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Prevalence and Clinical Correlates of Sexual Dysfunctions among Male Patients Attending the Outpatient Department of a Tertiary Care Hospital

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Abstract: ***Background:*** Sexual dysfunction (SD) is a common but underreported issue among men, impacting quality of life, mental well-being, and relationships. It includes conditions like erectile dysfunction, premature ejaculation, and low libido. Multiple factors contribute to SD, including chronic illnesses, psychological issues, and unhealthy lifestyles. In developing countries, stigma and lack of awareness hinder proper diagnosis and treatment. This study explores the prevalence and associated factors of SD in a tertiary care hospital setting. ***Objectives:*** To determine the prevalence and associated clinical and sociodemographic factors of sexual dysfunction among male outpatients at a tertiary hospital. ***Method and Materials:*** This cross-sectional study was conducted from June 2020 to May 2021 at Mymensingh Medical College & Hospital, involving 102 male outpatients. Data were collected using structured questionnaires through face-to-face interviews. Inclusion criteria included males aged ≥18 years who consented. Exclusion criteria involved psychiatric illness or incomplete data. Data were analyzed using SPSS v25, with significance at $p<0.05$. Ethical approval was obtained, and participant confidentiality was strictly maintained. ***Result:*** Among the 102 male patients, the most affected age group was 40–49 years (29.4%), with a mean age of 44.6 ± 11.5 years. Erectile dysfunction was the most common issue (66.7%), followed by premature ejaculation (48%). Hypertension (39.2%) and diabetes (35.3%) were the leading comorbidities. Notably, 52.9% had a sedentary lifestyle, and 43.1% reported low self-esteem as a psychological consequence of their sexual dysfunction. ***Conclusion:*** Sexual dysfunction is highly prevalent, linked to comorbidities and lifestyle factors, emphasizing the need for awareness and integrated management.

Keywords: Sexual dysfunction, Erectile dysfunction, Premature ejaculation, Male sexual health, Comorbidities.

Original Researcher Article

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Article at a glance:

Study Purpose: *The study aims to determine the prevalence and clinical correlates of sexual dysfunction among male outpatients at a tertiary care hospital.*

Key findings: *Sexual dysfunction, particularly erectile dysfunction, is prevalent among male patients, with hypertension and diabetes being common comorbidities.*

Newer findings: *This study highlights the impact of sedentary lifestyle and low self-esteem as significant psychological factors associated with sexual dysfunction.*

Abbreviations: *SD - Sexual Dysfunction, ED - Erectile Dysfunction, PE - Premature Ejaculation, BMI - Body Mass Index*

INTRODUCTION

Sexual dysfunction (SD) is a prevalent yet often underreported health issue affecting men worldwide, with significant implications for quality of life, mental health, and interpersonal relationships.[1] It encompasses a range of disorders,

including erectile dysfunction (ED), premature ejaculation (PE), delayed ejaculation, low libido, and orgasmic dysfunction.[2] Studies indicate that the global prevalence of male sexual dysfunction varies widely, ranging from 10% to 52%, depending on demographic factors, comorbidities, and assessment methodologies.[3, 4] In developing countries, cultural stigma and lack of awareness further contribute to underdiagnosis and undertreatment of these conditions.[5]

The etiology of male sexual dysfunction is multifactorial, involving physiological, psychological, and lifestyle-related factors.[6] Chronic medical conditions such as diabetes mellitus, hypertension, and cardiovascular diseases are strongly associated with ED due to vascular and neurological impairments.[7, 8] Additionally, psychiatric disorders, particularly depression and anxiety, exacerbate sexual dysfunction by altering neurochemical pathways and reducing sexual desire.[9, 10] Lifestyle factors, including smoking, alcohol consumption, and sedentary habits, further compound the risk.[11] Despite its high prevalence, many patients hesitate to seek medical help due to embarrassment, leading to prolonged suffering and decreased treatment efficacy.[12]

Tertiary care hospitals play a crucial role in diagnosing and managing male sexual dysfunction, given their access to specialized healthcare providers and advanced diagnostic tools.[13] However, limited data exist on the prevalence and clinical correlates of SD among male outpatients in such settings, particularly in low- and middle-income countries.[14] Understanding these factors is essential for developing targeted interventions and improving patient outcomes.[15]

Objectives of the Study

General Objective

To determine the prevalence and clinical correlates of sexual dysfunction among male patients attending the outpatient department of a tertiary care hospital.

Specific Objectives:

To assess the prevalence of different types of sexual dysfunction (e.g., erectile dysfunction, premature ejaculation, decreased libido) among the study population.

