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Original article

Sexual dysfunction in women with endometriosis: beyond dyspareunia. A multicenter cross-sectional study

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ABSTRACT

Objective: To characterize the domains of sexual function and describe the prevalence and patterns of female sexual dysfunction in a multicenter Colombian cohort of women with endometriosis.
Materials and methods: A multicenter cross-sectional study was conducted among women aged 18–50 years with a confirmed diagnosis of endometriosis recruited from a tertiary referral hospital and a national endometriosis patient association in Colombia. Participants reported sexual activity during the preceding four weeks. Sexual function was assessed using the validated Spanish version of the Female Sexual Function Index (FSFI), and female sexual dysfunction was defined as a total FSFI score <26.55. Baseline characteristics were compared according to FSFI status, and factors associated with female sexual dysfunction were evaluated using Poisson regression with robust variance.
Results: A total of 166 women were included. The median total FSFI score was 20.9 (IQR, 14.7–25.1), and 81.3% met the criterion for female sexual dysfunction. The lowest median scores were observed in sexual desire (2.4; IQR, 1.8–3.6) and pain/dyspareunia (2.4; IQR, 1.6–3.6), with additional impairment in arousal, lubrication, and orgasm. Women with female sexual dysfunction were more frequently represented in lower socioeconomic strata ($p = 0.028$). No independent associations were identified in the adjusted Poisson regression analysis.
Conclusions: Female sexual dysfunction was frequently observed in this multicenter Colombian cohort and involved multiple domains of sexual function beyond dyspareunia. Routine assessment of sexual function should be incorporated into comprehensive endometriosis care, while future prospective studies are needed to better understand the determinants of sexual dysfunction.

Introduction

Endometriosis is one of the most prevalent and clinically significant gynecological disorders encountered in routine practice worldwide. The burden of disease varies substantially across populations and according to the methodologies used for case identification and diagnosis. Studies based on administrative and health insurance databases have reported prevalence estimates as low as 0.7%, whereas investigations relying on clinical data have reported rates of approximately 6.8%. Among symptomatic women, the prevalence may reach up to 13% [1]. This variability likely reflects the inherent challenges associated with diagnosing endometriosis, as well as the limitations and delays that many women experience throughout their healthcare journey.

For many years, the therapeutic management of endometriosis has focused primarily on the control of chronic pelvic pain. This approach largely reflects the substantial clinical and socioeconomic burden associated with the disease, which affects millions of women worldwide and is estimated to cost approximately $78 billion annually in the United States due to pain-related disability [2]. However, growing evidence suggests that endometriosis has a much broader impact on patients' health and well-being, extending beyond pain alone. Recent studies have reported a higher prevalence of depressive disorders (18.9% vs.

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9.3%) and anxiety disorders (29.7% vs. 7.0%) among women with endometriosis compared with women without clinical or ultrasound evidence of endometriosis [3,4]. Likewise, the disease can significantly affect multiple dimensions of female sexual health and function, extending far beyond the presence of dyspareunia alone [5].

Although several studies have explored sexual dysfunction among women with endometriosis, data from Latin American populations remain limited, and the multidimensional characteristics of sexual function have been insufficiently described. Therefore, the present study aimed to characterize the domains of sexual function and describe the prevalence and patterns of female sexual dysfunction in a multicenter Colombian cohort of women with endometriosis.

Materials and methods

Study design and setting

We conducted a multicenter cross-sectional study including Colombian women diagnosed with endometriosis. Participants were recruited through the Hospital Universitario Mayor–Méderi and the Colombian Association of Endometriosis and Infertility (ASOCOEN). Sexual function was assessed using the validated Spanish version of the Female Sexual Function Index (FSFI), together with demographic and clinical variables collected through a standardized electronic questionnaire. Ethical approval was obtained from the Human Research Ethics Committee of Hospital Universitario Mayor–Méderi (Approval No. CEISH-2024005)

Study population and participant recruitment

Eligible participants were women of reproductive age (18–50 years) with a confirmed diagnosis of endometriosis who were recruited between February and August 2025. Participants were required to report sexual activity within the four weeks preceding survey administration, be physically and mentally capable of completing the questionnaire, and provide informed consent before enrollment. Women who were pregnant or had reached menopause were excluded from the study.

