# Let’s talk about sex: Midlife sexual function

**Louise Browne:** Hi everybody. My name's Louise Browne. I'm the Health Professional Education Manager at Jean Hailes. We are really happy to be here tonight and present this webinar, second webinar for 2018. Firstly, I'd like to acknowledge the traditional owners and custodians of the land we're presenting on and the lands we're reaching tonight, and pay my respects to Elders past, present, and emerging. For those of you who don't know us, Jean Hailes is a women's health organisation. We are national, we're not-for-profit, and we combine research, clinical care and education for women and for health professionals. Tonight we're talking about sexual function at midlife. Some of you have asked, well, what's 'midlife'? We're talking about 40 to 60, but that moves along with the population, age and demographics. You can see the agenda for the webinar on the screen. You can submit questions via the 'ask a question' button on the right.

We've got lots of questions already. We'll try to answer the most common ones as we go. We won't be able to address all of them. If you've got any technical problems, please remember to call the number on the player page below the screen. Don't submit your problem as a question because it won't get addressed. For those of you who haven't participated in one of our webinars before, if you're using an iPhone, it's not ideal, and some versions of the iPad, you may only see the video and not the slides. In the 'resource library' tab you can find the slides as a PDF. There's pre-reading, and there's other useful resources, and you can download those and refer to them later. After the webinar closes, the resources won't be there any longer, but when we put the webinar in the webinar library next week at Jean Hailes, you'll be able to download all those resources from there.

We'll send you an email when it's up and ready in the webinar library and you can go and look at it again. If you want to receive RACG points or a certificate for the webinar for your CPD records, you'll need to complete the evaluation at the end of the screen and that will come up as a link when we're finished.

I'd like to introduce tonight's fantastic panel. I'm not going to read their bios, you can see that in the resource tab if you'd like. We've got, I'll start from here. Janetta Webb, pelvic floor physiotherapist from Jean Hailes. Then we've got Wendy Vanselow. She's an associate professor at the Women's Hospital in Melbourne. We've got Professor Susan Davis who's an endocrinologist from Monash Uni and Alfred Health. And last but not least, Sara Whitburn, who is a GP in Melbourne. So, got a great panel, cross-disciplinary, so we've got lots of different approaches to the problem we're talking about.

So why are we talking about sexual function at midlife? We know that this is a really important area for women's health. We know that research shows us that 30 to 40% of women are having sexual difficulties of different kinds at midlife. And we also know from research that Jean Hailes has conducted, but also externally of course in the bigger world, that clinicians often don't feel particularly confident in talking about sex with patients. So initiating that conversation can be challenging. So that's why we are talking about this tonight, and hopefully you'll get some useful information to go on with. International Menopause Society has recently published a white paper on sexual wellbeing, that was one of the pre-reading materials, and it was done in an effort to raise awareness about the issue and to provide a framework for clinicians. So hopefully that can be useful for you in your work. And with that, we're going to start with Sara Whitburn and she's going to talk to us about talking about sex.

**Dr Sara Whitburn:** Thank you, Louise. So I want to pick up that point that we just said, that Jean Hailes has found through its research that clinicians often find it hard to talk about sex. And I wanted to talk about why that might be difficult to do. And I think it's both practitioner features, but also women's concerns and some of women's ideas as well. Women may be very embarrassed to bring up this topic. We know that sex can be taboo for some people. And just talking about sex can be very difficult depending on how comfortable people have been talking about sex in the past, and now they're coming to see a practitioner and they may have concerns. Women may have a lack of knowledge, they may not have had a lot of education, and they may not know what's normal or abnormal sexually. This might also impact on their body image.

And health practitioners may have had very limited experience with sexual history taking. And when I say 'sexual history taking', that may be taking a very medicalised idea about partners and infections and things like that, but also just around relationships, viewpoints of sex, and health practitioners may have a lack of knowledge about what to offer women, you may be very comfortable asking questions and be very patient-centred, but if you don't know what to offer or where to refer, that can put you in a very difficult situation, and you may not want to open up that conversation. And so I think in the consultation, some basic ground rules can really help. I'm sure it's simplifying it to say 'be respectful', but I think in all discussions with sex, talking about things really openly, putting things on the table like saying, 'Let's all be respectful', just starts the conversation going.

And I think that's why I've said let's get comfortable. I think the practitioner has to feel comfortable with the questions they're about to ask, and in that way can make the patient, or the woman in front of them, comfortable as well. I think opening the conversation with screening questions, and I've got a slide on that next, about some questions that can just start the dialogue, and using open questions. And I think the really important thing is if you're going to take a sexual history, to have no assumptions. It may be that people have open relationships, multiple partners. People may be sexually active, not sexually active. So I think keeping a really open mind is important and I think that also goes into 'expect the unexpected'. Though I've just said thinking about a sexual history being really open, and being open about gender and gender identification or sexuality, sometimes these conversations can bring up other topics, domestic violence or previous sexual assault.

So it's really feeling comfortable to ask questions, sitting with the answers, but allowing the space for what might happen. This is going to take time, and I know a lot of practitioners from whatever discipline can be time poor. So it may be that this is not going to all happen in one consultation. You may need several consultations or you may need to use a team to explore these histories more. So I've mentioned that some good open questions, or some warning questions. I've got my lady there sort of doing a warning shot across to say, 'I'm going to talk about sex.' And so things like, 'I always ask about sex' or, 'I'd like to talk to you more about sex' is a bit of a warning shot for your patients and women who you are seeing, but also for you as well to start the agenda, to get yourself comfortable, I think, 'Are you currently sexually active?' just is a really nice open way just to say, 'Are you sexually active? What are your sexual practices?' Sometimes you can say, 'How's it all going?' A nice open question. So I think it's really finding a question that you feel comfortable with that's open, says to your patient or the woman that you're talking to that you're going to start a sexual question.

I've mentioned some nice open questions and focused in on sexual questions, but remember this is a part of a general history. And I won't go through this list, but all of these questions can be part of your history taking, and I think you've got to think holistically. Sometimes certain physical conditions or medical conditions can impact on sexual issues. Sometimes sexual issues can impact on medical problems. So there's a list there of all the different areas that you might want to take your history questions into. And finally, there are some examinations and investigations that might be relevant for talking about sex in your consultations. If it's relevant, maybe this is the first time you've met this woman, you might want to do a general medical checkup or check that they've had a general checkup. I always sensitively offer to do a vulval and vaginal examination. And sometimes if there's urinary symptoms, having a urine analysis is really important to confirm or exclude urinary tract infections. If it's relevant, if there's discharge or you've got concerns about sexually transmitted infections, vaginal swabs may be relevant, but not always.