To identify the sociodemographic factors (age, occupation, and marital status) associated with sexual dysfunction.

To evaluate the relationship between sexual dysfunction and comorbid medical conditions (hypertension, diabetes, cardiovascular diseases).

METHOD AND MATERIALS

Study Design

This was a cross-sectional observational study conducted at the Outpatient Department of Mymensingh Medical College & Hospital, over a period of one year from June 2020 to May 2021. A total of 102 male patients attending the outpatient department were included in the study population. The study aimed to assess the prevalence and clinical correlates of sexual dysfunctions among male patients in this tertiary care setting.

Sampling Formula

The sample size was calculated using the following formula for prevalence studies:

$$n = \frac{Z^2 \times P \times (1 - P)}{d^2}$$

Where,

n = required sample size

Z = Z-score for 95% confidence level (1.96)

p = estimated prevalence of sexual dysfunction (assumed 50% = 0.5 to maximize sample size)

d = margin of error (0.1)

Data Collection Procedure

Data was collected through face-to-face interviews using a structured and pretested questionnaire. The questionnaire included sections on sociodemographic characteristics, sexual history, types and duration of dysfunction, associated medical conditions, lifestyle factors, marital status, and psychological effects. Prior to the interview, verbal and written consent was obtained. Confidentiality was strictly maintained. Relevant clinical histories and diagnoses were confirmed using patient medical records when available.

Inclusion Criteria

The study included male patients aged 18 years and above who attended the outpatient department of Mymensingh Medical College & Hospital. Participants were required to be mentally

competent and willing to provide informed written consent prior to inclusion in the study.

Exclusion Criteria

Patients with severe psychiatric disorders or cognitive impairments that hinder effective communication were excluded. Additionally, individuals with previously diagnosed congenital sexual dysfunctions, those unwilling to participate or unable to provide consent, and participants who submitted incomplete or inconsistent questionnaire responses were also excluded from the study.

Statistical Analysis

All collected data were checked for completeness, coded, and entered into SPSS version 20.0 for analysis. Descriptive statistics such as frequency, percentage, mean, and standard deviation were calculated to summarize patient characteristics and prevalence patterns. Associations between sexual dysfunction and various clinical or demographic variables were assessed using Chi-square tests or Fisher's exact tests, with a p-value < 0.05 considered statistically significant.

Ethical Consideration

The study was conducted following the ethical guidelines of the Declaration of Helsinki. Ethical approval was obtained from the Institutional Review Board (IRB) of Mymensingh Medical College prior to initiation. All participants were informed about the study objectives and procedures. Written informed consent was obtained. Privacy and confidentiality of the participants were strictly maintained throughout the study.

RESULT

Table 1: Age Distribution, Gender, Mean Age (±SD), and Occupation. (n=102)

Age Group (years)	Frequency	Percentage (%)
18–29	14	13.7%
30–39	24	23.5%
40–49	30	29.4%
50–59	22	21.6%
≥60	12	11.8%
Mean Age	44.6 ± 11.5 years	
Occupation		
Service Holder	35	34.3%
Businessman	30	29.4%
Daily Laborer	15	14.7%
Farmer	10	9.8%
Unemployed/Retired	12	11.8%

Table 1 shows, among the 102 male patients in the study, the largest age group was 40–49 years, accounting for 29.4% (30 patients), followed by 30–39 years at 23.5% (24 patients) and 50–59 years at 21.6% (22 patients). The younger group (18–29 years) comprised 13.7% (14 patients), while those aged 60 and above constituted 11.8% (12 patients). The mean age was 44.6 ± 11.5 years. All participants were male, as per the study design. Regarding occupation, the majority were service holders (34.3%, 35 patients), followed closely by businessmen (29.4%, 30 patients). Daily laborers made up 14.7% (15 patients), farmers 9.8% (10 patients), and the unemployed or retired 11.8% (12 patients).

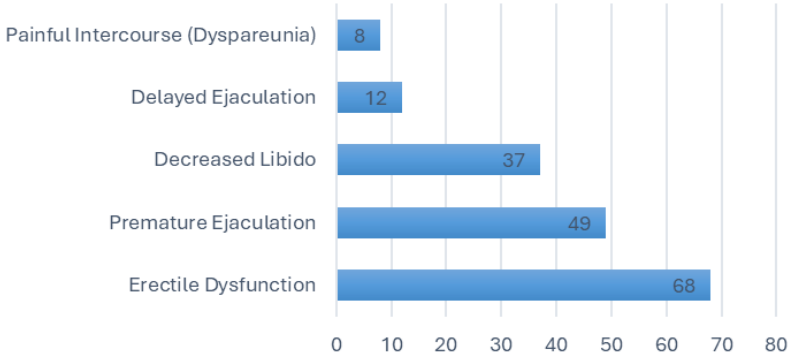

Figure 1: Types of Sexual Dysfunction Reported

Figure 1 shows the most commonly reported sexual dysfunction was erectile dysfunction, affecting 66.7% (68 patients). Premature ejaculation was the next most prevalent at 48.0% (49 patients), followed by decreased libido in 36.3% (37 patients). Less frequent issues included delayed ejaculation (11.8%, 12 patients) and painful intercourse (dyspareunia) (7.8%, 8 patients). Many patients experienced more than one type of dysfunction.

