NARRATIVE MEDICINE

Thoughts on Sexual Health

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ABSTRACT

As a practicing obstetrician/gynecologist for more than 18 years, I have realized the importance of sexual health as well as the embarrassing lack of training in this very important part of our patients' overall mental and physical health. If anyone should be expected to be not only comfortable but knowledgeable about sex, it should be us. Unfortunately, many of us had little or no education in sexual health during medical school or residency. I have been on a journey to educate myself so I might better help my patients.

INTRODUCTION

I often find myself sharing with patients how little education we, as physicians, get in sexual medicine. And in the specialty I chose, obstetrics and gynecology, it's even more disturbing to admit this. As a female physician in my 50s, I have found that many of my patients will share their sexual concerns with me—often whether I directly ask them or not. And it's embarrassing to admit that even as a female obstetrician/gynecologist, I often haven't asked. It wasn't that I didn't care or want to know; it was that I didn't feel I knew enough to be able to offer much help.

But women would share things. They would share that a family member molested them as a child. They would share about a first sexual experience in which they contracted a sexually transmitted disease and felt "dirty" ever since. Women would tell me that "sex was great" for a while, but now they have a job and 2 kids and have gained 6.75 kg (15 lb) and have been married for 11 years, and things aren't "the same" anymore. I've seen patients whose breast cancer treatments led to premature menopause, causing not only body image concerns but also vaginal dryness to the point at which sex feels "like sandpaper." When their oncologists told them absolutely no estrogen, I found myself empathetic but feeling fairly useless.

I wanted to help. I went into this profession to help women. I can deliver a baby; I can do surgery; I can help with irregular bleeding and pelvic pain (sometimes!). But there are so many factors that are involved in sexual health. And as we all know, it takes time. Time we often feel we don't have to ask and listen and learn. It takes time for a patient to trust you. But when a patient does get up the courage to share her concerns, how can we not offer her something?

EDUCATING MYSELF

Because I didn't feel very well educated, even as a gynecologist, I started to focus on lectures and conferences that addressed these issues. I tried to learn more about menopause and perimenopause and vaginal dryness. I did research on vulvodynia and vaginismus. The more I learned, the more I realized how little I actually knew about the extremely wide variety of sexual experiences, attitudes, and practices.

I began to realize that I inadvertently made assumptions regarding sexual preferences. If a woman stated she was married, I assumed this meant to a male partner and that she had no other partners. The more I learned, the more I asked and tried to adjust my questioning to be as open and as unassuming and nonjudgmental as possible.

I learned not to act surprised when a woman asked to be "tested everywhere" for sexually transmitted infections. I learned that sometimes when a woman says, "I don't have any other partners, but I'm not sure about my husband," this could be true, or it could be that she or they both have other partners but she doesn't want to share that they are "swingers" or "polyamorous" or "consensual nonmonogamists."

I started investigating other sexual practices and lifestyles so I could be more aware and less likely to be surprised (or even shocked) when a woman shared an intimate detail with me. I found myself actually honored when a woman shyly told me her partner wanted to try anal intercourse, and she was curious but also scared and didn't know whom to ask about this.

In the process of trying to educate myself, I have met some wonderful marriage and family therapists, sex therapists, and sex coaches. I have also been unpleasantly enlightened about the harm we sometimes do to patients when they are brave enough to share their sexual concerns. One therapist I met shared a story of her client who had been making great progress in her work with vaginismus, until she went to see a gynecologist and was told it was just something she would have to "deal with." I have to hope that this physician's response was based on the fact that he didn't know there are ways to help with this condition, not that he didn't care.

OPENING A DIALOGUE

The American College of Obstetricians and Gynecologists (ACOG) recently issued a Committee Opinion stating that obstetricians/gynecologists are in a "unique position to open a dialogue on sexual health issues."[1] In this opinion, the College addresses much of what I've been feeling, including "a lack of adequate training and confidence in the topic, a perception that there are few treatment options, a lack of adequate clinical time to obtain a sexual history, patients' reluctance to initiate the conversation, and the underestimation of the prevalence of sexual dysfunction."

I was encouraged that in this report, ACOG acknowledged sexual health as an important "element of overall health" and also supported the World Health Organization statement that

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sexual health is "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity."[2]

Additionally, ACOG warns that sexually transmitted infections are on the rise. It quotes the alarming fact that 2015 was the second year in a row in which the rates of chlamydia, gonorrhea, and syphilis have increased. As health care practitioners we may be able to have an impact on this and on related health risks (eg, pelvic inflammatory disease, ectopic pregnancy, infertility, epididymitis) by asking all patients about being tested, discussing safer sex practices with everyone, and never making the presumption that it isn't necessary.

