



Women's Sexual Health Journal

Editorial

Passionate About Sexual Health

It is difficult to describe what an honor it is to step into the role of Editor of the Women's Sexual Health Journal. I feel like an ant among giants, a sex therapist in private practice in Orange County, CA, rather than a hotshot at a prestigious academic setting or a maverick working in a famous hospital. Yet I know that my passion about women's sexual health is no less great than the esteemed founder of the Foundation, Lisa Martinez, RN, JD and the members of its board of directors. I am very much looking forward to continuing in Dr. David Ferguson's role, and hope to get to know many of you better in the coming seasons.

As I reviewed the articles for this issue, I found myself chuckling that I was old enough to remember a certain deceased entertainer who would remark, "We have a really big shoe tonight!" (That's Ed Sullivan for you kids out there.) That was my thought about the journal, which is varied but carries one common theme: the quality of medical care, not just for sexual concerns but across the board. Rocker Christine Baze's story reminds us that, with proper care, women can triumph over cervical cancer, a diagnosis that has, unfortunately, become more common among young women. More than that, read her story to discover how sorrow and anger can be transformed to create a greater good.

The Mayo Clinic is fortunate to have a fully integrated team for optimizing women's sexual dysfunction, and we are fortunate to have an article submitted by Dr. Schuster et al describing their approach. As a former co-owner of an integrated medicine clinic, I can vouch that a team approach is to be lauded, but it is difficult to pull off in a stand-alone clinic. It is, I think, much better to have this work supported within a hospital setting. Hopefully, this approach will become the viable norm in the future, as common as the ubiquitous urgent care centers that dot across our cities.

Desire at midlife is an ever-pondered topic, and in this issue clinical social worker Melissa F. Crown writes about her own discovery of a study from Italy on the effect of the olfactory system on desire in midlife women. She advocates for an exploration of the sensual self at this stage of a woman's life. Who wouldn't rally behind her?

Finally, Lisa Martinez provides an article that can become a great handout for patients on how to find quality medical care. She tells readers how to ask the most important questions, and what to do if you don't get the answers that you seek from your medical provider.

In coming issues, we have gathered together a wide range of material on post partum sexuality, another topic much discussed but not well understood. We hope you will find these upcoming articles as enlightening as we have.

Editor—Stephanie Buehler, MPW, PsyD, CST

Invitation to Attend TWSHF 3rd Annual Education Event

The Women's Sexual Health Foundation and Columbia University College of Physicians and Surgeons Department of Obstetrics and Gynecology invite all women to attend **Reclaiming Healthy Intimacy, Passion and Pleasure**, Friday, October 5 in

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Published four times yearly by The Women's Sexual Health Foundation, Cincinnati, Ohio. The Journal (WSHJ) is an educational service to provide valuable information to professional, student, and public members of the Foundation. Founded in April of 2003, and directed by Lisa Martinez, RN, JD, The Women's Sexual Health Foundation (TWSHF) is a nonprofit corporation. TWSHF supports a multidisciplinary approach to the treatment of sexual health issues and serves as an educational resource for both the lay public and healthcare professionals. The Professional Advisory Board: Yitzchak (Irv) M. Binik, PhD, David Ferguson, PhD, MD, FACCP, Jean Fourcroy MD, PhD, Marjorie A. Green, MD, MPH, Andre T. Guay, MD, FACP, FACE, Susan Kellogg-Spadt, PhD, CRNP, Michael L. Krychman, MD, FACOG, Talli Rosenbaum, PT, Eusebio Rubio, MD, PhD, Gita Singh, MD, Mitchell Tepper, PhD, MPH, and Beverly Whipple, PhD, RN, FAAN.

Articles, letters, and questions may be submitted to Dr. Stephanie Buehler, at info@twshf.org.

New York City at Columbia University, Alfred Lerner Hall, The Roone Arledge Cinema, 2920 Broadway (at 115 Street), New York, NY 10027. Registration for this event is required and includes a buffet breakfast.

The focus will be empowering women on how to address their sexual health concerns and to reclaim the intimacy that they deserve. This is an opportunity to discover solutions from the experts, to ask questions, and to understand why menopause, pregnancy, cancer, incontinence, diabetes, stress and other life changing events can impact healthy intimacy.

The speakers will include experts in the area of women's sexual health and intimacy: Dr. Hilda Hutcherson, Dr. Beverly Whipple, Dr. Saundra Leiblum, and Lisa Martinez RN/JD.