The diagnosis of endometriosis was established according to internationally accepted clinical and diagnostic criteria, following the recommendations of the European Society of Human Reproduction and Embryology (ESHRE) and the American College of Obstetricians and Gynecologists (ACOG) [6,7]. These guidelines recognize that endometriosis may be suspected based on clinical symptoms, particularly dysmenorrhea, chronic pelvic pain, and cyclical pelvic pain, and may be supported by imaging findings on ultrasound or magnetic resonance imaging, or confirmed by surgical and/or histopathological findings when available. Participants recruited through the ASOCOEN had a previously established diagnosis of endometriosis made by their treating physicians. These diagnoses were reviewed by the study investigators and verified to be consistent with current ESHRE and ACOG diagnostic recommendations.

Female sexual function was assessed using the FSFI, a 19-item self-administered questionnaire designed to evaluate sexual function during the preceding four weeks. The FSFI has been translated, culturally adapted, and validated in Colombian women and is one of the most widely used instruments for the assessment of female sexual function in both clinical practice and research settings [8]. The instrument evaluates six domains of sexual function, including desire (items 1–2), arousal (items 3–6), lubrication (items 7–10), orgasm (items 11–13), satisfaction (items 14–16), and pain (items 17–19). Domain scores are obtained by summing the corresponding item responses and applying domain-specific weighting factors, resulting in a total score ranging from 2 to 36 points. Consistent with previous validation studies, sexual dysfunction was defined as a total FSFI score <26.55 [9]. In addition to the overall FSFI score, each sexual function domain was analyzed separately to characterize the multidimensional impact of endometriosis on female sexual health.

Women meeting the eligibility criteria were invited to enroll in the study. Those willing to participate provided electronic informed consent through a secure web link or QR code. After consent was obtained, access to the study questionnaire was granted through the REDCap (Research Electronic Data Capture) platform, and data were collected remotely using electronic forms distributed via email or WhatsApp.

Statistical analysis

A non-probability consecutive sampling strategy was employed. Given the exploratory nature of the study, a formal sample size calculation was not performed, as the primary objective was to characterize sexual function domains among women with endometriosis rather than to test a specific hypothesis. The sample size was therefore determined according to feasibility considerations and the anticipated number of eligible participants during the recruitment period. Considering the expected patient volume, approximately 150 women were anticipated to be included. Consequently, all women meeting the eligibility criteria during the study period were invited to participate.

Categorical variables were summarized using frequencies and percentages, whereas continuous variables were described as means with standard deviations or medians with interquartile ranges, as appropriate. Data distribution was assessed using the Shapiro–Wilk test. Baseline characteristics were compared according to FSFI status (FSFI < 26.55 vs. ≥ 26.55) using the Wilcoxon rank-sum test for continuous variables and Fisher's exact test for categorical variables. Factors associated with female sexual dysfunction were evaluated using univariable and multivariable Poisson regression models with robust variance, and results are presented as prevalence ratios (PRs) with 95% confidence intervals (95% CIs).

Descriptive tables and graphical displays were used to summarize the study variables. Data were collected using a structured electronic questionnaire with mandatory fields, requiring participants to complete all required items before proceeding to the next section. Consequently, no missing data were present in the study database, and no data imputation procedures were necessary. All statistical analyses were performed using R statistical software (version 4.5.1).

Results

A total of 166 women with a diagnosis of endometriosis were recruited from the two participating institutions. The participant recruitment process is summarized in Fig. 1.

Regarding sociodemographic characteristics, women with and without female sexual dysfunction had a similar age distribution and marital status. Most participants in both groups were single or living in a common-law union. Socioeconomic status was the only demographic characteristic that differed significantly between groups ($p = 0.028$), with women without female sexual dysfunction more frequently belonging to the upper-middle and high socioeconomic strata, whereas those with female sexual dysfunction were more commonly represented in the lower-middle and middle strata. Regarding reproductive and gynecologic history, age at menarche and reproductive characteristics were comparable between women with and without female sexual dysfunction. The median age at menarche was 12 years in both groups, and no significant differences were observed in the number of pregnancies, vaginal deliveries, cesarean sections, or miscarriages. Detailed sociodemographic, reproductive, and gynecologic characteristics are presented in Table 1.

