MADISON NEUROLOGY · NEUROLOGY SYMPTOM GUIDE

New sexual dysfunction

Structured history, interpretation & clinical review

Symptom 85 of 94
Clinical educational workbook
Version 1.0 · October 2026

Not for clinical use. This guide cannot diagnose, triage, or exclude an emergency. Seek emergency care for severe, sudden, or worsening symptoms.

Contents

Scope and safe use 3

Section 1: Input form 4

- 1A. Immediate safety screen 4
- 1B. Timeline 4
- 1C. Discriminating features 5
- 1D. Associated findings 5
- 1E. Clinical context 5

Section 2: Interpreting the input form 7

Section 3: Clinical review 9

Selected references 11

> **Document purpose**
> A structured educational history and diagnostic-reasoning workbook. Treatment is outside its scope.

Scope and safe use

New sexual dysfunction is assessed by onset, desire/arousal/orgasm pattern, genital sensation, bladder/bowel symptoms, spinal signs, endocrine/vascular factors, medication, and psychological context.

Not for clinical use.
This educational workbook does not diagnose, triage, estimate probability, replace examination, or exclude an emergency. If a safety-screen answer is Yes or uncertain, follow the stated action rather than continuing routine interpretation.

How to complete the workbook

- Record the current episode and the person's usual baseline; use a witness account for events with impaired awareness.
- Check one option per question unless a clinician documents a different combination. "Not sure" is unresolved information, not a negative answer.
- Complete the safety screen before all other sections. Record exact onset or last-known-well time for sudden deficits.
- Use Section 2 only after the form is complete. More than one pattern may be relevant; urgency takes precedence.
- Use Section 3 to plan focused examination and clinician-selected investigations. No test is automatic or universally required.

Specific escalation rule

New severe headache, new focal weakness or numbness, new speech/language difficulty, reduced consciousness, a prolonged seizure, severe breathing or swallowing difficulty, sudden visual loss, or rapidly progressive weakness requires emergency assessment. Call 911 in the United States.

Section 1: Input form

Checkbox history for New sexual dysfunction

1A. Immediate safety screen

Is there new urinary retention, loss of bladder or bowel control, saddle numbness, or new sexual dysfunction?

☐ No ☐ Yes ☐ Not sure

If Yes: Go to an emergency department now for cauda-equina assessment; do not wait for routine imaging.

Is there rapidly progressing weakness in one or more limbs, a sensory level, or new inability to walk?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now for possible spinal-cord compression or another acute cord process.

Is there fever, immune suppression, recent spinal procedure, injection-drug use, cancer, or severe unremitting night pain?

☐ No ☐ Yes ☐ Not sure

If Yes: Arrange same-day assessment; fever or progressive neurological deficits require emergency care.

Did significant trauma precede the pain, or is there new deformity or immediate neurological loss?

☐ No ☐ Yes ☐ Not sure

If Yes: Seek emergency assessment now and avoid unnecessary movement of the spine.

> **Stop rule:** Any Yes answer triggers the action printed under that question. Any Not sure answer requires prompt in-person clarification; do not treat it as No.

1B. Timeline

How did the symptom begin?

☐ Suddenly, over seconds or minutes ☐ Over hours to days ☐ Gradually over weeks or months ☐ Longstanding or since childhood ☐ Not sure

Use the first occurrence for recurrent episodes; use the current episode for a changing symptom.

What is the overall course?

☐ One persistent episode ☐ Separate recurrent episodes ☐ Steadily worsening ☐ Fluctuating or variable ☐ Currently resolved

Has this exact pattern been assessed before?

☐ Definitely new ☐ The same pattern occurred before ☐ Present and stable for a long time ☐ Not sure

1C. Discriminating features

Which change is most prominent?

☐ Erection, lubrication, or arousal difficulty ☐ Reduced genital sensation or pleasure ☐ Orgasm or ejaculation change ☐ Reduced desire

Is there back pain, saddle numbness, leg weakness, urinary retention, or bowel incontinence?

☐ Yes ☐ No ☐ Not sure

Was onset abrupt after injury/surgery, or gradual?

☐ Abrupt after injury, surgery, or a new medicine ☐ Gradual ☐ Only in particular circumstances ☐ Not sure

Are there diabetes, vascular/endocrine symptoms, depression/stress, relationship factors, or relevant medicines?

☐ Diabetes, vascular, or endocrine clues ☐ Medication or substance ☐ Mood, stress, or relationship context ☐ None identified

1D. Associated findings

Are there other neurological symptoms—weakness, numbness, speech change, double vision, swallowing difficulty, or severe imbalance?

☐ Yes ☐ No ☐ Not sure

Are there systemic clues—fever, weight loss, cancer, infection risk, pregnancy/postpartum status, or a new medication?

☐ Yes ☐ No ☐ Not sure

How much does this affect daily activity?

☐ Noticeable but activities continue ☐ Some activities are limited ☐ Cannot perform usual activities ☐ Not sure

1E. Clinical context

Who is being assessed?

☐ Adult or adolescent ☐ Child under 12 ☐ Adult aged 65 or older

Could a medicine, substance, withdrawal, or recent dose change be relevant?

☐ No plausible contributor ☐ Yes or possibly ☐ Not reviewed

Include sedatives, dopamine-blocking drugs, stimulants, decongestants, anticholinergics, alcohol, and non-prescribed substances when relevant.

Is there a relevant neurological, muscular, metabolic, cardiovascular, autoimmune, or sleep disorder?

