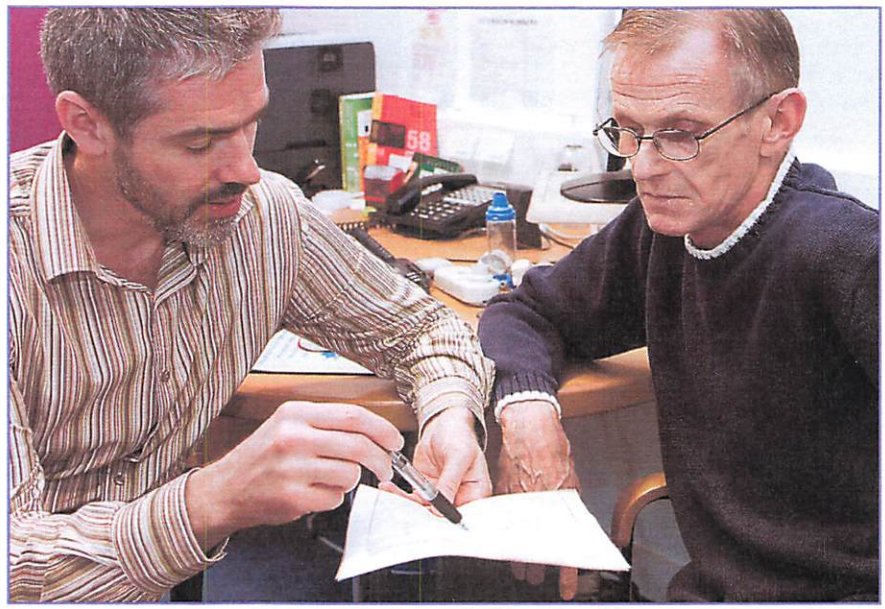
The use of questionnaires to assess sexual function

GEOFFREY HACKETT

Questionnaires are often seen as time-consuming in a busy clinic or surgery and more suited to clinical research. They can be useful to help diagnosis and to provide a baseline against which to monitor changes in symptoms and response to therapeutic interventions. Dr Hackett provides a guide to the most useful questionnaires in the sexual health area.



Questionnaires can help show patients progress they may have made with a treatment (© Life in View/Science Photo Library)

ERECTILE DYSFUNCTION (ED)

The International Index of Erectile Function (IIEF) is a 15-item assessment tool developed to assess changes in the five domains of erectile function for trials involving medications such as phosphodiesterase type 5 inhibitors (PDE5Is). While generally regarded as too time-consuming for use in the clinic, the shortened version, the IIEF-5 or Sexual Health Inventory for Men (SHIM), takes only two to three minutes to complete (Figure 1).

It provides important information on:

1. Baseline ED severity (mild, moderate or severe)
2. Confidence in getting and maintaining erection
3. Assessment of change with treatment

These assessments can be particularly important when patients are reviewed by different healthcare professionals (HCPs), and to demonstrate therapeutic response to the patient. It can also be very useful to distinguish between ED and premature ejaculation (PE), especially as both conditions frequently co-exist in the same patient. Men with PE often produce low scores, as their confidence is low and they are not satisfied with the sexual experience because they have ejaculated too quickly.

The Erection Hardness Scale (EHS) involves a 1–4 response to a single question to assess firmness of erection, where 3 is sufficient for penetration and 4 is a rigid erection (Figure 2). The sheer simplicity of the EHS means that no paperwork is involved and an answer is obtained in seconds. The EHS is criticised by therapists as only assessing one dimension of sexual function, namely erection firmness.

Geoffrey Hackett, Consultant in Urology and Andrology, Good Hope Hospital, Sutton Coldfield, Birmingham

OVER THE PAST 6 MONTHS						
1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
Add the numbers corresponding to questions 1–5.						TOTAL:
The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints: 1–7 severe ED 8–11 moderate ED 12–16 mild to moderate ED 17–21 mild ED						

Figure 1. The Sexual Health Inventory for Men (SHIM) takes only two to three minutes to complete and provides useful information to assess erectile function

The Sexual Encounter Profile (SEP) is a log diary completed after each sexual attempt, providing information as to whether the erection was hard enough to penetrate (SEP 2), or whether it was maintained for completion (SEP 3) or a satisfactory sexual experience (SEP 4). This provides accurate information as to precise effect and speed of onset, but is time-consuming and largely used for research purposes.

0 – Penis does not enlarge
1 – Penis is larger, but not hard
2 – Penis is hard, but not hard enough for penetration
3 – Penis is hard enough for penetration, but not completely hard
4 – Penis is completely hard and fully rigid

Figure 2. The Erection Hardness Score (EHS) is a single-item Likert scale. The tool asks men to consider the question 'How would you rate the hardness of your erection?' and select one of the options above

The International Prostate Symptom Score (IPSS) is often conducted at the same time as the IIEF or SHIM as lower urinary tract symptoms (LUTS) is the most common shared comorbidity (Figure 3). In addition, PDE5Is are highly effective for both ED and LUTS (only tadalafil [Cialis] 5mg licensed), such that assessment of improvement in LUTS may be equally as important as improvement in ED. Although cost currently limits the inclusion of daily PDE5Is on formularies, this situation is likely to change significantly when all three first-generation PDE5Is become generic in November 2017, allowing for improvement in both conditions with a single medication. This may mean that men opt to continue with PDE5I therapy due to LUTS improvement even if ED response is modest – a point that may be missed had the severity of LUTS not been assessed.