For more information on attending this event or on becoming a sponsor, contact Josephine Caputo at 201-346-7003 or at jc2768@columbia.edu.

Current Sponsorship for this event is provided by Procter and Gamble, King Pharmaceuticals, and The Women's Sexual Health Foundation. If you would be interested in becoming a sponsor, contact The Women's Sexual Health Foundation at info@TWSHF.org.

A Woman's Story:

My Story: Cervical Cancer

By Christine Baze

"I'm going to be a rock star!" That was my dream in January of 2000, when I quit my day job to pursue fulltime my one true passion, music. My band was doing great, and I could not have been happier. One week later, I saw blood. Immediately, I called my gynecologist, who chalked it up to stress, told me not to worry, and said he would see me at my annual exam in March. Of course, he's the doctor, so I trusted him and happily continued to write songs and book my band to play. I felt so lucky to be able to pursue my dreams.

This was not to last. Although all of my previous Pap tests had been normal, the results from my Pap in March showed some abnormal cell growth on my cervix. My doctor ordered a colposcopy, a more advanced exam that allowed him to take a biopsy to test my cells for problems. At that point, I barely knew where my cervix was, much less about cell mutations that could turn into cancer many years down the road if untreated!

My doctor assured me that because of my history of normal Paps, he was sure I did not have cancer. It was, he said, probably just "dysplasia"—pre-cancerous cells that can be easily treated. We were to

meet the following week to discuss the results of the colposcopy and biopsy, and I was scheduled to have a simple follow-up procedure to remove the bad cells.

The doctor was wrong. On April 18, 2000, I was diagnosed with invasive cervical cancer with extensive lymphatic invasion. Everything happened so quickly after that. Ten days after the diagnosis, I had a radical hysterectomy. One month after that, I had a laparoscopic procedure to move my ovaries out of the "frying zone." Then, I had five weeks of daily pelvic radiation, concurrent with four rounds of chemotherapy followed by three rounds of internal radiation (brachytherapy). They basically gave me everything they had to save me. Within four months, I was done with everything. Except, that is, for the deep, dark depression to follow.

Everyone knows that the treatment is hard, and it takes an awful toll on the body. But for me, the depression was undoubtedly the worst. I felt like I lost everything. Music, the one passion that always centered me and guided my life, was gone. I couldn't play, sing or write; I didn't know who I was anymore. Like my cancer treatment, I attacked the depression with full force, using individual therapy, group therapy, antidepressants, acupuncture, yoga, journaling, and more. Time and perseverance gradually began to work; I had already worked so hard to stay alive, and I refused to quit. I wanted my life back. However, the music seemed to have left my body with my uterus, and I felt like it would never return.

My life-altering moment occurred while watching the movie "Harold and Maude." The character of Maude is an older woman who embraces all that life has to offer -- every sensation, touch, smell, feel. She lives in the moment while teaching a young boy, Harold, to do the same. Maude's spirit and the Cat Stevens soundtrack drew me back to the piano. I felt the song "Trouble" had been written for me, describing what the last year and a half of my life had been. That moment, in the fall of 2001, changed my life. I knew I needed to help others through my music and my voice. Thus, I was motivated to create *Popsmeat.org*.

At first, *Popsmeat.org* was one benefit concert – in the fall of 2002 – to raise money and awareness among women about the importance of the Pap test, and specifically how much more accurate the liquid Pap is at picking up cell changes. (My doctor had always used the traditional, less accurate Pap, and it wasn't until he switched to the liquid Pap that my cancer was caught.) In addition, I was just learning about HPV - the human papilloma virus (HPV), the virus that causes cervical cancer. I could NOT understand how I had never even heard of it, despite the fact that 80% of all women will get it by the time they are 50. And I was excited to learn there was a test (the HPV test) that could be given at the same time as the Pap to let women know if they were at risk even before cells started to change. I had educated myself, so I wanted to educate others. *(continued on page 3)*

My message was simple—cervical cancer is preventable if we use the tools available. Ladies, take care of you. Go to your annual visit. Have a conversation with your doctor. Ask for the best—the liquid Pap—and if you are 30 plus, the HPV test.