Table 2: Duration of Sexual Dysfunction

Duration	Frequency	Percentage (%)
<6 months	24	23.5%
6 months to 1 year	33	32.4%
1–2 years	28	27.5%
>2 years	17	16.6%

Table 2 shows in terms of symptom duration, 32.4% (33 patients) reported having symptoms for 6 months to 1 year, while 27.5% (28 patients) had symptoms for 1–2 years. About 23.5% (24 patients) experienced symptoms for less than 6 months, and 16.6% (17 patients) had a duration of over 2 years. These numbers indicate that a majority have experienced symptoms long enough to potentially affect their quality of life and mental health.

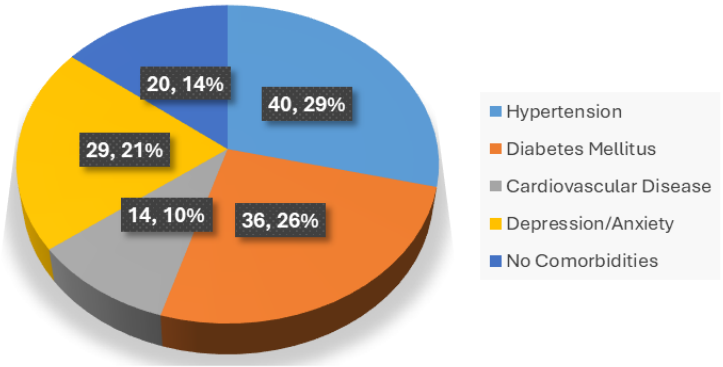

Figure 2: Associated Medical Conditions

Figure 2 presents among the participants, 39.2% (40 patients) had hypertension, and 35.3% (36 patients) were diagnosed with diabetes mellitus. Depression or anxiety disorders were present in 28.4% (29 patients), while cardiovascular disease was reported by 13.7% (14 patients). Notably, 19.6% (20 patients) reported no comorbidities, suggesting that sexual dysfunction may occur independently of systemic illness in some cases.

Table 3: Lifestyle Factors

Factor	Frequency	Percentage (%)
Smoking	45	44.1%
Alcohol Consumption	28	27.5%
Sedentary Lifestyle	54	52.9%
Regular Exercise	20	19.6%

Table 3 shows, regarding lifestyle habits, 44.1% (45 patients) were smokers, and 27.5% (28 patients) consumed alcohol. More than half of the study population (52.9%, 54 patients) reported having a sedentary lifestyle, while only 19.6% (20 patients) engaged in regular exercise.

Table 4: Marital and Relationship Status

Relationship Status	Frequency	Percentage (%)
Married (living together)	72	70.6%
Married (living apart)	10	9.8%
Unmarried	14	13.7%
Divorced/Widowed	6	5.9%

Table 4 shows that most participants were married and living with their partners (70.6%, 72 patients), indicating a direct impact of sexual dysfunction on marital relationships. 9.8% (10 patients) were married but living apart, while 13.7% (14 patients) were unmarried, and 5.9% (6 patients) were divorced or widowed.

Table 5: Help-Seeking Behavior

Action Taken	Frequency	Percentage (%)
Visited a doctor	58	56.9%
Self-medicated	21	20.6%
Spoke to partner	32	31.4%
Took no action	25	24.5%

Table 5 shows, when it came to managing their condition, 56.9% (58 patients) had consulted a doctor, whereas 20.6% (21 patients) practiced self-medication. Only 31.4% (32 patients) discussed their issues with their partner, while 24.5% (25 patients) did not take any action.

Table 6: Psychological Impact of Sexual Dysfunction

Impact Felt	Frequency	Percentage (%)
Low Self-Esteem	44	43.1%
Marital/Relationship Strain	36	35.3%
Anxiety	28	27.5%
Depression	21	20.6%
No Significant Psychological Effect	33	32.4%

Table 6 shows the most commonly reported psychological consequence was low self-esteem, experienced by 43.1% (44 patients). Marital or relationship strain was cited by 35.3% (36 patients), while anxiety and depression were present in 27.5% (28 patients) and 20.6% (21 patients) respectively. However, 32.4% (33 patients) reported no significant psychological effects, though underreporting due to stigma cannot be ruled out.