And if you're doing a generalled history, and this might be the first time you've seen this woman and she's in midlife, blood tests for general health. So I'm thinking thyroid or diabetes, or other conditions. Being holistic and thinking broadly, but it is not always relevant for the person that's in front of you. And so I'm going to leave it there and pass it on. Thanks Louise.

**Louise Browne:** Thanks Sara. Sue is going to talk about the biological, and there has been a couple of questions just about hormonal changes at midlife, so Sue will cover that when she talks to us.

**Prof Susan Davis:** Thanks very much, Louise. I'm only going to briefly touch over the biological issues. There's much more that could be covered in just a few minutes. Firstly, this is data from a study we did of over 2000 Australian women recruited nationally, looking at the prevalence of low libido associated with personal distress. And as you can see, about one in three women aged 40 to 64 years of age in Australia have low libido that causes them distress. Now, although we're talking about women at midlife tonight, I would like to emphasise two additional points. We extended this study to women aged 65 to 79, and found that 15% of older women also had low libido that caused them distress. So don't simply think that this is not something that persists into older age, it does, and often older patients will be very grateful for you to have the discussion with them.

And the other issue that you should be aware of is that sexually related personal distress and low libido is also very prevalent in unpartnered women. So just because a woman doesn't have a specific partner, don't assume that she does not have a problem. The question should still apply to her just as much as the partnered woman. Now at menopause, oestrogen levels fall very dramatically. Acutely, women usually present with hot flushes, night sweats, mood change, anxiety and vaginal changes do tend to follow a bit later. But the fall in oestrogen causes thinning of the vagina, loss of elasticity and vaginal dryness. And vaginal oestrogen alleviates these symptoms, and lowers vaginal pH, and normalises the vaginal environment, so you get regrowth and rehabitation of lactobacilli and the low vaginal pH that's healthy. So vaginal oestrogen therapy is not the same as hormone therapy that's given systemically.

Vaginal oestrogen therapy is local therapy. It can be used in virtually any woman. There are no absolute contraindications, and it can be used almost lifelong. It can be administered as oestradiol pessaries, a cream that's commonly available in Australia, and it is effective and it's safe. Oops, I'm going to go the other way. Women can also use vaginal moisturisers and these will be discussed further. They lower pH and can alleviate painful intercourse. And you have to be selective about which ones you might recommend because they vary in their osmolality and their ability to irritate. Vaginal lubricants are what we recommend for sexual activity, they prevent vaginal dryness, but they're only effective for the acute episodes. They're not effective for treating vaginal health between sexual activities.

Vaginal rejuvenation therapy is being heavily promoted globally. And I draw your attention to this because this is not a treatment that is approved by any regulatory body anywhere in the world. It's using machinery that's been approved for skin therapy, et cetera, but not vaginal therapy. And there's still a lack of safety data, and really lack of long-term evidence that this is an effective treatment. So when we're talking about treating women with hormones, and the caveat on this is that your patient will have already gone through your assessment in terms of history, examination and assessment for psychosocial factors and factors that might be appropriately referred for counselling or physiotherapy. But if you're looking at hormones, oestrogen will improve sexual function if a woman specifically has vaginal atrophy, or if she has severe symptoms of vasomotor symptoms, poor sleep and lowered wellbeing because of menopause. Tibolone is slightly more effective than oestrogen therapy, in terms of in clinical trials, for low libido.

But the effect, the benefit's really marginal, and we've only shown a marginal benefit in clinical trials. People often talk about DHEA as a treatment for sexual function. It has not been shown to be effective in any study when administered as a tablet. There is a vaginal DHEA available overseas, but that is not available in Australia, and that's just to treat vaginal atrophy. And I'll briefly mention testosterone. So unlike oestrogen that falls acutely at menopause, testosterone declines slowly with age. And I'd like to point out that the most rapid fall in testosterone in women is between the ages of 35 and 45. So before menopause. There is no change in testosterone with natural menopause, and after natural menopause it declines slowly with age. So testosterone does not change at natural menopause. If a woman at 52 or 54 has low testosterone, she's probably had low testosterone for several years.

And we and other groups have shown that testosterone is effective for the treatment of low desire that causes the patient to stress if a woman's surgically postmenopausal on oestrogen only, naturally postmenopausal on oestrogen progestin, if she's postmenopausal on no hormone therapy, and also premenopausal women in their late reproductive years. So a woman does not have to have her menopause ticket to merit a trial of testosterone therapy. We've also shown that it is a benefit to women who have SSRI or SNRI emergent sexual dysfunction. And it improves desire, arousal, pleasure, and orgasm.

The side effects are not seen if you use a non-oral therapy and a dose appropriate for women. And I strongly, strongly urge you against using compounded testosterone therapy or compounded hormone therapy. These are not TGA approved, there's no efficacy data and there's no safety data. And patients do not understand that these are not research therapies. Now we do have available to us in Australia a transdermal testosterone cream, and when we do prescribe it, we start at half a mil daily. It's applied to the lower half of the body to prevent a patient transmitting it from their arm to another person or a child. And also to prevent exposure to the breast. We always check the blood levels after three to four weeks of prescribing the therapy. And we aim at keeping testosterone levels within the range for normal young, healthy women. If it's higher, we always reduce the dose. And we always review patients regularly, and if it doesn't work at six months, treatment should be stopped. And women should always be monitored as long as they're using the therapy. So I'll stop there, and pass over to Janetta who's going to talk to you.

**Louise Browne:** Just before you start Janetta, sorry.

**Janetta Webb:** Sure.

**Louise Browne:** Sue, I'm just wondering, because there's been quite a few questions about testosterone, and obviously people don't feel confident using it, is there a good resource that they could look at to help them along the way if they wanted to find out more? And you've told us about when to use it and how, but I'm just wondering if there might be some more detail somewhere that they could access. Is there anything we could include?

**Prof Susan Davis:** So at the risk of promoting a pharmacotherapy and seemingly so, Australia's unique in that we do have the 1% testosterone cream. Can I use the brand name? Is that permissible?