It worked. People took notice—the press took notice—and most importantly, the message got out to thousands of women. Therefore, in 2003, I made *Popsmeat.org* my non-profit organization and decided to take my story and music on the road and created The Yellow Umbrella Tour. We played six cities and *Ms. Magazine* named me one of “50 women who made a difference in 2003.” Since then I have done 3 other national Yellow Umbrella Tours totaling 86 cities. I’ve been in the New York Times, Chicago Tribune, Boston Magazine, Oxygen, Jane, and so many others. I’ve now received a few other awards for my efforts as an activist. I got to sing at Fenway Park and Madison Square Garden and speak on Capitol Hill. The last few years, I have toured the country each fall with people like Ben Folds, The Fray, and Kaki King—singing my songs and giving the message: cervical cancer is preventable. I love my life.

Now this is what I do. I talk about my experience, and I sing my songs, and I motivate people to say SOMETHING, do SOMETHING—because this doesn’t have to happen to anyone else. And now, with the vaccine, we truly have all the tools necessary to ELIMINATE cervical cancer. I’m incredibly passionate because I know what it feels like on this end.

And that’s the thing that doesn’t change. I know what it feels like to have a hysterectomy at 31 . . . to feel that pain and that emptiness. I will never have a kid that has my blue eyes and my curly hair. I know that. I felt like less than a woman for years—and I still struggle with my femininity, not feeling quite whole. And I know what it feels like to go behind those big thick metal doors and get zapped every day—and what it’s like to have chemo pumped into your arm for five hours before getting zapped. I know what it’s like to fight through it when it’s happening, how to fight when you are so sick after, and how to fight each and every day, almost seven years later, with the side effects that won’t go away. I know what it’s like to have the memories, the nightmares, and the feelings that come with cervical cancer.

I had a reporter recently comment on my music career benefiting from my cancer. I told her I would give up EVERYTHING if I could go back in time and NOT get cancer. There are no songs, or tours, or interviews, or level of popularity that will ever replace what I lost. Ever.

It is too late for me – but not for others. So that is why I do what I do, and will continue to do, until I see it happen... until I see the elimination of cervical cancer.

Donation Recognition

2007 TWSHF Donors

The Women’s Sexual Health Foundation would like to thank the following donors for helping the Foundation advance its mission.

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For more information on opportunities for giving, please email: info@twshf.org.

All gifts are recognized on the TWSHF website at our Donor page, unless the donor prefers to remain anonymous.

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Supporting the Foundation

Thank you for your interest in supporting the work of The Women’s Sexual Health Foundation, an international non-profit organization. We seek to empower women with information about sexual health. It is only through your generous donation that the Foundation can achieve its mission: to provide educational resources with the latest research for women and healthcare providers, to support a multidisciplinary approach to sexual health issues, and to increase worldwide awareness on women’s sexual health.

No contribution is too small to further the mission of the Foundation.

All gifts are recognized on the TWSHF website at our Donor page, unless the donor prefers to remain anonymous.

If you would like to make a donation, please send your tax deductible contribution to:

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Addressing Women's Sexual Concerns Through an Integrated Team Approach

*By Lynne T. Shuster MD, FACP, Mary
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A 26-year-old woman seeks care for concerns that include inability to have an orgasm and lack of pleasurable sensation to sexual touch. Her gynecological history is notable for painful and heavy menstrual periods, endometriosis, past pelvic surgery for a uterine septum, and D&C for heavy, irregular bleeding. Her medical history is notable for obesity, depression, and a nipple discharge. She is taking a birth control pill, an antidepressant medication, and analgesics for dysmenorrhea. How would you approach treatment with this patient?

This woman, who sought care at our Women's Health Clinic, is typical of other women with sexual dysfunction whose symptoms and concerns cross boundaries of traditional medical specialties. Typically a primary care provider might offer one treatment, gynecologist another, psychologist/psychiatrist another, internist another, and rarely would there be an opportunity for the providers committed to this woman's care to interact and coordinate an integrated care plan. Also, these individual providers might have variable training, interest, or comfort in caring for a woman with sexual concerns.

The multidisciplinary team at the Mayo Clinic Women's Health Clinic for Menopause & Sexual Medicine is comprised of providers specializing in internal medicine and women's health, obstetrics and gynecology, sex therapy, and nutrition/lifestyle counseling, all of whom are co-located at one site. The team also collaborates with a compounding pharmacist and pelvic floor physiotherapy program.