With respect to endometriosis-related management, no significant differences were observed between women with and without female sexual dysfunction regarding current medical treatment, pharmacological therapy, or previous surgical procedures. Although women with female sexual dysfunction tended to report more frequent use of medical treatment, particularly dienogest, and a higher prevalence of previous

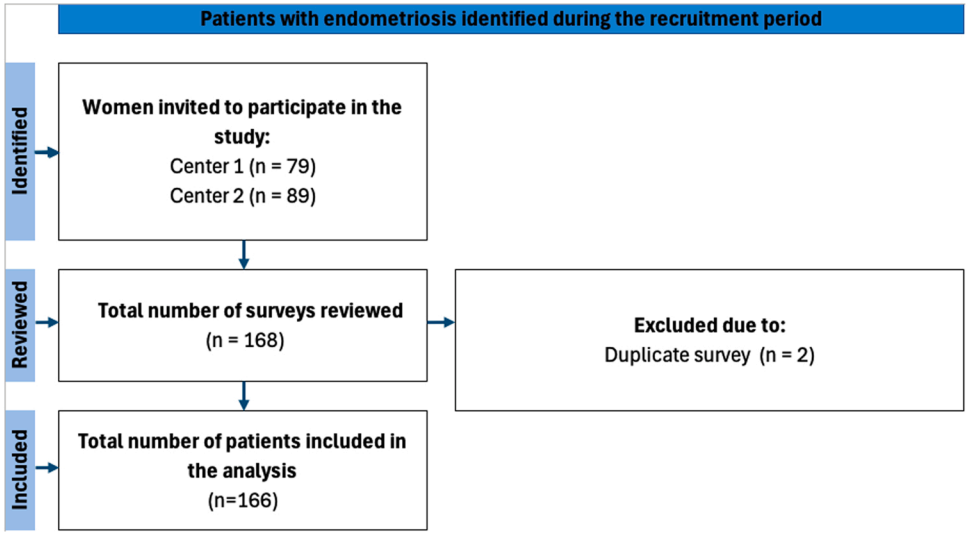

Fig. 1. Flow diagram of participant recruitment and selection process.
Flowchart showing participant recruitment from the two participating centers: Center 1, Hospital Universitario Mayor–Méderi (Bogotá, Colombia), and Center 2, the Colombian Association of Endometriosis and Infertility (ASOCOEN).

surgical procedures, these differences did not reach statistical significance. Detailed treatment-related characteristics are presented in Table 1.

Evaluation of sexual function demonstrated a high frequency of female sexual dysfunction among women with endometriosis. The median total FSFI score was 20.9 (IQR: 14.7–25.1), and 135 of the 166 participants (81.3%) met the validated criterion for female sexual dysfunction (Fig. 2).

Analysis of the individual FSFI domains revealed impairment across multiple dimensions of sexual function. The lowest median scores were observed in the domains of sexual desire (median 2.4, IQR: 1.8–3.6) and pain/dyspareunia (median 2.4, IQR: 1.6–3.6), indicating that these were the most affected domains of sexual function within the study population. Impairment was also identified in the domains of sexual arousal (median 3.6, IQR: 2.1–4.8), lubrication (median 3.9, IQR: 3.0–4.5), and orgasm (median 3.6, IQR: 1.6–4.8), reflecting a broader impact of endometriosis on female sexual function beyond pain alone. In contrast, the satisfaction domain demonstrated a relative tendency toward less impairment compared with the other domains of sexual function (median 4.2, IQR: 2.8–5.2). The distribution of FSFI domain scores is presented in Fig. 3.

In the Poisson regression analysis, none of the evaluated variables were significantly associated with female sexual dysfunction in either the crude or adjusted models. Age, current medical treatment, history of surgical procedures for endometriosis, and pharmacological treatment showed no independent association with an FSFI score <26.55 after adjustment for potential confounders. Detailed estimates of crude and adjusted prevalence ratios are presented in Table 2.

Discussion

Main findings

In this multicenter study, female sexual dysfunction was highly prevalent among women with endometriosis, affecting 81.3% of participants. Although dyspareunia was one of the most impaired domains, a tendency toward impairment was also observed in sexual desire, arousal, lubrication, and orgasm, suggesting that the impact of endometriosis on sexual health may extend beyond pain alone. Notably, sexual satisfaction was comparatively less affected and showed a tendency toward higher scores than the other domains of sexual function.

Comparison with prior literature

Endometriosis is a globally prevalent gynecological condition that affects women across diverse geographic, cultural, and socioeconomic settings. Latin America is no exception to the burden imposed by this disease, which has substantial implications for women's physical, psychological, and sexual health. The impact of endometriosis in the region may be further exacerbated by socioeconomic disparities and inequalities in healthcare access, which contribute to delays in diagnosis, limited access to specialized treatment, and inadequate long-term follow-up [10]. Consequently, many women experience prolonged symptoms and reduced quality of life before receiving appropriate medical care.