**Louise Browne:** Yes.

**Prof Susan Davis:** So AndroFeme 1% cream is available. I do not have any pecuniary interest in this. And they have available on their website a lot of information that we have helped them put there to guide both the patient and the doctor through the use of the therapy. And my PhD student did pharmacokinetic studies of this, so we know the doses that are appropriate. And I think that's a really valuable resource. And in addition to that, I would suggest the white paper that we've produced from the International Menopause Society is very helpful.

**Louise Browne:** Okay, well the white paper everyone can access, so that's great. Thank you. Alright, sorry Janetta to steal your thunder. Off you go.

**Janetta Webb:** No problem.

**Louise Browne:** Janetta's going to talk about physio.

**Janetta Webb:** Thanks Louise. So firstly I'd just like to talk about the common presentations that a physio might see at midlife for a woman who is having some sexual difficulties. So probably one of the most common is the experience of dyspareunia. But also we will often see women who have pelvic organ prolapse, and perhaps that's having an adverse effect on their body image, you know, 'I'm concerned if my partner sees my prolapse, that's making me feel less sexual,' or actually with pelvic organ prolapse, difficulty with some sort of discomfort vaginally. Women also often come along to see a pelvic floor physio reporting a reduction in vaginal sensation or anorgasmia. And they may also report urinary incontinence or faecal incontinence, which is then of course adversely affecting their interest in sex.

Also, there may be significant effects on the relationship, which we're going to talk about quite a bit more tonight. But quite often women might present to a physio with an issue such as urinary incontinence because they don't want to come along and say, 'Actually I'm having sexual difficulties.' So it's really important, for us as physios, but for all practitioners, as Sara said in her introduction, that we ask the question. Or women may have had an issue for a long time, but they only present when it's having a significant issue on their relationship, a significant effect on their relationship, or maybe when they're in a new relationship. And quite often they'll present with feelings of helplessness or hopelessness or, 'Am I really too old for this?' So lots of reassurance, as we'll be discussing. There is usually a trigger. So the genitourinary syndrome of menopause, which I have up here with some of the issues that women may experience, this term isn't something that is necessarily something that is going to be continued to be used.

So we might address that in a little more detail. I don't know if you want to comment on that at the moment, Wendy or Sue. But the issues that women may report, vaginal dryness, a reduction in vaginal elasticity, introital narrowing, and I think one of the things I'd like to highlight here is it's so important for us to be really careful with what we say to women. Because someone being told, oh, your vaginal opening has narrowed, or shrunk, that will often stay with them forever. And they feel that it's a hurdle, that it's really difficult to get over. And of course recurrent UTIs. I mentioned before, being in a new relationship and some of the issues that can bring. And also a return to sexual function after different types of surgery, as listed there. As we've already mentioned, a history of trauma or some sort of abuse, whether it be sexual, emotional, physical. And some women will present because now they feel in midlife that they've actually got some breathing space and time to address the issues that they're having. I'm not going to read through every word on this slide, but when we talk about dyspareunia, if you just read through that, you'll see that there's a cycle that potentially can continue to go around and around until a woman seeks some assistance, and then there's a possibility of breaking that cycle and helping her onto a new path. And so now hand over to Wendy.

**Louise Browne:** Thanks Janetta. So Wendy, in her role is a sexual counsellor, so she's the one who we think can pull together all these different aspects. Sorry about that. It's giving you a big task, but I think you'll be able to do justice to it very well.

**Assoc Prof Wendy Vanselow:** Yeah, so I've had a background in general practice, so usually we don't get such a thorough history as Sara has provided us, but we do cover all that ground as necessary. But by the time they've been referred for specialist counselling, usually these are women with more severe issues and often a history of trauma. So we do need to create a safe space for the women. Sorry, just, doesn't seem to be working. Sorry. Yep. Sorry.

So we need to create a safe space for the woman to tell her story. Usually women can be quite articulate about why they've come and what they want to achieve. However, for some, you may only get a very limited amount of information initially, which may build over time. So you may detect that there's some difficulty, but allowing space and allowing them to tell their story is often a large part of the therapy. We use attentive listening, we try and pick up cues from the women in terms of their language and including their body language and things that might obstruct the story. And we try and create a collaborative atmosphere, because often working to the doctor's agenda is not really where they want to go. So we try and allow them to bring up what's important. And in the end I believe we do get a more thorough picture when you allow them to tell their story. We try and establish rapport and respect and empower the patient. We try not to re-traumatise. So if people aren't ready to discuss some more sensitive issues, we tell them that they can do that in their own time. And we reassure that we are going to be confidential, and that this problem will be taken seriously. Many women will come saying that someone's made a joke of the problem they've presented and they feel quite dismissed. So we try and reassure them on that matter.

I don't seem to have luck with this. So I think Sara's ably mentioned that it's a difficult subject enough for the patient. It's also pretty difficult for the practitioner as well. And look, it's a matter of practice, practice, practice, that you start to become more at ease talking about these issues. I find it's very helpful for both parties actually to have large diagrams in front of me, to jointly look at together, so we can identify where the pain may be, or where the problem, or what the changes are that they've noticed, trying to use correct language. And I guess introducing a little bit of education along the way which helps them to bring up issues of things they're not sure about, and also to dispel some mythology about various parts of the anatomy, and allowing questions. I love to have partners in as well because I find the partners are often just as interested, if not more so, to learn about the anatomy and physiology of female sexual response.

I do not have the knack. Okay, thank you. So we're trying to take a biopsychosocial approach and Sue, has really talked, and Sara, talked very ably about the biological side, which we do cover also, but we move quite quickly to look at the psychological effects of what's happening, and also the contributing factors about what's happening in the relationship and in the person themselves. We know that there's often relationship dysfunction that has prompted the visit. So the 'why now?' question is very pertinent. Okay, so I will often as I speak to the woman, start building a bit of a genogram, which as you may well know, is a diagram of the family structure in generational terms. So I'll build a genogram of what the situation is in the current household, perhaps with some significant previous relationships there. And it's an opportunity to talk about how one related to the other, and if there was past trauma, and ask about what's happening now. Is there freedom to express yourself in this relationship?