Women presenting with sexual concerns meet first with the sex therapist, then with an internal medicine or gynecology physician. Providers meet with one another after evaluating the woman's concerns to formulate an integrated treatment plan, and then meet with her to provide recommendations on the same day of the initial visit or on a subsequent day if diagnostic testing is recommended. Referral to other providers within our multispecialty group practice is managed depending on the patient's medical and psychological needs.

What did we do with this patient? Her psychosexual development was reviewed, depression

and other mental health concerns assessed, personal and relationship strengths identified, and information about sexuality provided. Her gynecologic issues with past pelvic surgeries and ongoing pain were carefully addressed. Genital sensation was tested and found to be compromised. Contraception options to the birth control pill were reviewed, her antidepressant regimen modified, and referral to pelvic floor physiotherapist provided. Sex therapy addressed ways to optimize sexual activity to deal with impaired genital sensation. Breast concerns were evaluated and found to be benign. Nutrition and body image concerns were assessed and strategies to help her succeed with personal goals for healthy eating, regular exercise, and weight control were identified.

For this particular patient, the outcome was similar to that for other women seeking care for sexual concerns. Some of the specific symptoms prompting her to seek care improved, others did not. But her overall satisfaction with care and personal rating of satisfaction from treatment were outstanding. She reported her health status to be improved, relationship enhanced, self-image stronger, and need to seek treatments from medical providers diminished. She felt better able to use self-care strategies for sexual and mental health concerns as well as the medical concerns. She reported experiencing closer emotional and sexual intimacy with her partner.

Case #2

A 52 year old woman, accompanied by her husband of 28 years, sought care for severe vaginal dryness and painful intercourse. Her medical history was notable for Stage II breast cancer treated with lumpectomy, radiation, and chemotherapy 3 years ago, followed by a two year course of tamoxifen. Four months prior to evaluation at the Women's Health Clinic, she was switched from tamoxifen to anastrozole. She developed menopausal symptoms during the course of cancer therapy and took venlafaxine for hot flashes. Gynecological examination at the Women's Health Clinic confirmed severe atrophic vaginitis.

While she was grateful to survive breast cancer, her sexual relationship had not fared as well. She reviewed the developmental experience of her sexuality across the stages of her life. She identified feelings of sadness about her decrease in response to sexual stimulation and loss of sex drive, while she retained her desire to restore and rebuild her sexuality. She was concerned as well about the impact on her partner's sexual satisfaction and on their relationship. Once again, a team approach allowed the providers to address biological concerns while supporting her as a woman evolving her sexuality in a new context, and assisted them as a couple in the challenge of restoring sexual intimacy.

How could we help this woman's vaginal dryness, dyspareunia, and arousal changes? She was

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not a good candidate for systemic estrogen in view of her history of breast cancer. Is she a candidate for local, vaginal estrogen? Is she willing to take it? Is her oncologist comfortable with it?

An acceptable therapy for some women with a history of breast cancer is a vaginal moisturizer. Moisturizers such as Replens provide a bioadhesive polymer that binds to vaginal epithelium, releasing purified water, and producing a moist film over vaginal tissues. It can be helpful when used regularly and in conjunction with an over-the-counter personal lubricant at the time of sexual intimacy. For some women, this approach may be adequate, but for others, more aggressive therapy may be required, particularly in order to help with arousal and orgasm.

This patient was taking an aromatase inhibitor, which blocks the conversion of androgen to estrogen in the body, thereby markedly lowering systemic estrogen levels with the goal of reducing cancer recurrence or metastases. Typical symptoms of estrogen deprivation may include vaginal dryness, dyspareunia, hot flashes, sleep disruption, and arthralgias. While systemic estrogen therapy is contraindicated, local vaginal estrogen is often considered to help provide relief from urogenital symptoms. The longterm safety of adding vaginal estrogen for women with a history of breast cancer and taking aromatase inhibitors is not known. Small studies have shown systemic levels of estradiol to be low in women using vaginal estradiol tablets or a vaginal ring.^{1,2} In a recent small study of breast cancer survivors taking aromatase inhibitors and using vaginal estradiol tablet or cream, five of seven women had small initial increases in serum estradiol levels, but a notable decrease in serum estradiol levels by 12 weeks of therapy.³ Two of the seven women had a later rise in serum estradiol level, prompting discontinuation of the therapy.