The clinical relevance of endometriosis in Latin American populations has been highlighted by Flores-Caldera et al., who conducted a large multicenter cross-sectional collaborative study aimed at characterizing the clinical and demographic profile of Hispanic/Latina women with endometriosis. The study included 1,378 women from 23 countries across Latin America, the Caribbean, and Spain, representing one of the largest cohorts of women with endometriosis in this population. One of the most relevant findings was a mean diagnostic delay of 6.6 years, with symptom onset occurring at a mean age of 21.9 years and diagnosis established at 27.6 years. Regarding symptom burden, 86.4% of participants reported dyspareunia, with a mean age of onset of 25.1 years, and up to 82.5% reported avoiding sexual intercourse because of pain [11]. The authors concluded that endometriosis in Hispanic/Latina women is characterized by a substantial symptom burden, considerable diagnostic delay, and significant physical and emotional impact, highlighting the need for strategies aimed at improving early recognition and providing comprehensive management of the disease and its consequences.

Studies evaluating the multidimensional impact of endometriosis on female sexual function, similar to the present investigation, have also been conducted in Latin American populations. Fairbanks et al.

Table 1
Population characteristics according to female sexual function (FSFI score).

Characteristic	FSFI ≥26.55 (N = 31)	FSFI < 26.55 (N = 135)	p-value
Age (years)			0.60
Median [Q1, Q3]	34.00 [31.00, 39.00]	35.00 [31.00, 39.00]	
Marital status, N (%)			0.80
Single	15 (48%)	53 (39%)	
Married	7 (23%)	39 (29%)	
Common-law union	8 (26%)	39 (29%)	
Divorced	1 (3.2%)	4 (3.0%)	
Socioeconomic stratum, N (%)			**0.028**
Stratum 1 (Very low)	1 (3.2%)	6 (4.4%)	
Stratum 2 (Low)	4 (13%)	24 (18%)	
Stratum 3 (Lower-middle)	7 (23%)	48 (36%)	
Stratum 4 (Middle)	9 (29%)	44 (33%)	
Stratum 5 (Upper-Middle)	6 (19%)	11 (8.1%)	
Stratum 6 (High)	4 (13%)	2 (1.5%)	
Age at menarche (years)			>0.9
Median [Q1, Q3]	12.00 [11.00, 13.00]	12.00 [11.00, 13.00]	
Number of pregnancies			>0.9
Median [Q1, Q3]	1.00 [1.00, 2.50]	1.00 [1.00, 2.00]	
Number of vaginal deliveries			0.90
Median [Q1, Q3]	1.00 [0.00, 1.50]	1.00 [0.00, 1.00]	
Number of cesarean sections			0.20
Median [Q1, Q3]	0.00 [0.00, 0.50]	1.00 [0.00, 1.00]	
Number of miscarriages			0.60
Median [Q1, Q3]	0.50 [0.00, 1.00]	0.00 [0.00, 1.00]	
Current medical treatment for endometriosis, N (%)			0.30
Yes	19 (61%)	97 (72%)	
No	12 (39%)	38 (28%)	
Pharmacological treatment, N (%)			0.30
Dienogest 2 mg/day	13 (42%)	74 (55%)	
Levonorgestrel-releasing IUD (Mirena)	5 (16%)	9 (6.7%)	
Combined oral contraceptives	3 (9.7%)	16 (12%)	
No pharmacological treatment	10 (32%)	36 (27%)	
History of surgical procedures, N (%)			0.40
Yes	21 (68%)	104 (77%)	
No	10 (32%)	31 (23%)	

Statistical significance indicated in bold. Data presented as median [Q1, Q3] or N (%). FSFI: Female Sexual Function Index. A score ≥26.55 indicates normal sexual function; a score <26.55 indicates female sexual dysfunction.