DISCUSSION

The present study found that the largest proportion of male patients with sexual dysfunction (SD) belonged to the 40–49 age group (29.4%), followed by those aged 30–39 (23.5%) and 50–59 (21.6%). This aligns with existing research

indicating that middle-aged men are at higher risk for SD due to age-related physiological changes, increasing prevalence of chronic diseases, and psychosocial stressors.[16] A study by Corona *et al*. similarly reported that sexual dysfunction peaks in men aged 40–60, with erectile dysfunction (ED) being the most common complaint.[17] The mean age of participants in our study (44.6 ± 11.5 years) further supports the notion that SD is a significant concern among middle-aged men, warranting early screening and intervention. Erectile dysfunction was the most prevalent sexual dysfunction (66.7%), followed by premature ejaculation (48.0%) and decreased libido (36.3%). These findings are consistent with global epidemiological data, where ED is reported as the leading male sexual disorder, affecting 10–30% of men worldwide.[18] A study by McCabe *et al*. highlighted that ED and premature ejaculation frequently coexist, exacerbating psychological distress and reducing treatment compliance.[19]

The high prevalence of ED in our study may be linked to the substantial proportion of patients with hypertension (39.2%) and diabetes (35.3%), both of which are well-established risk factors for vascular and neurogenic ED.[20] A notable finding was that 32.4% of patients had experienced SD symptoms for 6 months to 1 year, while 27.5% reported symptoms lasting 1–2 years. Prolonged symptom duration suggests delayed healthcare-seeking behavior, possibly due to stigma or lack of awareness. This aligns with a study by Shindel *et al.*, which found that men often delay seeking medical help for SD due to embarrassment or misconceptions about treatment options.[21] The persistence of symptoms likely contributes to the high rates of psychological consequences observed, including low self-esteem (43.1%) and marital strain (35.3%). Lifestyle factors also played a significant role, with 44.1% of participants being smokers and 52.9% leading a sedentary lifestyle. Smoking and physical inactivity are known to impair vascular health, exacerbating ED and other SDs.[22] A meta-analysis by Gupta *et al*. confirmed that smoking doubles the risk of ED, while regular exercise improves erectile function and sexual satisfaction.[23] These findings emphasize the need for lifestyle modification as part of SD management. Interestingly, 19.6% of patients had no comorbidities, suggesting that SD can occur independently of chronic illnesses. Psychological factors, such as stress, anxiety, and depression, may play a dominant role in these cases.[24]

A study by Atlantis *et al*., demonstrated a bidirectional relationship between depression and SD, where each condition exacerbates the other.[25] This underscores the importance of comprehensive assessment, including mental health evaluation, in patients presenting with SD. Despite the high prevalence of SD, only 56.9% of participants had consulted a doctor, while 20.6% resorted to self-medication. This reluctance to seek professional help is consistent with global trends, where cultural stigma and lack of awareness hinder appropriate care.[26] A study by Althof *et al*. found that men often turn to unproven remedies before seeking medical advice, delaying effective treatment.[27] Encouraging open discussions between patients and healthcare providers, as well as public health awareness campaigns, could improve early diagnosis and management. The psychological impact of SD was evident, with 43.1% reporting low self-esteem and 35.3% experiencing marital strain. Similar findings were reported in a study by Rosen *et al*., where SD was strongly associated with reduced quality of life and interpersonal conflicts.[28] Addressing these psychosocial aspects through counseling and partner-inclusive therapy may enhance treatment outcomes.[29]

CONCLUSION

This study highlights the high prevalence of sexual dysfunction among male outpatients, particularly erectile dysfunction and premature ejaculation, with significant associations with hypertension, diabetes, and poor lifestyle habits. The prolonged duration of symptoms before seeking medical help indicates a need for better awareness and destigmatization of SD. Future interventions should focus on integrated care, including medical treatment, psychological support, and lifestyle modifications.

Limitations of the Study

This study has several limitations that should be acknowledged. First, the sample size was relatively small (n=102) and restricted to a single tertiary care hospital, which may limit the

generalizability of the findings to broader populations.

Recommendation

Routine screening for sexual dysfunction should be incorporated into outpatient assessments, especially for middle-aged men with comorbidities like hypertension and diabetes. Awareness programs are essential to reduce stigma and encourage help-seeking behavior. Multidisciplinary approaches involving urologists, psychologists, and primary care providers are recommended for comprehensive management.

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