This woman was counseled regarding benefits and potential risks of vaginal estrogen therapy and chose to use an over-the-counter vaginal moisturizer. She also elected to continue venlafaxine. Meanwhile, body image, sexual function, and relationship changes were addressed, and expanded approaches to sexual and emotional intimacy were explored. She reported an improvement in her emotional concerns and feelings about sexual intimacy.

Case #3

A 46-year-old woman presented for evaluation of decreased libido for 7 months. Genital touch no longer felt pleasurable, vaginal lubrication was adequate, but the ability to experience arousal and orgasm was gone. She was in a long-term committed relationship. Her work was stressful and parenting responsibilities challenging due to a joint custody arrangement following divorce.

Past medical and surgical history were notable for multiple problems including fibromyalgia with widespread musculoskeletal pains, lumbar laminectomies for recurrent radiculopathy, partial colectomy for intractable bowel evacuation problems, migraines, recurrent depression, and recent irregular, heavy menstrual periods. Current medications included trazodone for sleep, ketoprofen when needed for headaches, naratriptan when needed for migraines, low dose venlafaxine, multivitamins, and minerals. She completed a full medical evaluation with her primary medical provider several months prior, and no changes were suggested to her medical regimen.

Comprehensive medical evaluation at the Women's Health Clinic included a review of worsening headaches and neck pain, in addition to the sexual concerns. Complete physical, gynecological, and neurological examination revealed decreased genital sensation without other identifiable abnormalities. She was referred for magnetic resonance imaging of the spine that revealed a high-grade cervical stenosis. She is awaiting neurologic evaluation and treatment and will return later for follow-up of sexual concerns.

Over the past year, we have seen several patients presenting for evaluation of sexual concerns who were subsequently found to have spinal cord processes causing sexual dysfunction. In each case, the underlying process was not identified until the patient sought evaluation for sexual changes.

Discussion

As the science of sexual medicine is advancing, increasingly we are able to identify underlying medical issues contributing to female sexual dysfunction. Whether there are hormone deficiencies, medication side effects, impairment of blood flow or nerve sensation to the genitals, pelvic floor disorders, or some of the other most frequently identified causes, treatment always requires addressing the underlying physiologic problem as well as psychosexual and relationship issues that develop in response to compromised sexual function. Each woman's psychosexual development, emotional health needs, relationship, family, and socio-cultural context need to be woven together with medical treatments to mend the fabric of her life that may have been disrupted by sexual dysfunction.

For those committed to the care of women with sexual concerns, it is rare to be able to provide care all in one site with an integrated team of providers. Having a core team of providers able to address the medical, gynecological, psychosexual, and emotional needs of each patient and to formulate an integrated, individualized treatment plan is optimal.

Measurements of success with treating female sexual dysfunction need to be expanded beyond traditional medical care models seeking "cure." We find the process of evaluating, educating, and guiding

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the whole woman toward improved sexual intimacy is treatment in itself. This journey can be healing for the woman and gratifying for her care team.

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1 *Notelovitz M, Funk S, Nanavati N, Mazzeo M. Estradiol absorption from vaginal tablets in postmenopausal women. Obstet Gynecol 2002; 99:556-62.*

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3 *Kendall, A, Dowsett M, Folklerd E, Smith I. Vaginal estradiol appears to be contraindicated in postmenopausal women on adjuvant aromatase inhibitors. Ann Oncol 2006; 17:584-7.*

Awaken the Body's Senses: Midlife Desire

By Melissa F. Crown, LCSWC

One client exploring matters of the heart confided: "I married later in life. With two children and my turning 50, how do you get things juicy again?"

Women at midlife must navigate a rugged landscape, both emotional and physical, with grown children leaving home, possible divorce, the loss of a parent or a dream un-lived. These challenges, coupled with menopause--a time of hormonal fluctuations--can send the body on a biochemical roller coaster. For many women, the wings of desire with its feelings of longing and sexual appetite crucial to an intimate and caring relationship also fly away. At midlife the

question becomes: How can this elusive element, desire, be rekindled?

While men pay attention and get excited by visual images of a woman's full lips or gazelle-like legs, women are different. They rely on the emotional connection, a shared sense of intimacy, and the smell of a man.