Primary care physicians are usually aware that medical conditions such as diabetes, hypertension, thyroid disorders, cancer, and depression can have an impact not only on a patient's physical and emotional health but also on his/her sexual health. Often, however, we don't know much about what we can do to help, and because of this, we don't even want to ask.

One technique that is simple but useful is the PLISSIT Model[3] of giving permission (P) for patients to discuss their sexual concerns, providing limited information (LI) and specific suggestions (SS) to help, and then referring for intensive therapy (IT) if needed.

There are also simple questionnaires such as the Decreased Sexual Desire Screener (DSDS), which has 5 yes or no questions. If a clinician is interested in going into more depth, there is the Female Sexual Function Index (FSFI),[4] which has 19 questions to which a patient rates her responses from 1 to 5. There is also the Sexual Health Inventory for Men (SHIM). These questionnaires, including how to interpret them, are easily found online and are free to download and use.

COMMON PATIENT CONCERNS AND TREATMENTS

Decreased sexual desire is the most common concern brought up by my patients (and the one we often dread hearing a patient bring up as our hand is on the doorknob). There are medication options now, but for most women it seems to be reassuring when we discuss how very common this is (up to 40% of women) and that this is not necessarily a medical problem. It may help women to discover that, although they may not walk around thinking about sex all the time, if they are able to respond to their partner's advances or an erotic film or image or book, they are very normal. We discuss that there may be a discrepancy in how often they want or initiate sex as opposed to their partner (there is actually a term for this called *desire discrepancy*), and it can help to address all the varied factors that come into play (so to speak!). We discuss that sexual motivation can be complicated and include many important factors, such as their relationship with their partner, the length of time in the relationship, children or concerns about getting pregnant or not getting pregnant, work/life stress, body image, aging, history of abuse, lack of experience, boredom/routine, cultural upbringing, religion, medications, hormones, and so on.

Many of my perimenopausal and menopausal patients, and sometimes even breastfeeding women and women using oral contraception, complain of vulvovaginal pain with vaginal penetration. This is often caused by hypoestrogenic atrophic vaginal changes or the "genitourinary syndrome of menopause,"[5] which can cause vaginal dryness and subsequent pain with penetration as well as vaginal itching, burning, and discharge.

I knew to inform women to avoid harsh soaps and detergents, but now I've learned about the variety of lubricants, including water-based, silicone, hybrids, and oil-based. I've learned about additives or preservatives to avoid, such as propylene glycol (often found in antifreeze) and chlorhexidine, that can cause burning and irritation and, like glycerine or sometimes coconut oil, even yeast infections. I knew about not using oil-based lubricant with latex condoms but have learned that it is acceptable with nitrile and polyurethane but not polyisoprene barriers. And I've discovered that you shouldn't use silicone lubricants with silicone vibrators as they can cause disintegration of the vibrator. I've been able to share this information with my patients. I also recommend vaginal moisturizers (eg, Luvena, Replens, Lubrigyn), which, used on a regular basis, can help improve vaginal dryness in some women, especially those who don't want to use vaginal estrogen.[6]

Many physicians are still not aware that vaginal estrogen appears to be more effective than systemic therapy for the treatment of vaginal atrophy. They are also concerned that the Food and Drug Administration (FDA) has applied the black-box warning regarding the potential risks of oral and transdermal estrogen to vaginal preparations. I talk to women about the benefits of vaginal estrogen, including the fact that low-dose options such as vaginal estrogen tablets and the vaginal estrogen ring have minimal to no systemic absorption of estrogen and, as such, appear to carry minimal if any risk. However, the vaginal tablets (Yuvafem, Vagifem) and the ring (Estring) sometimes do not help enough. They tend to only improve lubrication in the upper two-thirds of the vagina. If penetration is painful, it's not enough for the upper two-thirds to be lubricated when the lower one-third remains dry and painful. Vaginal estrogen cream (Estrace, Premarin) does appear to be slightly more systemically absorbed, but often provides better overall lubrication and improvement in vulvovaginal atrophy.

In 2016, ACOG issued a Committee Opinion regarding the use of vaginal estrogen for managing urogenital symptoms in women currently undergoing treatment of breast cancer or with a personal history of breast cancer.[7] ACOG advises that nonhormonal approaches are still the recommended first-line choices, but that vaginal estrogen could be considered for those patients unresponsive to nonhormonal treatment, and that data do not show an increased risk of cancer recurrence. I discuss this with my patients and suggest they try silicone lubricants and vaginal moisturizers first, but let them know vaginal estrogen could be an option. For many patients, even before the ACOG opinion, this is a quality-of-life issue and an option they are relieved to have.