What is difficult and how are you feeling about it? I also go back a generation to their family of origin, and look at what was good and what was bad in their experiences. Is there a history of neglect, abuse, drug and alcohol problems? And mental health issues loom large here. And what were the attitudes to sex growing up? What was spoken and unspoken? How was the parental relationship? And so forth. And usually, often the woman will present by herself initially, but if possible I ask for the partner to attend, if that's appropriate in the situation, because I think you get a lot of information from looking at how the couple interact, and we know that the partner will often have sex problems also that are contributing. In fact, it's sometimes the major issue, sometimes there's depression in one partner that's affecting the couple relationship, or health issues.

So I look at couple dynamics, how each of them view the current situation, and ask them about what's attracted them to each other in the first place, and also watch their communication styles. And as far as societal changes go, we know that we've all experienced big changes in society since we grew up and so have our patients. There are loosening of the bonds of family. There are more complex family relationships, women are having fewer children later in life, and more women are working and financially independent. There's been huge changes in LGBTIQ acceptance and so on. And one big thing I think is the internet, with greater access to pornography and different practices. Violence against women is also becoming more of a visible issue. So I try and give a bit of feedback to the patients. Obviously we talk about hormones. We talk about responsive desire in the older woman, and I'll probably talk a bit more about that later in the cases. And try and find their psychological strengths and weaknesses. I'm not going to talk anymore about a couple issues, but we try and give them some feedback and some tips on how they might improve the situation.

**Louise Browne:** Great. Thanks so much Wendy. I think it's, the kinds of information or approach that Wendy's been talking about, it's going to be really crucial, especially for clinicians who are working in areas where they may not be able to refer to a counsellor. I think that's, not everybody's got the option to refer on. So some of these things are probably something you can look at a little bit later on, and there may be some ideas that you can do, and I'm sure there's courses you can take too. I know, Sara, you said you've done some sexual counselling too, so it is there for GPS to be able to do it. So I think that's great. So we'll move on to our first case study, where we can put some of these theories into practice. And we've got Ana. And I'll start with you, Sara.

**Dr Sara Whitburn:** Thank you very much. So Ana's a 59-year-old woman and she's presented to a GP, her GP. And she's presented because she is getting recurrent urinary tract infections and she wants to talk about that. And I think that brings up a lot of really interesting issues, which is a time for us to go into our history, as I sort of talked about in my introduction slides, this is a time to start exploring this a bit more. As Janetta said, recurrent urinary tract infections can actually be part-and-parcel of midlife vaginal/vulva menopausal changes, but it also can be a more acceptable way to come in and see somebody like myself with any sort of genital problems or sexual problems. So this is a time when, as I said, it may take time, which means we may need to take a couple of appointments, but I really want to get a more detailed history.

And I'm going to start with the history of the urinary symptoms. That's what Ana's presented with, so it gives us something to start the discussion, but I'm going to want to really hear a lot more about, what does she mean by UTIs or urinary tract infections? Have they actually been actually been positive on testing? Or are they a symptom or a feeling that she gets? When does she get them? What's happening? Is there any incontinence? And I'm hoping that would then allow me to go into other questions around her menopause, sort of segueing from something that's acceptable to Ana, into more, 'Well, this is very common in menopause. Can I ask you about menopausal symptoms?' And especially start to talk about vulva/vaginal, or vaginal/vulva. I'm not sure which way I've meant to have that around, but both of them, I'll be definitely asking about both of them. Symptoms. And then I would definitely use one of my 'warning shot' questions or opening questions to say, 'Women who often come in with recurrent urinary tract infections, sometimes this can impact on their sexual life. And have you—', I would probably use the, 'Have you got any concerns?' But I think it's the one you're comfortable with, as Wendy said, you practice and get the questions that you feel comfortable with.

So hopefully after all of that I'd have a bit more history. And in our case study, my further questions have revealed that Ana's not interested in sex, and that is a concern to her. She's experiencing painful sex, and she is feeling, was sexually withdrawn. I would really want to tease out what that means to her personally. Is that about libido, desire or arousal? And that's where, once again, finding words you are comfortable with. Even asking Ana just to explain it in her own words, and then ask about how is that at home with her partner. And in this case, this is causing conflict with Ana's partner, and her partner feels rejected. And I'm hoping because we've spent time on the symptom of her urinary symptoms and really said, 'Look, this is important, but I also want to know about other things,' that she has said to me that she's scared that she'll actually be incontinent during intercourse.

So I think I would also then thank her for bringing that information to me, and acknowledging that it is a safe space and that I want to talk about these things. When I say normalise, I wouldn't be normalising these symptoms, but I'd be normalising that this is something that's worth talking about and that this occurs and that there are things that can be done. And I would provide whatever patient-centred education I could use at that time, whether that be around the menopause, or UTIs, or that there is help for sexual concerns. That might be all I do in my general practice consult, but I'd be trying to make it as safe a space as I could. I would examine Ana's abdomen and her vulvovaginal area, looking for signs of atrophy or skin thinning. Is there any problems around the bladder or the urethra? I'd be looking for all sorts of skin conditions like lichen sclerosus, looking for discharge, and I would take vaginal swabs if I thought that was appropriate at the time. I would definitely be asking about change of partner, and if she had had a recent change then I'd definitely be doing swabs for sexually transmitted diseases.

I always send, or at least dip a urine, but I often send for a urine, because I want to confirm, is this actually a urinary tract infection? I'm still going to offer her all the support, but I do need to confirm whether this is an infection and do we need to treat this first. So it is very important to always send for, in this case, to send to confirm if this is a true urinary tract infection in pathology. And I'm going to discuss lubrication, lubrication for sex. And I think that's going to be talked about in more detail so I won't go into too much. But skincare, I always talk about moisturisers and barrier creams just like any other skin that might be irritated or sore. And I would offer her vaginal oestrogen or at least talk about it. And I would discuss with her physiotherapy. And I would discuss with her other specialists, maybe not refer her at the first appointment, but I'd definitely make her aware that that's available and that I'd like her to come back to talk about referral if we haven't referred already.

