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 COMMENTS AND  
 RESPONSES
 

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**Comment on: Wing  
 et al. Effect of  
 Intensive Lifestyle  
 Intervention on  
 Sexual Dysfunction in  
 Women With Type 2  
 Diabetes: Results  
 From an Ancillary  
 Look AHEAD Study.  
 Diabetes Care 2013;  
 36:2937-2944**

We read with interest the article of Wing et al. (1) reporting the prevalence of sexual dysfunction in a group of obese women with type 2 diabetes and the effect of intensive lifestyle changes. The 50% prevalence of female sexual dysfunction (FSD) they found in 227 obese women appears conservative, at the least, which may lead to an underestimation of FSD prevalence in the sample. The choice to exclude sexually inactive women is questionable, as the direction of the association was not defined on an a priori basis: FSD might have been responsible for being sexually inactive. We found a 53.4% prevalence of FSD in a large population ( $n = 595$ ) of younger type 2 diabetic women (mean age: 57.9 years) (2). Abu Ali et al. (3) evaluated 613 diabetic women and 524 nondiabetic women in Jordan and found a prevalence of FSD in 59.6% in diabetic women  $\geq 50$  years of age as compared with 45.6% found in the age-matched nondiabetic women. Recalculating the prevalence of FSD in the ancillary Look AHEAD study (1), 66% of these women met the criteria of FSD: 113 sexually active with FSD + 111

sexually inactive women likely to have been categorized as having FSD (224/338 responders = 66%).

The higher female sexual function index (FSFI) cutoff may explain the difference in prevalence between the studies (1,2). FSFI scores range from 2 to 36, with a higher score indicating better sexual function. The FSFI total score of  $\leq 26.55$  was used to classify participants as having FSD at baseline (1). However, this cutoff point may give rates of sexual dysfunction ranging from 22 to 50% in fertile women, leading to the unlikely chance that the majority of fertile healthy women in their 40s should be at risk for sexual dysfunction (2). We used a more conservative measure of sexual function, with the FSFI cutoff set at 23, based on the lower quartile of distribution in 115 nondiabetic women (4), which was 22.9 (upper quartile 31.5, median 28.9), and was considered pertinent with a cutoff point of 23. The prevalence of FSD was significantly higher in menopausal (63.9%) women as compared with premenopausal (41.0%) women (2); unfortunately, we do not have this information from the ancillary Look AHEAD study.

We found that both depression and marital status were independent predictors of FSD: women with type 2 diabetes were 1.86 and 1.59 times more likely to have FSD if they were depressed or married, respectively (2). Only the Beck Depression Inventory score was related to FSD in the study of Wing et al. (1), but marital status was not considered. Cardiovascular risk factors were not independent predictors of FSD in both studies (1,2). The Third Princeton Consensus Conference (5) assessed, for the first time, the association between FSD and presence of systemic vascular endothelial dysfunction and its consequences in women. Although cardiometabolic risk factors are associated with more FSD, and that treatment of metabolic syndrome/obesity is associated with less FSD, at present there are no data to support that

FSD is a predictor of future cardiovascular events, as it happens for erectile dysfunction in type 2 diabetic men.

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