■ ■Spontaneous remission may occasionally occur33 but may take 6 months to become apparent, if at all,30 and may be more likely related to a reduction in severity of illness, rather than tolerance to the antipsychotic itself. ■ ■When symptoms persist, the most obvious first step is to decrease the dose (although a correlation between dose and all types of sexual dysfunction has not been conclusively demonstrated)79 or discontinue the offending drug, where appropriate. ■ ■The next step is to switch to a different drug that is less likely to cause the specific sexual problem experienced (Table 1.46). Another option is to add 5–10mg aripiprazole – this can normalise prolactin and improve sexual function.37,80 ■ ■If this fails or is not practicable, ‘antidote’ drugs can be tried: for example, cyproheptadine (a 5HT2 antagonist at doses of 4–16mg/day) has been used to treat SSRI- induced sexual dysfunction but sedation is a common adverse effect. There is some evidence that mirtazapine (also a 5HT2 antagonist as well as an α2 antagonist) may relieve orgasmic dysfunction in patients treated with FGAs.81 Amantadine, bupropion, buspirone, bethanechol and yohimbine have all been used with varying degrees of success but have several adverse effects and interactions with other drugs. Given that hyperprolactinaemia contributes to sexual dysfunction, selegiline, which enhances dopamine activity, has been investigated but was not effective.82 Testosterone patches have been shown to increase libido in women, although breast cancer risk may be significantly increased.83,84 Table 1.46 lists remedial treatments for psychotropic-induced sexual dysfunction.

Schizophrenia and related psychoses CHAPTER 1 Table 1.46 Remedial treatments for psychotropic-induced sexual dysfunction. Drug Pharmacology Potential treatment for Adverse effects Alprostadil12,85 Prostaglandin Erectile dysfunction Pain, fibrosis, hypotension, priapism Amantadine85,86,87 Dopamine agonist Prolactin-induced reduction in desire and arousal (dopamine increases libido and facilitates ejaculation) Return of psychotic symptoms, GI effects, nervousness, insomnia, rash Bethanechol88 Cholinergic or cholinergic potentiation of adrenergic neurotransmission Anticholinergic-induced arousal problems and anorgasmia (from TCAs, antipsychotics, etc.) Nausea and vomiting, colic, bradycardia, blurred vision, sweating Bromocriptine9 Dopamine agonist Prolactin-induced reduction in desire and arousal Return of psychotic symptoms, GI effects Bupropion89,90 Noradrenaline and dopamine reuptake inhibitor SSRI-induced sexual dysfunction Concentration problems, reduced sleep, tremor Buspirone91 5HT1a partial agonist SSRI-induced sexual dysfunction, particularly decreased libido and anorgasmia Nausea, dizziness, headache Cyproheptadine85,91,92 5HT2 antagonist Sexual dysfunction caused by increased serotonin transmission (e.g. SSRIs), particularly anorgasmia Sedation and fatigue. Reversal of the therapeutic effect of antidepressants. Flibanserin (licensed in USA)93 5HT1A agonist, 5HT2A antagonist, dopamine antagonist Lack or loss of sexual desire in premenopausal women. Appears to be safe in women taking antidepressants.94 Hypotension, syncope, sedation, dizziness, nausea, dry mouth Sildenafil,12,95–98 tadalafil,99 lodenafil,100 vardenafil101 Phosphodiesterase inhibitors Erectile dysfunction of any aetiology. Anorgasmia in women. Effective even when prolactin raised. Mild headaches, dizziness, nasal congestion Yohimbine12,85,102–104 Central and peripheral α2 adrenoceptor antagonist SSRI-induced sexual dysfunction, particularly erectile dysfunction, decreased libido and anorgasmia Anxiety, nausea, fine tremor, increased blood pressure, sweating, fatigue Pimavanserin74 Inverse agonist at 5HT2A and 5HT2C Sexual dysfunction in depression with inadequate response to antidepressants. Improvement in sexual function independent of effect on depression unconfirmed. Peripheral oedema, nausea, confusion Bremelanotide105 Melanocortin receptor agonist Hypoactive sexual desire in premenopausal women. No published data on use in patients with psychiatric diagnoses. Flushing, nausea, headache Note: The use of the drugs listed above should ideally be under the care or supervision of a specialist in sexual dysfunction. GI, gastrointestinal; TCA, tricyclic antidepressant.

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