**Louise Browne:** Great, thanks Sara.

**Dr Sara Whitburn:** She took me up on my offer, Janetta.

**Louise Browne:** She's heading to the physio.

**Janetta Webb:** Okay, thanks Sara. So Ana has come along and, as Sara mentioned, it's important to ensure what is actually going on in terms of UTI. So I won't talk about that in any more detail, but women may often present to a physio first, saying, 'I'm getting recurrent UTIs', so then I'd possibly want her to go back to Sara to ensure, okay, well that is actually what's happening, and have adequate treatment. But it could also be that she's describing vulval pain or vulvodynia, which could be generalised. So throughout the vulva, and pain a lot of the time during the day, or it might be provoked, so she's only actually experiencing pain with touch, with penetration, with finger, penis, or on examination. It may be that she's experiencing bladder pain or urethral pain or dysuria, but just because she's experiencing dysuria doesn't necessarily mean that she's got a UTI.

So it can be quite challenging even for a woman to work out, 'Oh well I just assumed if it was a bit uncomfortable when I did a wee that I must have a UTI.' Of course I'd want to take a history, as Sara mentioned, of her incontinence and work out, the two most common types of incontinence are stress or urge incontinence, and we often see incontinence at penetration associated with a reduction in urethral closure pressure and associated with stress incontinence. Whereas incontinence at orgasm is more commonly associated with overactive bladder symptoms. And I'm interested also in any voiding dysfunction, because that could suggest that possibly she has overactive pelvic floor. So I'm wanting to know a few questions about her dyspareunia, does it reduce during intercourse? Is it every time she has sex or is it only sometimes? What is it with? Toy, penis, finger? Is she actually getting aroused? Because how can you get aroused about something that's going to be uncomfortable?

So really important to address these issues, and if there's any continuation of pain after sex. So in terms of physio, as Wendy's already talked about, the anatomy of, I like the 3D pelvis, I like lots of diagrams. Talking about, if the woman hasn't already, what actually happens during sexual arousal? Because most women know exactly what happens for a man during arousal, but maybe they're not quite sure what happens for them other than lubrication because they can't actually see those changes. I like to talk to a woman, 'Here's what I think is happening. This is why I think, Ana, you are experiencing these issues.' and I showed you before my pain cycle, so to talk about how pain can start and continue, and that maybe in Ana's situation it's her brain saying to her, 'Don't do this, this is dangerous', and then maybe her pelvic floor muscles are switching on as a protective mechanism.

So it may be a part of that response, or it may actually be that throughout any sexual activity she's desperately trying to keep her pelvic floor muscles contracted because she doesn't want to have any incontinence. So you can see there the sorts of things that a physio will look at in terms of examination, breathing, posture, a visual examination of the vulva and the pelvic floor, as Sara mentioned. There's a little diagram there of the Q-tip test, which you can look up. It just maps areas of vulvodynia around the area. External palpation. And then a gentle and sensitive examination, with consent, of the pelvic floor muscles, for all of these different aspects of pelvic floor function, as well as the ability of the woman to both work and release her pelvic floor muscles. And these are the things that I might then look at with Ana, pelvic floor muscle down training if she has overactive pelvic floor muscles, or it may be that she doesn't have overactive pelvic floor muscles and her muscles are weak, so then she needs to progress on to strengthening.

But with dyspareunia we more commonly would see overactivity. Desensitisation of the skin. And sometimes just taking the emphasis off penetration, and making the emphasis more on arousal and enjoyment of intimacy rather than just the focus purely on penetration. And vulval skincare of course is really important. There are other sorts of things that physios may use. Myofascial, which is just muscles and fascia, treatment. The use of vaginal trainers, to train muscles to release, not to force them to release. So you'll find that physios will often use the word 'trainers' rather than 'dilators'. Maybe, if appropriate, I wouldn't necessarily use all of these things with Ana, but these are the range of things that could be used. The suggestion of using clitoral or vaginal vibrators, self-treatment with the wand in the photo there, various types of biofeedback, but even using a mirror, cool packs. And then of course treatment for her incontinence, addressing her fitness with a view to returning to comfortable penetration. Over to you, Wendy.

**Louise Browne:** Thanks Janetta.

**Assoc Prof Wendy Vanselow:** So, I mean, initially probably with this type of thing we would look at medical issues initially, checking, as everyone prior to me has stressed, that there is a urinary tract infection or not. Possibly even a diabetes screen in someone of this age. And also checking medications which can be pertinent to this. I would also, if there's tenderness at urination, look for urethral caruncle, because often at menopause or postmenopause, there's prominence of the urethral mucosa that becomes very uncomfortable and irritated during intercourse. So I will often prescribe vaginal oestrogen, or if that isn't effective, possibly even systemic oestrogen, as some people do get irritated with local oestrogen. I check the skin particularly for dermatitis, lichen sclerosus, and I am in the position to treat that if necessary. From a practical point of view, occasionally we will use medication prior to intercourse if women are getting recurrent leakage, often with orgasm as you mentioned, that can happen at any age really. And also ask them to reduce caffeine and alcohol.

And I do not know why this button doesn't like me. So as mentioned before, a lot of emphasis I put on the female arousal response and educating both partners. Asking the woman to tune into her own arousal, not just respond automatically to the male arousal, which is often part of the script in the partnership. Sexual practices such as sex toys, anal or oral sex may contribute to redistributing bacteria on the vulva, and that needs to be looked at if that's a contributing factor. A new partner can also contribute to the risk, as we know, not just with sexually transmitted infections, but also the microbiome of a new partner apparently has a contributing effect. And we know that a well oestrogenised vagina is more resistant to infection. Some women do use prophylactic antibiotics post-intercourse for recurrent urinary tract infections. We don't have a lot of evidence one way or the other for that, but it does seem to be worthwhile. And make sure we're using good quality lubrication that doesn't block the urethra. Partners are part of the solution. We need to create good conditions for intimacy with adequate attention, time, place, privacy, caring and sensuality, and no pressure for intercourse. We talk about 'outercourse', it sounds very unsexy, but really it's sexual activity without penetration, basically. And we defer penetration until the woman is comfortable again.

**Louise Browne:** Okay, thanks Sue.

**Prof Susan Davis:** So I would often see someone like Ana when she has had partial relief for dyspareunia. Her urinary symptoms are well controlled, but the thing women often come and say is, 'It's like a light went out, I enjoyed sex and now I don't. And it's not how I want to spend the next 20 years of my relationship.' And particularly if someone's previously had a good sexual relationship in the past, it's usually because the issues are then not due to lack of being able to have a good sexual relationship, it's just something's changed. And in that setting I talk to the patient about hormones and aging, and particularly the role of sex steroids. So it's not uncommon to see a patient who has been prescribed vaginal oestrogen but still says she's got vaginal dryness during sexual activity. And that's because to lubricate, a woman has to become aroused, and part of the arousal cycle is to have desire.