There is now an FDA-approved product for the treatment of moderate to severe dyspareunia available for prescribing since July 2017.[8] It is a daily intravaginal suppository of dehydroepiandrosterone called prasterone (Intrarosa). It is a prohormone that gets converted to local estrogen and testosterone and has

been demonstrated to improve lubrication; decrease pain at sexual activity; and consequently, improve sexual function, desire, arousal, orgasm, and satisfaction. Because prasterone is not an actual estrogen, it does not have the mandated black-box FDA warning that all estrogen products currently must have, but there still may be potential concern.

Ospemifene, a selective estrogen receptor modulator that acts as an estrogen agonist in the vagina, can also address this problem. It is a daily, oral medication, approved by the FDA in 2013 for the treatment of moderate to severe dyspareunia caused by vulvovaginal atrophy in menopausal women. It appears to have minimal estrogenic effect on the endometrium and breast but may cause systemic side effects such as hot flashes and the potential increased risk of thromboembolism. This product is also contraindicated in women with a prior history of breast cancer or in women with an increased risk of thromboembolism.

The laser devices that are touted as treatments of vulvovaginal atrophy are still not FDA approved for this condition, and at least currently, there is scant published evidence that this procedure improves vaginal epithelium and subsequently symptoms of atrophy. It is also quite expensive.

Many of us have attempted to examine patients who have extreme difficulty tolerating a speculum. I certainly wasn't taught that vaginismus (the marked tensing and tightening of the vaginal muscles) can be voluntary or involuntary when a woman is anticipating pain, and that this often develops in response to a past painful experience. It can be related to a less-than-optimal first sexual experience, a history of abuse, or simply a former painful vulvovaginal condition that left the memory in both her emotional and physical response. We can even cause this condition if a patient has a bad first experience with a pelvic examination or Papanicolaou test.

I sometimes gently joke with my patients and tell them, "Your vagina isn't stupid. It's trying to protect you." I work on having a patient consciously contract her vaginal muscles while I gently place a gloved, lubricated finger at her introitus. I then have her intentionally relax those muscles and breathe while I gradually and gently insert my finger a little farther. If it's too much, she tells me, and we stop. We repeat this slowly until a woman is able to accommodate my finger and later a speculum. If that doesn't work, we start with a small vaginal dilator either in the office or at home, again using time and lubrication and relaxation techniques and gradually increasing the dilator size (see Sidebar: Dilator Resources). This allows women to be in control of the situation, alone or with a partner. Because many partners are fearful of hurting the woman, it can be comforting to them to be able to participate in helping her relax and start to be able to enjoy intercourse and be comfortable with penetration (if this is the goal). It helps, of course, if the patient and her partner are motivated and have good communication. But this can even help improve communication around sex and what feels good and what doesn't (see Sidebar: Resources for Genitourinary-Pelvic Pain Disorders in Women).

Orgasmic dysfunction can be related to a medical condition or medication, but I have had women share with me that they are nonorgasmic (or their male partners have told them this) because they never had an orgasm from penile-vaginal intercourse. For these women to be reassured that this is quite normal and that most women need some type of direct stimulation of the clitoris can be very affirming. It may require open discussion with a partner regarding what she enjoys or requires to achieve orgasm, or some experimentation with stimulatory devices, but often just the knowledge that she is not "abnormal" is empowering.

There are an almost endless variety of vibrators, including an erection-enhancing ring for men, which may also contain a clitoral stimulation device for a female partner to better provide direct clitoral stimulation during penile-vaginal intercourse.

There are also personal care products such as the Fiera, a vibrating device that provides vacuum suction to increase circulation to genital tissues and, as such, may help with stimulation, lubrication, and orgasm, and potentially with hypoactive desire. It can cost around $200 though, and, if the patient seems receptive, I will sometimes try joking that there are other, less costly ways to provide suction to the clitoris that may have the same effect. However, we certainly must exercise caution, because it can be very difficult to know a patient's comfort level with various sexual practices or even with the discussion of something such as a vibrator or "self-stimulator" (see Sidebar: Retail Web Sites).