performed a cross-sectional study in Brazil aimed at assessing the association between endometriosis and sexual dysfunction among women of reproductive age. The study included 254 women with endometriosis and 329 controls without the disease. The authors found that overall sexual dysfunction was significantly more frequent among women with endometriosis than among controls (43.3% vs. 17.6%), indicating that the disease more than doubled the risk of impaired sexual function. Furthermore, women with endometriosis demonstrated significantly worse performance across all evaluated domains of sexual function, including sexual desire, arousal, pain during intercourse, and satisfaction/orgasm. Dyspareunia emerged as one of the strongest factors associated with global sexual dysfunction (OR 2.48; 95% CI: 1.57–3.91), while chronic pelvic pain (OR 1.88; 95% CI: 1.17–3.03) and severe dysmenorrhea (OR 1.91; 95% CI: 1.20–3.04) were also independently associated with an increased risk of sexual dysfunction [12]. These findings are consistent with our results, which demonstrated a high prevalence of sexual dysfunction and impairment across multiple FSFI domains, supporting the concept that the negative impact of endometriosis on female sexual health extends beyond dyspareunia alone and affects several dimensions of sexual function.

A study conducted in a Colombian population reported findings that closely resemble those observed in our cohort. Espitia-De la Hoz conducted a cross-sectional study aimed at evaluating the prevalence and characteristics of sexual dysfunction among women with endometriosis in Armenia, Colombia. The study included 137 women older than 18 years with histologically confirmed endometriosis who were treated at three high-complexity centers between 2017 and 2022. Sexual function was assessed using the FSFI, the same instrument employed in the present study. The authors reported an overall prevalence of sexual dysfunction of 75.9%, which is comparable to the 81.3% prevalence observed in our cohort. Similar to our findings, dyspareunia represented the most frequently affected domain, followed by impairments in sexual desire, lubrication, arousal, and orgasmic function. Furthermore, dysmenorrhea, dyspareunia, and chronic pelvic pain were among the most prevalent symptoms reported by participants, highlighting the close relationship between pain-related symptoms and impaired sexual function in women with endometriosis [13].

Although our study identified a slightly higher prevalence of sexual dysfunction, both investigations consistently demonstrate that endometriosis negatively affects multiple domains of female sexual function rather than pain alone. Collectively, these findings strengthen the evidence from Colombian populations and support the incorporation of routine sexual function assessment into the comprehensive clinical management of women with endometriosis.

Clinical implications

The available evidence suggests that sexual health should be considered an integral component of the comprehensive management of women with endometriosis. In our study, women with female sexual dysfunction were more frequently represented in the lower socioeconomic strata, a finding that may reflect disparities in access to specialized care, timely diagnosis, and appropriate treatment. Although the interval between symptom onset, diagnosis, and treatment initiation was not evaluated in the present study, delayed access to specialized care has been consistently described in women with endometriosis and may contribute to worse sexual health outcomes. These observations highlight the importance of ensuring equitable access to specialized multidisciplinary care and warrant further investigation in prospective studies.

This concept is further supported by evidence from a systematic review and meta-analysis showing that women with untreated endometriosis experience significantly impaired sexual function, reflected by lower scores across all FSFI domains, as well as greater severity of dyspareunia and chronic pelvic pain compared with women without the disease. Importantly, these findings suggest that the sexual consequences of endometriosis extend beyond the anatomical burden of disease and may also be influenced by psychological and emotional factors [14]. Taken together, this evidence underscores the importance of early diagnosis and timely treatment while supporting a multidisciplinary approach that integrates not only gynecological care but also psychological support when appropriate, with the goal of preserving sexual health and overall quality of life.

Similarly, evidence suggests that women with more advanced forms of endometriosis may also benefit from targeted therapeutic interventions. A systematic review including 20 studies and 2,145 women with deep infiltrating endometriosis found that surgical treatment was associated with significant improvements in sexual function and a