So if there's no innate desire, you can put as much oestrogen up the vagina or in the mouth or rub it on the skin, but it's still not going to translate into lubrication if nothing's happening in that person's brain. That really is where testosterone can make a difference. It's not for every patient, I'm not saying that it should be reached for immediately, but it certainly should be in every clinician's either thought armamentarium where you would refer onto someone who would perhaps prescribe, or where you feel you might be comfortable, prescribe. So a testosterone is a trial of therapy. There is no blood test that will predict who will respond. And there is no blood test or level below which we will treat or not treat. Because at any age, women will respond with different testosterone levels in their blood. It's not about what's in the blood, it's how their cellular receptors in their body and their brain respond to the hormones.

And I've mentioned previously in my slide about the starting doses, et cetera. It's important, two things are really important to explain to the patient if you're going to prescribe. Firstly, it is, as I said, a trial of therapy. Secondly, if you are going to use, and I would only encourage you to use a physiological dose of testosterone such as the 1% cream we have in Australia, the woman needs to be treated for at least four to six weeks before you will see, or she will see, a benefit. So it's not like you prescribe the cream and three weeks later she expects to have a dramatic change in her sexual function. That's not going to happen. On average, it's about six weeks before the woman will notice a difference. And she's not going to suddenly become a raging nymphomaniac, nor is she going to grow a beard. What she will notice is that suddenly she's more responsive. When her partner makes overtures, she will respond without thinking. She may have sexual thoughts or have inclinations to masturbate. So it's a subtle change, it's not a dramatic change, and it takes time and there's no predictor about the responder.

**Louise Browne:** I'm just going to pop in a couple of questions, because they've come in while we've been talking. One is, what's the functional difference between oestradiol and oestriol pessaries?

**Prof Susan Davis:** So oestradiol is the most potent oestrium we have in our body. When it's metabolised, it's broken down into oestrone or oestriol. Now the oestrone, it can be back-converted from oestrone to oestradiol, but once it's converted to oestriol, it's out into the urine. So the oestriol as a pessary is a much weaker oestrogen. But interestingly it's just as effective. In general, if a woman has had breast cancer, we would prefer to prescribe oestriol as a pessary cream. Having said that, that's based on expert opinion, no data. So we just believe it's probably safer. Whether it's safer or not, we don't know. But both low dose oestradiol and oestriol are similarly effective and ultimately it becomes a patient preference.

**Louise Browne:** Okay, great. And there was another question about, wouldn't vaginal oestrogen interfere with oral sex?

**Prof Susan Davis:** Well, what—

**Louise Browne:** One assumes we would use it afterwards.

**Prof Susan Davis:** The important thing is that, to explain to the patient that the vaginal oestrogen is not like a lubricant, or even a vaginal moisturiser. It's not to be used as a precursor to sex. It's used intimately, two to three times a week, regularly, to keep the vagina healthy so that when sexual activity occurs, the vagina is receptive. I just want to add one other point. Up until a couple of years ago, the classic vaginal little pessary, Vagifem, was a 25 microgram vaginal pessary used twice a week. For some completely inexplicable reason, probably to be politically correct because of the WHI data which is meaningless, the company decided to reduce the pessary to a 10 microgram pessary used twice a week. So now women are using, twice a week, a dose that wasn't even equivalent to a once-a-week dose. And most women find this ineffective, and the recent study has shown it's no better than placebo. So when you prescribe Vagifem at 10 micrograms and tell them to use it twice a week, and they come back and say, 'Doctor, it doesn't work.' They're right, it doesn't work. So either they need to use the Vagifem three times a week, or I tell them to put in two little tablets twice a week in order, to get a meaningful dose.

**Louise Browne:** And the other thing that has not come in, but just in terms of the use of the oestrogen cream, did I read something recently about getting patients to put the cream in much more towards the outside than right into the vagina? Is that right?

**Assoc Prof Wendy Vanselow:** Yes. The hormone receptors seem to be more prevalent mid-zone, on the front wall of the vagina. So it's quite acceptable even to put the amount on your finger and just smear it down the front wall. It's less messy. Most of it is absorbed within the first hour. So I don't think you should time any sexual activity away from that time.

**Louise Browne:** But the question about it interfering is, it doesn't have to go in before?

**Assoc Prof Wendy Vanselow:** No, no. It shouldn't be put in just before.

**Prof Susan Davis:** But when you say absorbed, it's not absorbed into the body. It's absorbed locally.

**Assoc Prof Wendy Vanselow:** Yeah, the tissue.

**Prof Susan Davis:** Into the tissue, it's not absorbed systemically.

**Assoc Prof Wendy Vanselow:** Yep.

**Louise Browne:** Great. Good. We've covered off a few things. Let's go to our second case study, Sara, and I'll get you to start with that one again.

**Dr Sara Whitburn:** Okay, so this is Jen. Jen is a 45-year-old woman. She's got three children aged five, seven, and 10. And she's come to see a GP saying that she's not interested in sex since her youngest child was born. And this is a concern to her. And she tells you that unfortunately a colleague, another GP, has told her to relax, have a weekend away and it'll all be okay. And as we sort of said, sometimes it may be that practitioners are trying to be helpful but aren't quite sure what to say, and so say something like this. So hopefully with some of the things we've talked about, what would happen is that we would go on to do a history, as we've described with Ana, as we've described in our introduction, is that we'd acknowledge that her concerns are valid, are important, and normalise it and talk about that it is common for women to have perhaps a change in sexual function after childbirth and after children.

I would want to, once again with my opening questions, want to explore more. What's happened? What's, just like any condition, when did it start? How long has it been going on? What triggers were there, what does it mean to her? And so once again, using your opening communication skills-based questions to really get those details. If I had time, or maybe over a couple of appointments, or just trying to get maybe a point here or there to help with referrals or a longer history, I try and hear a little bit about her past sexual history or let her know that that's important and at another time we might talk about that.