As an obstetrician/gynecologist, I don't deal as much with male sexual dysfunction, but conditions such as premature ejaculation or erectile dysfunction can certainly have an impact on

Retail Web Sites

AdamandEve.com: www.adamandeve.com

Babeland.com: www.babeland.com

Eve's Garden: www.evesgarden.com

Good Vibrations: www.goodvibes.com

MiddleSexMD: http://middlesexmd.com

Walgreens: www.walgreens.com (sexual wellness)

Dilator Resources

Vaginal dilators can be purchased online at:

- CooperSurgical: www.coopersurgical.com
- Current Medical Technologies Inc: www.cmtmedical.com
- MiddleSexMD: http://middlesexmd.com
- Pure Romance: www.pureromance.com
- Soul Source: www.soulsource.com/
- Vaginismus.com: www.vaginismus.com

Resources for Genitourinary-Pelvic Pain Disorders in Women

International Pelvic Pain Society: www.pelvicpain.org

National Vulvodynia Association: www.nva.org

Vaginismus.com: www.vaginismus.com

Vulvodynia.com: http://vulvodynia.com

my female patients, their sexual response, and, of course, their relationships. In addition to looking at the possible medical and psychological causes of these conditions, the distress that this may cause both partners must be addressed.

I believe we should do what we can to open communication around the important sexual aspect of our overall health. Patients should be able to speak freely to their health care practitioner without shame, embarrassment, or the fear of being judged. Few of us may currently encounter patients who are lesbian, gay, bisexual, transgender, or gender-dysphoric (feeling distress that the gender you are born does not match the gender with which you identify yourself); or perhaps we do but just don't realize it. In a recent survey, a large percentage of these patients stated that they delayed or did not seek medical care as a result of discrimination.[9] For a homosexual woman or a transgender man (a person born female but who self-identifies as male), a pelvic examination can be very uncomfortable. Many of these patients are nulliparous, and some have had limited or no vaginal penetration. Use of relaxation techniques, communication, sometimes topical lidocaine jelly at the introitus, and the smallest, narrowest speculum possible can be helpful during a pelvic examination.

Bibliotherapy for Patients

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Informative Web Sites for Patients and Clinicians

American Association of Sex Educators, Counselors and Therapists: www.aasect.org

American College of Obstetricians and Gynecologists: www.acog.org

American Sexual Health Association: www.ashasexualhealth.org

Association of Reproductive Health Professionals: www.arhp.org

International Society for the Study of Women's Sexual Health: www.isswsh.org

Kinsey Institute: www.kinseyinstitute.org

North American Menopause Society: www.menopause.org; module on "Sexual Health & Menopause" (www.menopause.org/for-women/sexual-health-menopause-online)

Society for Sex Therapy and Research: www.sstarnet.org

REFERRALS AND RESOURCES

A multifaceted approach can be helpful for many medical and psychological conditions as well as sexual disorders or concerns. A qualified physical therapist can be quite helpful in the treatment of vaginismus and dyspareunia. Mindfulness-based stress reduction, now more commonly called "mindfulness" or "being present" focuses on nonjudgmental awareness of one's thoughts, feelings, perceptions, and environment.[10] It may help improve sexual functioning, as can cognitive behavioral therapy.

For patients whose issues are too complex to be dealt with in ordinary office practice, practitioners or patients can find a certified sex counselor or therapist in their area at the American Association of Sexuality Educators, Counselors and Therapists (AASECT) Web site (www.aasect.org). A licensed marriage and family therapist can also be helpful, because sexual problems can certainly affect a relationship, or conversely, the relationship can be part of the reason for a sexual problem. I have found that an AASECT-certified therapist is often a very good resource for patients dealing with the many interrelated components of sexual and relationship issues. The Society for Sex Therapy and Research (www.sstarnet.org) can also be helpful for finding a reliable and knowledgeable professional (see Sidebar: Informative Web Sites for Patients and Clinicians).

For patients whom I believe might benefit from reading material, I use bibliotherapy (see Sidebar: Bibliotherapy for Patients) and printed handouts (eg, on recommended lubricants and information regarding the risks and benefits of vaginal estrogen) as well as informative and retail Web sites (see Sidebars: Retail Web Sites and Informative Web Sites for Patients and Clinicians).

CONCLUSION

It is refreshing to me that, although I may not have all the answers, I can help women by asking and listening, and often normalizing their experiences and concerns. There is no shame in not knowing all the answers, but there is shame if a woman never feels comfortable enough to ask for our help. ❖

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Consecration of Marriage Vows

She [the bride] should be informed that it is a consecration of the marriage vows and a bond of union between her husband and herself. She should be told that it is right and proper for her to experience pleasure in its performance … it is only fair for the girl to understand that there is no immodesty in her active participation, but on the contrary that such action on her part will increase the interest of the event for both her husband and herself.

— Denslow Lewis, 1856 - 1913, gynecologist, teacher, and author