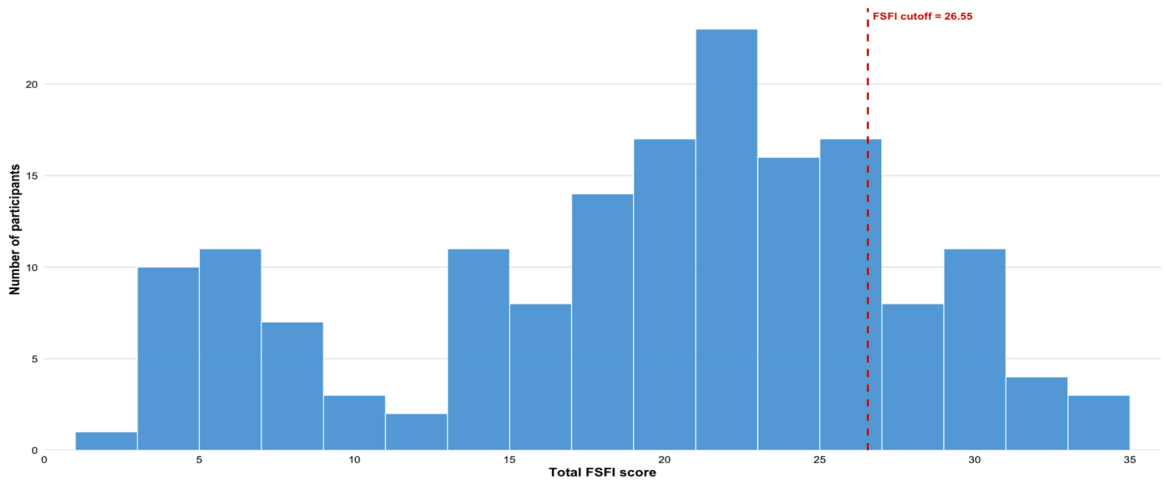

Fig. 2. Distribution of total Female Sexual Function Index (FSFI) scores among women with endometriosis.
The histogram illustrates the distribution of total FSFI scores in the study population. The red dashed vertical line indicates the validated cutoff score for female sexual dysfunction (FSFI < 26.55), with most participants scoring below this threshold.

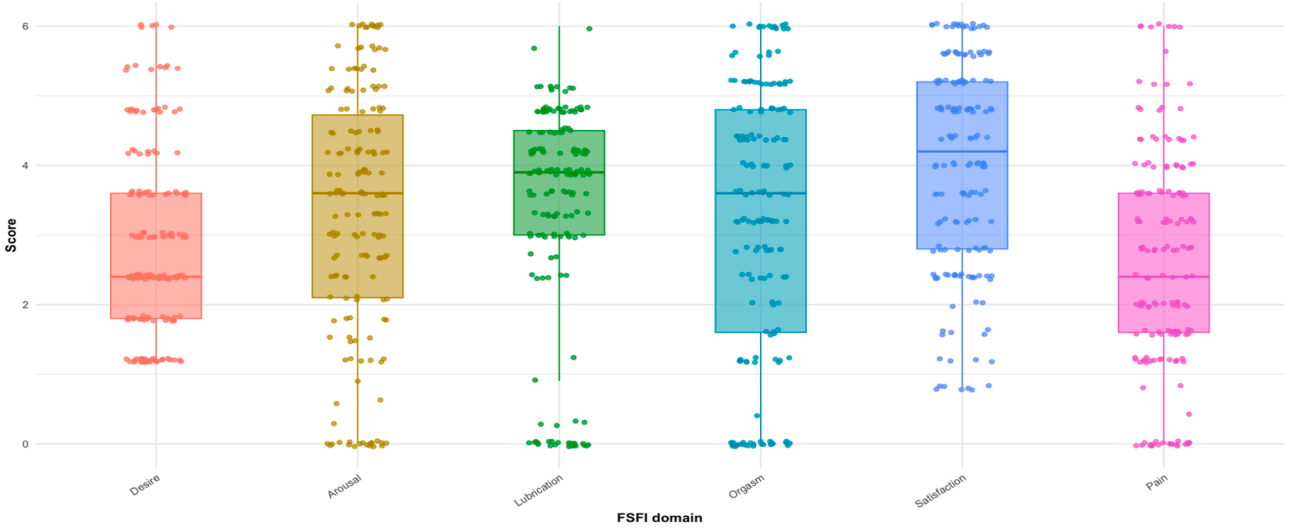

Fig. 3. Distribution of Female Sexual Function Index (FSFI) domain scores among women with endometriosis.
Boxplots represent the distribution of scores for each FSFI domain, including sexual desire, arousal, lubrication, orgasm, satisfaction, and pain/dyspareunia.

consistent reduction in dyspareunia. Benefits were observed across multiple domains of sexual health, including sexual desire, satisfaction, frequency of sexual intercourse, and overall sexual quality of life [15]. These findings support the role of surgical management as an effective therapeutic option for selected patients with severe disease and substantial impairment of sexual health.

Consistent with these observations, studies evaluating advanced laparoscopic excision techniques have reported favorable outcomes at six months of follow-up, including improvements in sexual function and pain-related symptoms. Nevertheless, the potential benefits of surgical treatment should be interpreted within the context of each patient's clinical characteristics, as concomitant conditions such as uterine fibroids, adenomyosis, and other sources of pelvic pain may also influence sexual function and overall treatment response [16]. Therefore, careful patient selection and comprehensive clinical assessment remain essential when considering surgery as part of the therapeutic strategy.