That's right. The Research Group for Sexology, at the University of Catania, Italy is investigating how the body's senses, especially the sense of smell, can influence our human sexual response. The olfactory sense organ is made up of a mucous membrane consisting of 2 major layers: an epithelium and a connective tissue. Dr. Salvatore Caruso, principal investigator of the research group commented via an email interview on their findings that giving hormonal therapy to post menopausal women for a period of 8 months enhances not only the olfactory epithelium tissues but also desire. What surprised him about his study? Caruso responded, "that I did not expect hormones to play such an important role enhancing the epithelial system."¹

Caruso described the importance of the olfactory system beyond its connection to desire. It helps us adapt and learn from our environment. Memories of events stored in the central nervous system are accessed, in part, through the olfactory nerves. Simply said, memories are brought to life through smell.

Menopausal women today, however, must proceed with caution as they decide whether, in what combination, and for how long to take hormonal therapy after the 2002 Women's Health Initiative was stopped because of the concern that hormones (Prempro) slightly increase the risk of breast cancer and heart disease.²

"The normal aging process has a way of changing our sense organs," adds endocrinologist Zidi Berger, a longevity specialist practicing in Bethesda, MD. Berger asks, "How are women to compensate for this natural process? By adapting to these changes and consulting dedicated professionals who are exploring sexuality."

Many women ask why desire is important, especially at this stage in their lives. Beyond the benefits associated with the "pleasure principle," sexual engagement promotes longevity, pain management, and improves mood.³ The body at midlife holds the possibility of desire, not center stage, as in earlier years, but nonetheless, in a way that makes a woman feel more alive.

*"Eroticism is the poetry of the body, the testimonies of the senses. Like a poem, it is not linear, it meanders and twists back on itself, shows us what we do not see with our eyes, but in the eyes of our spirit . . . The senses become servants of imagination, and let us see the invisible and hear the inaudible."*⁴

(Continued on page7)

- 1 Caruso S, Grillo C, Agnello C, et al. Olfactometric and rhinomanometric outcomes in post-menopausal women treated with hormone therapy: a prospective study. *European Society of Human Reproduction* 2004; 19:2959-2964.
- 2 Women's Health Initiative; *JAMA* 2002; 288:321-333.
- 3 Published in cooperation with the Society for the Scientific Study of Sexuality. *The Health Benefits of Sexual Expression*. 2003; Planned Parenthood Website.
- 4 Octavio Paz. *The Double Flame: Love and Eroticism*. New York: Harcourt Brace and Company, 1995.

Question and Answers

By Lisa Martinez RN/JD
Executive Director

The Women's Sexual Health Foundation

Q: How do I find a professional to help me with my intimacy difficulties, and what questions should I ask?

A: Often we will spend more time researching a new car purchase or the renovation of our kitchen, than we should finding a competent and caring physician or healthcare professional. If we really think about this, our bodies are much more important than a home renovation or a car and deserve the best care possible.

Define your concern

Ask yourself what kind of difficulty you are having. Is it pain with intercourse after pelvic radiation? Is it lack of arousal since being diagnosed as a diabetic? Is it lack of desire or a combination of difficulties? When did you become concerned and what seems to have brought this difficulty on?

Ask friends and other doctors and nurses for a recommendation

These individuals may be able to recommend professionals who specialize in women's intimacy difficulties. You may need to see a team of professionals. Potentially, you may need to see a gynecologist, endocrinologist, a pelvic floor physical therapist, a psychologist, and/or a sex therapist, or other professionals. Solutions to these concerns often require a multidisciplinary team.

Ask about training and experience

If you are looking for physicians, are they Board Certified, and how much training did they receive in the area of women's health and sexuality? Where did they receive their training? How long have they been treating women for sexual health disorders?

If you are looking for a sex therapist, is the therapist AASECT certified? How long has this therapist been seeing patients?

Similar questions should be asked of any professional you may be seeing for your concerns.

Get a second opinion

If surgery or an invasive treatment is recommended, get a second opinion. If the first physician you saw is upset that you have obtained a second opinion, then find another physician. Second opinions are the norm. Do not get a second opinion from a physician within the same office.

Speak with other patients

Ask to speak with several patients who have had the same surgery or treatment. Preferably you should speak with women who are at least one year post treatment or surgery. This is especially important if this is a relatively new procedure or treatment.

Also you may want to chat with patients in the waiting room. Ask how long they have been seeing this provider and what do they think? This is a productive way to pass the time in the waiting room.

Good bedside manner

A competent healthcare provider has a good bedside manner. If he/she is dismissive or abrasive you may feel intimidated to ask questions. The days of, "I just want a competent professional and I do not care if that individual is nice" are over.