TESTOSTERONE DEFICIENCY (TD)

The Androgen Deficiency in the Ageing Male (ADAM) score screening tool is designed to detect TD, but the questions lack specificity for quantitative assessment.

The Ageing Males' Symptom (AMS) scale is a well validated 17-item score that is easily completed (five minutes) before a consultation. As the diagnosis of TD involves the presence of symptoms and a finding of low testosterone, the AMS can provide important confirmatory evidence. The three sexual questions (15 – diminished erections with sexual activity, 16 – loss of morning erections and 17 – low sexual desire) along with sweating and flushing are most predictive of low testosterone. Positive results in association with multiple, less specific symptoms are strongly suggestive of TD. In contrast, men with vasculogenic ED typically have poor scores on question 15 and 16 but preserved desire. Men with

INTERNATIONAL PROSTATE SYMPTOM SCORE (I-PSS)
Patient Name: Date of birth: Date completed:

In the past month:	Not at all	Less than 1 in 5 times	Less than half the time	About half the time	More than half the time	Almost always	Your score
1. Incomplete emptying How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
2. Frequency How often have you had to urinate less than every two hours?	0	1	2	3	4	5	
3. Intermittency How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
4. Urgency How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
5. Weak Stream How often have you had a weak urinary stream?	0	1	2	3	4	5	
6. Straining How often have you had to strain to start urination?	0	1	2	3	4	5	
	None	1 Time	2 Times	3 Times	4 Times	5 Times	
7. Nocturia How many times did you typically get up at night to urinate?	0	1	2	3	4	5	
TOTAL I-PSS SCORE							

Score: 1–7 mild 8–19 moderate 20–35 severe

Quality of life due to urinary symptoms	Delighted	Pleased	Mostly satisfied	Mixed	Mostly dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6

Figure 3. The International Prostate Symptom Score (IPSS) is often conducted during consultations around erectile dysfunction due to the comorbidity with lower urinary tract symptoms

psychogenic ED typically have preserved morning erections on question 16 and preserved desire on question 17. Use of the AMS scale in this way might reduce the need for elaborate biochemical assessment when resources are limited.

The AMS can be extremely helpful in writing clinic letters and reviewing notes from other HCPs where the details of initial history are sketchy or illegible. That the AMS clearly diagnoses the severity of TD and justification for therapy is of fundamental importance in the case that other physicians later question the validity of treatment based on biochemistry results. The AMS also produces clear evidence for response with time that can be demonstrated to the patient and

RESOURCES

- International Index of Erectile Function (IIEF), Sexual Health Inventory for Men (SHIM) and Premature Ejaculation Diagnostic Tool (PEDT) (https://www.ktph.com.sg/uploads/1390966536Website%20tables%20scores%20chart.pdf)
- International Prostate Symptom Score (IPSS) (http://www.urospec.com/uro/Forms/ipss.pdf)
- Ageing Male's Symptom Score (http://www.issam.ch/AMS_English.pdf)
- British Society for Sexual Medicine. Guidelines on the management of erectile dysfunction (http://www.bssm.org.uk/downloads/BSSM_ED_Management_Guidelines_2013.pdf)

HCPs across multiple symptoms that may be at least as important to the patient as firmness of erections. From personal experience, I have seen many cases where erection-focused HCPs have been looking to discontinue testosterone therapy, only to change their minds when clear evidence of improvement across multiple domains can be demonstrated.

PREMATURE EJACULATION

The Premature Ejaculation Diagnostic Tool (PEDT) can provide baseline evidence of timing, control and patient and partner distress, allowing for accurate baseline assessment and impact of therapeutic interventions.

Despite the clear advantages that will result from accurate quantitative assessment, in practice the Index of Premature Ejaculation (IPE) is less user-friendly than the IIEF and has essentially become a research tool little used in clinical practice.

HISTORY AND EXAMINATION PRO FORMA

Years of experience have taught me the value of a standard history pro forma providing tick boxes of important comorbidities to ensure that these are addressed in addition to effective management of the sexual problem. We have found it equally important to record NHS Schedule 2 qualifying conditions, introduced in 1998 and often not assessed by HCPs only occasionally managing ED. Failure to register associated conditions due to the involvement of multiple HCPs may result in patients being inappropriately charged several hundred, even thousands of pounds for private medications over many years. The duty to recognise and record NHS qualifying conditions clearly rests with the HCP and not the patient, and HCPs are legally liable for financial recompense for inappropriate charges. Likewise, the NHS could potentially recoup charges from the HCP if medication had been incorrectly provided at NHS expense.

CONCLUSIONS

Based on 25 years of clinical experience in managing sexual dysfunction, I would advocate the use of:

- History pro forma to capture important comorbidities
- SHIM
- IPSS
- AMS

Declaration of interests

Geoffrey Hackett has been an occasional speaker for Lilly, Besins and Bayer.