☐ No known relevant condition ☐ Yes ☐ Not sure

What prior information is available?

☐ A previous examination or investigation ☐ Prior records but no clear explanation ☐ No useful prior assessment ☐ Not sure

Additional history and documentation

Record exact dates/times, witness details, relevant medication doses and changes, prior investigation reports, and the person's baseline function.

Section 2: Interpreting the input form

Answer combinations generate a differential and an assessment pathway—not a diagnosis.

> **Precedence:** Emergency safety answers override every pattern below. Otherwise, the highest-urgency fully matched pattern takes precedence. If entries are incomplete, contradictory, or match no pattern, use the unresolved-information pathway.

Pattern 1: Sexual change with spinal emergency features

Is there back pain, saddle numbness, leg weakness, urinary retention, or bowel incontinence? Yes

Emergency warning pattern — Now

New sexual dysfunction with saddle, sphincter, back, or leg findings requires emergency spinal assessment.

Differential to review:

- Cauda equina, spinal, or pelvic-nerve dysfunction

Action: Call 911 or go to the nearest emergency department now. Do not drive yourself.

Pattern 2: Abrupt post-injury or medication pattern

Was onset abrupt after injury/surgery, or gradual? Abrupt after injury, surgery, or a new medicine

Urgent assessment pattern — Same day

Abrupt post-procedure or medication-associated change needs prompt cause-specific review.

Differential to review:

- Cauda equina, spinal, or pelvic-nerve dysfunction
- Medication, endocrine, vascular, or metabolic dysfunction

Action: Arrange same-day medical assessment. If symptoms are rapidly worsening or severe, call 911.

Pattern 3: Medical or metabolic pattern

Are there diabetes, vascular/endocrine symptoms, depression/stress, relationship factors, or relevant medicines? Diabetes, vascular, or endocrine clues / Medication or substance

Prompt clinical review pattern — Promptly

Vascular, endocrine, diabetes, or drug clues guide targeted medical assessment.

Differential to review:

- Medication, endocrine, vascular, or metabolic dysfunction
- Chronic neurological or autonomic disorder

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Pattern 4: Situational or psychosocial pattern

Was onset abrupt after injury/surgery, or gradual? Only in particular circumstances
Are there diabetes, vascular/endocrine symptoms, depression/stress, relationship factors, or relevant medicines? Mood, stress, or relationship context

Structured clinical review pattern — Routine review

Situational symptoms with psychosocial context need a confidential whole-person assessment.

Differential to review:

- Psychological, relational, pain-related, or situational contributor
- Medication, endocrine, vascular, or metabolic dysfunction

Action: Arrange a routine in-person clinical review. New, severe, or worsening symptoms change this pathway.

Unresolved-information pathway: The entries need structured in-person characterization.

Prompt clinical review pattern — Promptly

Do not guess missing answers or convert uncertainty into reassurance. Document what is unknown, perform an in-person examination, clarify the timeline with a witness or records when available, and reassess if any new feature appears.

Action: Arrange an in-person medical or neurological review promptly, usually within days. Seek sooner care if the pattern changes.

Section 3: Clinical review

Diagnostic modules and focused investigation logic

The examination comes before a test list. Select investigations only after localization, urgency, comorbidity, pregnancy status, renal function, anticoagulation, and prior results have been considered.

3.1 Cauda equina, spinal, or pelvic-nerve dysfunction

Discriminating features: Acute dysfunction with saddle sensory loss, sphincter change, back pain, leg deficits, or pelvic injury.

Logical investigations: Emergency spinal assessment for combined acute findings; otherwise targeted neurological/pelvic evaluation.

3.2 Medication, endocrine, vascular, or metabolic dysfunction

Discriminating features: SSRI/antipsychotic and other drugs, diabetes, vascular disease, hormonal symptoms, or systemic illness.

Logical investigations: Medication and medical review with targeted glucose, hormonal, and vascular assessment as indicated.

3.3 Chronic neurological or autonomic disorder

Discriminating features: Gradual dysfunction with orthostatic, bladder, sensory, or movement features.

Logical investigations: Neurological/autonomic examination and selected testing based on associated phenotype.

3.4 Psychological, relational, pain-related, or situational contributor

Discriminating features: Situational variation, distress, depression, anxiety, pain, or relationship context without focal deficits.

Logical investigations: Confidential psychosocial, pain, and relationship assessment after medical/neurological contributors are considered.

Reassessment and documentation

- If the symptom pattern changes, repeat the safety screen and timeline rather than carrying forward an earlier interpretation.
- If a test is unrevealing but the deficit persists or progresses, revisit localization and seek specialist review; a normal result does not automatically end assessment.
- If symptoms resolve, document duration, completeness of recovery, recurrence, and any residual deficit. Resolved sudden focal symptoms can still require urgent vascular assessment.
- If the history and examination conflict, obtain collateral information and in-person review rather than forcing a single diagnostic label.

Selected references

Sources provide background standards and do not replace local emergency pathways or current specialist guidance. Accessed October 2026.

1. National Institute for Health and Care Excellence. (2010, updated 2023). *Transient loss of consciousness (“blackouts”) in over 16s (CG109)*. https://www.nice.org.uk/guidance/cg109
2. National Institute for Health and Care Excellence. (2019, updated 2023). *Suspected neurological conditions: recognition and referral (NG127)*. https://www.nice.org.uk/guidance/ng127