With any treatment ask the risk, benefits and alternatives

Medications

Some medications are ordered off label in the United States. This means that it has not been FDA-approved for the purpose that it is being ordered for. Physicians may order a medication off label, but you should ask if the medication has been FDA-approved for the purpose your physician or nurse practitioner is prescribing it for.

Ask why it is being prescribed; what benefit you should expect to see; and how long will it take to see a benefit. How many patients does this provider have on this medication? What you are looking for is the breadth and depth of experience that this provider has with this medication. Of course if they have numerous women on a medication, that does not tell you if they are ordering the medication appropriately.

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What are the side effects? Are there any other alternatives that could be used? If this medication does not work, what will be suggested as a next step? Find out if you will need to have blood work or other tests while on this medication, and why are these needed.

If the provider will not answer these questions or seems to be rather vague in answering your questions, find another one.

Surgery or Procedures

Ask for the physician's complication rate concerning the surgery/procedure being recommended. Then research the complication rate on the web. How does this compare to your physician's?

How many of these surgeries or procedures has the physician performed over the past 3 years? How many has he/she performed over the past year? You do not want to see that your provider is doing less of the type of surgery/procedure you are asking about when compared to the last 3 years. For example, if the physician states she has performed 300 of these procedures over the past 3 years, but has only performed only 5 over the last year, you should ask why. This may be a red flag.

If they have never done the procedure, seriously consider seeing another physician who has much more experience in performing the surgery or procedure. Typically the more procedures a professional performs with the least or minimal complication rates is what is you are looking for.

Emergency

Ask what is the procedure to contact the healthcare professional in an emergency? If the answer is that you should go to the emergency room, then you should also ask how the emergency room contacts this professional. Is there a call schedule that they use? Is this professional available 24 hours per day, seven days a week for emergencies? Or do they have an answering service that will assist you with your questions and page the professional for you?

Go with your instincts

If your gut tells you this is not the professional for you, try to validate your concerns with some of the above questions. However, if you still do not think this professional is the one for you, find another. It is your body and your health.

Websites

Go to Health Grades at <http://www.healthgrades.com/> to research your physician. This website often can provide detailed information on physicians.

Calendar for 2007

January 27 - February 3 [4th Annual Advances in Surgical Gynecology and Female Sexuality](#), San Jose, Costa Rica

February 22 - 25 [International Society for the Study of Women's Sexual Health \(Annual Meeting\)](#), Orlando, Florida

March 8 - 11 [Society for Sex Therapy and Research](#), Atlanta, Georgia

May 5 - 9 [American College of Obstetricians and Gynecologists 54th Annual Clinical Meeting](#), San Diego, California

May 19 - 24 [Annual Meeting of the American Urological Association](#), Anaheim, California

June 2 - 5 [The Endocrine Society Annual Meeting](#), Atlanta, Georgia

June 21-23 [Controversies in Women's Health](#), Nisswa, Minnesota, e-mail womenshealth@mayo.edu

June 20 - 24 [American Association of Sex Educators, Counselors and Therapists \(Annual Meeting\)](#), Charlotte, North Carolina

October 3 -7 [North American Menopause Society Annual Meeting](#), Dallas, Texas

October 13 - 17 [63rd Annual Meeting of the ASRM](#), Washington, DC

December 6 - 9 [Sexual Medicine Society Meeting](#), Chicago, Illinois

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Donations

As a nonprofit organization, The Women's Sexual Health Foundation is supported through individual donations, memberships, and in a small measure, by the bulk sales of TWSHF brochures and the Journal. We are currently seeking to finance research projects through grants from government agencies and nonfederal sources such as corporations, women's groups, and medical organizations. However, private gifts will always be the mainstay of the Foundation.

All donations are tax deductible. The Women's Sexual Health Foundation will send you an acknowledgement receipt for your tax records.

If you would like to make a donation, please send your contribution to:

**TWSHF
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Information

See www.twshf.org for information on membership, donations, instructions for authors, volunteering, and additional resources.

Editor's Note

The Editor welcomes articles, letters, meeting notices, pertinent internet websites, breaking news, information on support groups, and publications that may be of interest to the readers.

Disclaimer

TWSHF recommends that you consult with your health care provider to determine appropriate treatment. TWSHF is not responsible for any consequences that occur based on information contained in this publication.