This time, I think because it's impacting on her partner and it seems to be at a life change, though this is relevant for all patients, perhaps in this case from what she's saying to me, I might spend more time on asking about relationship and social history. But once again, if time is an issue, I may flag that in my letter of referral to someone like Wendy and say, look, 'I think this relationship here, I think Jen would like to talk about this more', if I'm not able to do it. I'd definitely get a history of pregnancies, and especially any problems during the pregnancies, and want to know about deliveries in detail. And I'm sure Janetta is going to talk a bit more about deliveries and the impact that might have physically and psychosexually. What was post-pregnancy like? I think nowadays I'm asking more and more, what happened with delivery and how the woman felt about it.

And really talking about and saying to women, it is starting to be more common to acknowledge that what happened during pregnancy, delivery and postpartum is something that's significant and worth talking about, if the woman wants to. And I'll ask more about her pain, like any pain in the body. And once again, I'd ask about vulval and vaginal symptoms. In my examination, I would sensitively and respectfully examine Jen's vulvovaginal area. I'd discuss her options, again. I have just put a point in here, Jen's 45 and she's had a family. I don't know if her family's complete, I don't know if she needs contraception or what's going on. And as I've said many times, these things are time-dependent. But if it was appropriate, I may discuss her contraception as part of her sexual history and health, especially as some contraception could impact on her desire or libido, depending on what she means. And I'm thinking, and I'll look to Sue to elaborate if I've got this wrong, but things like the progesterone contraception, I find patient reports the dampened libido. I'm not sure about the research in that, these are more patient histories, but, so I've put a big question mark there to cover myself. But I would, if appropriate, I would talk about contraception at the time. And I think also, if we're talking about condoms, that also can impact on what lubrication you can use. So it is important to talk about, but I might leave it there and hand it over.

**Prof Susan Davis:** Do you want me to comment on contraception? So it's actually not the progesterone, it's the oestrogen. So women make androgens from two sources in their body. They make androgens from the adrenals and the ovaries. When you are 20 and your adrenal function is robust, if you are on the oral contraceptive pill, that will completely put the ovaries to sleep, and the ovaries do not make testosterone. And also the contraceptive pill will increase, the oestrogen will increase sex hormone binding globulin, which binds up testosterone, so the amount of testosterone that's available to go into cells is diminished. But when you're 25 and the adrenals are pumping out the hormones, you're fine. When you're 45, your adrenal function is much less, and there's about a 50% decline in the hormones made by the adrenals, the androgens. So suddenly now, you're on the Pill that didn't bother you when you're 25, but at 45 you've now got much lower testosterone as a result of the Pill. So simply taking the patient off the Pill can improve sexual function. Obviously you have to discuss options. And in fact, there was a beautifully designed study published last year that confirmed this, a placebo pill versus women on the real Pill, and showed that women on the contraceptive pill have lower libido than women not on the Pill. So it's oestrogen in the Pill.

**Dr Sara Whitburn:** I've learned something. Before I sidetrack it, what do you think about things like Implanon and Mirenas? Is this more of a patient-driven ideas and expectations? Because that's why I put a big question mark and looked at you, but the time I get it reported is often when we are using the long-acting progesterone-only contraceptions, and I myself would be interested to know about that.

**Prof Susan Davis:** So Mirena, the answer is 'no'. And the other thing is, there's a huge amount of psychology in sexual function. So when we do clinical trials, there's so much placebo effect with sexual function that thoughts will change everything. So if women believe that the Mirena, and there's probably a lot of chitchat on the internet, if they believe the Mirena's doing bad things, it will do bad things. But in fact, the Mirena does not affect ovarian function. Implanon will dampen ovarian function, and some women more than other women. And so it's, potentially Implanon can have an adverse effect on sexual function because it's switching off ovarian function, but not Mirena.

**Dr Sara Whitburn:** Thank you.

**Louise Browne:** Okay, great. Sorry, I've got questions coming in. We've got to move it right along. Because we need time for these questions.

**Janetta Webb:** Yes. Okay. So I hope that you were all listening to Sue and Sara talking then, but while you were doing that, you were probably also reading through my slide. Just at the things that I'll be interested in, if at some stage in her management, Jen does present to physiotherapy. So I might move on because you will have had a good time to look at those. But these are the common physical issues that a woman like Jen may raise with her physio. And as I mentioned before, when I was giving my introduction, I talked about sometimes we can give unhelpful messages to a woman. So I relatively frequently see a woman who has given birth vaginally and she'll say to me, 'Oh, and after I gave birth, I was told that, oh, I'm definitely going to have problems with prolapse later on.'

And so that may have just been a warning or a suggestion that Jen should be doing something in terms of prevention, but it's really stayed with her. And lots of women are concerned that episiotomy scarring or sight may be contributing to dyspareunia or difficulties. Or just that, 'I don't have pelvic floor muscles', is another common thing that women will say, 'I feel like they've gone to sleep.' So here are the things that I would be interested with Jen, just making sure that pelvic joints, lumbar spine, hips are not causing her any issues. Again, sensitively examine her, palpate her pelvic floor muscles. And I'm then going to give her a pelvic floor training program according to what I've found, or possibly some treatment. And all the time reassuring her, 'It's fine, you are going to be able to make some improvements,' rather than, 'Yes, you've got no pelvic floor muscles, they're so weak and it's going to take you ages to get them strong.'

And in terms of management, again, education is so important so that the woman really understands, what are the issues as you see it? And how can she help herself to improve unwanted sensations that she's having? And of course, as physios, we suggest that, and we know from research, that a pelvic floor training program needs to be intensive. So a couple of squeezes here and there at the traffic lights a couple of days a week isn't going to be enough necessarily to change symptoms such as incontinence or prolapse symptoms. Again, I mentioned before biofeedback that can be used, but don't always think of biofeedback as being machinery. Just using a mirror, self-palpation, the use of vaginal weights, as well as surface EMG can be helpful. And here's a picture of one type of muscle stimulator if pelvic floor muscles are really weak. We have had a question about scar tissue, particularly in terms of surgery, but also, if there is tenderness, or there is thickening of scar tissue, again, be very sensitive in terms of the way you discuss that, but Jen can actually learn to help to improve the elasticity of that area. And here's an idea of a fitness program for women who are improving the fitness of their pelvic floor muscles who also wish to participate in some sort of general fitness. So it's strength training, stretching that they can then add into their cardio program. And I'll pass over to Wendy.