Strengths and limitations

One of the main strengths of this study is the use of standardized and internationally accepted diagnostic criteria for endometriosis, based on current ESHRE and ACOG recommendations, which enhances the validity and reproducibility of the findings. Additionally, participant recruitment was not restricted to a hospital-based population, as women were enrolled from both a tertiary referral center and a national patient association. This approach allowed the inclusion of a broader and more heterogeneous population, improving the representativeness of women with endometriosis from different clinical and social backgrounds.

Given the exploratory nature of the study, several limitations should be acknowledged. First, the cross-sectional design, together with the use of consecutive non-probability sampling from two specialized referral centers, precludes establishing causal relationships between endometriosis and sexual dysfunction and may limit the generalizability of the

Table 2
Factors associated with female sexual dysfunction (FSFI total <26.55). Crude and adjusted prevalence ratios estimated by Poisson regression with robust variance.

Variable	Crude analysis Crude PR (95% CI)	Adjusted analysis Adjusted PR (95% CI)
Age (years)	1.01 (0.99–1.02)	1.00 (0.99–1.02)
Current medical treatment for endometriosis		
Yes	Reference	Reference
No	0.91 (0.76–1.08)	0.84 (0.62–1.14)
History of surgical procedures for endometriosis		
Yes	Reference	Reference
No	0.91 (0.75–1.10)	0.88 (0.73–1.07)
Pharmacological treatment		
Dienogest 2 mg/day	Reference	Reference
Levonorgestrel-releasing IUD (Mirena)	0.76 (0.51–1.13)	0.75 (0.50–1.11)
Combined oral contraceptives	0.99 (0.80–1.23)	1.00 (0.80–1.24)
No pharmacological treatment	0.92 (0.77–1.10)	1.08 (0.79–1.47)

PR: prevalence ratio; CI: confidence interval; FSFI: Female Sexual Function Index; IUD: intrauterine device. The adjusted model included all listed variables simultaneously.

findings to the broader population of Colombian women with endometriosis. Second, although sexual function was comprehensively assessed using a validated instrument, the study did not collect information on several clinical characteristics that may influence sexual function, including the method used to establish the diagnosis of endometriosis (surgical, histopathological, imaging-based, or clinical), disease stage, presence of deep infiltrating endometriosis, pain severity, and disease duration. Consequently, it was not possible to explore the relationship between disease phenotype and sexual dysfunction. Third, other factors that may influence sexual health, including psychological well-being, anxiety, depression, relationship dynamics, and partner-related factors, were not evaluated and may have contributed to the observed findings. In addition, the four-week assessment period inherent to the design of the FSFI may not fully reflect long-term changes in sexual function.

Conclusion

In this multicenter Colombian cohort, female sexual dysfunction was frequently observed among women with endometriosis, affecting more than four out of five participants. Although dyspareunia was among the most impaired domains, lower scores were also identified in sexual desire, arousal, lubrication, and orgasm, suggesting that alterations in sexual function extend beyond pain alone. These findings emphasize the importance of routinely assessing sexual function as part of the comprehensive evaluation of women with endometriosis and provide a foundation for future studies exploring the clinical, psychological, and disease-related factors associated with female sexual dysfunction.

Author contributions

All authors contributed substantially to the conception and design of the report, literature review, data interpretation, and manuscript writing. Each author meets all four ICMJE authorship criteria, including approval of the final version and agreement to be accountable for all aspects of the work.

Consent to participate

Written informed consent was obtained in accordance with the directives of the institutional medical ethics committee.

Ethics approval

Ethical approval was obtained from the Human Research Ethics Committee of Hospital Universitario Mayor–Méderi (Approval No. CEISH- 2024005).

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The authors declare that no external funding was received for this study.

Availability of data and material

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

Declaration of competing interest

The authors declare that they have no competing interests to disclose. No commercial, financial, or personal relationships existed that could be perceived as influencing the work reported in this manuscript.

This study did not receive any external funding from public, commercial, or not-for-profit organizations.

The authors further declare that they have no financial interests related to the materials, interventions, products, or organizations discussed in this manuscript.

All authors have reviewed and approved the final version of the manuscript and agree with the statements provided in this declaration.

The Declaration of Interests tool was completed, and no competing interests were identified or declared by the authors.

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