**Assoc Prof Wendy Vanselow:** Thank you. So with Jen, again, I would be looking at, was there any birth trauma and also was there any postnatal depression? And how things were managed at the time. You may not find that there's anything in the obstetric and postpartum history, or you might find that there are some issues. Maybe one of the children has a developmental problem or illness, and the whole family is devoting time and effort to this, and the couple are not having space or time for themselves. This will often bring up issues of desire discrepancy.

This is a condition ably described by Dr. Rosie King in a lot of her literature, which will be appended to this webinar. But desire discrepancy occurs when one partner has higher levels of desire than the other, and it can become an issue where there is more pursuing of the less libidinous partner to the point where they either keep distancing themselves, or feel that because their partner needs to have sex sometime, they'll give what's called 'mercy sex' to keep the couple happy. Now this often leads to even worse aversion in the lower desire partner. So we are trying to point this out to the couple, and looking at ways to break that cycle. And using negotiation skills. Women, when they are at times having lower desire, and that's not just women, men too obviously, but, need to develop some negotiation skills to be able to look at when they may be motivated to have sex rather than be driven by libido. And this has been found to be quite a common issue in women, where they will get involved in sexual activity, become aroused, and that will, in turn, drive desire and build more arousal. And so this is what we call 'responsive desire'.

I will also check, as Janetta mentioned, for other issues that might be contributing. And we also talked briefly about contraception. Often things like IUDs and vasectomy are good at this stage in life because of the family's finished, but we obviously would need to discuss it further.

I've done it. So one issue that a lot of women will find is that they are silencing themselves, once they become mothers and finding over time that their own personal needs are subsumed by their roles as mother, wife, carer, and even provider. And possibly a sense of 'who am I' at this stage in life. It's a common theme underlying women's depression, and motherhood can also re-trigger issues from the distant past. So we need to be very sensitive to look at other issues emerging. It's a common time for domestic discord and violence. We need to look even wider towards alcohol and drug use and addiction. We may need to be even looking at mental health referrals and so forth.

**Louise Browne:** Just thinking about, there's a couple of questions about emotional wellbeing at midlife and whether there's anything to show that there is a higher incidence of depression when people are at this point in life. I mean this woman's not menopausal, but let's talk about midlife generally. Would anyone like to comment on that? And just the impact that may have on sexual function?

**Prof Susan Davis:** It increases. So for women under the age of 55 who are postmenopausal, there is a spike in anxiety symptoms and depression. It seems to slowly resolve over time. But what we do know is that around menopause, perimenopause and the early postmenopause, there is an increased use of benzodiazepines, increased use of SSRIs, women self-medicate with alcohol, and women actually take up smoking again. And it's very clear that this occurs.

**Louise Browne:** And there's obviously a lot of flow on effects in terms of sexual function with that.

**Assoc Prof Wendy Vanselow:** And I think women, too, who've had hormonally related depression are more likely as well to have issues. If they've had postnatal depression, premenstrual depression, they're more likely to get menopausal, perimenopausal depression.

**Prof Susan Davis:** That's true. So I also often see women who present in their forties, late thirties, early forties, mid-forties, with changes, and they've done all the other stuff and seen their GP and psychologists, but they still have no desire. And they're often very relieved to have the discussion that there is a hormonal change at this time. And again, it's not that every woman should, you reach for the testosterone, but even having the conversation that this is hormonal can be a huge help to the woman. And this is an instance where having the partner present to explain that this is potentially beyond the woman's control, in terms that she's got biological change, can be incredibly important. One thing we haven't mentioned, in fact, is women often feel loss of self-esteem of their physical appearance. So breasts start to droop a bit, you start to get the midlife spread, and women don't feel as, that they'll be as sexually pleasing to their partner. And again, some of it is about physical fitness and health, and some of it is truly just you can't, breasts do get a bit more droopy when your hormones don't kick in as much, and these changes are important, again, to have that conversation with the partner is often good.

**Louise Browne:** Alright, so can I, that's good. Thanks Sue. There's so many things to discuss. Where to start? I might just, there's a couple of questions that came in. One was, what was the name? There's a lot of testosterone questions, can I tell you? But we can't let that dominate proceedings, but the name of the testosterone cream?

**Prof Susan Davis:** AndroFeme.

**Louise Browne:** Excellent. How long can a woman stay on testosterone?

**Prof Susan Davis:** As long as she wants. I have patients in their eighties who tell me they have a great golf swing.

**Louise Browne:** Excellent. And could you confirm testosterone is via cream, not oral?

**Prof Susan Davis:** It's absolutely essential testosterone is not given orally. We do not even treat men with oral testosterone. It must be transdermal. Or rarely with little pellet implants, but mostly transdermal.

**Louise Browne:** And we are using cream.

**Prof Susan Davis:** Cream. It's a cream.

**Louise Browne:** Yep. Beautiful. Thank you. Ticked those off. Can I just go back to something we talked about earlier? Vaginal moisturisers. So this is not for intercourse, this is regular, use three times a week, would that be right? Can someone give me—

**Dr Sara Whitburn:** That's vaginal oestrogen?

**Louise Browne:** No, no, no. Moisturiser.

**Dr Sara Whitburn:** Well, I'd say moisturising and general skincare could be daily. So I think it depends what you mean by vaginal moisturiser.

**Assoc Prof Wendy Vanselow:** You're probably talking internally.

**Dr Sara Whitburn:** Yeah, I think when you're talking about dermatitis and other skin conditions, we're very keen on moisturisers as well, but I agree they're not vaginal moisturisers.

**Louise Browne:** Yeah, I was talking about vaginal moisturisers.

**Dr Sara Whitburn:** So I think it's being careful with that because in vaginal atrophy and dermatitis and things like that, we use daily skin moisturisers. Cetaphil, Aveeno QV, externally. Externally.

**Louise Browne:** The vaginal moisturisers could be three times—

**Prof Susan Davis:** Three times a week.

**Louise Browne:** Beautiful. Thank you. Tick that one off. So just thinking about this whole idea about discussing sexual function, someone wrote in and said, the 45 to 49-year-old health check, comprehensive health check. Should we be asking a question regarding sexual function incorporated in the health check?

**Dr Sara Whitburn:** I think the short answer is 'yes'.

**Louise Browne:** Yes, tick do it.

**Dr Sara Whitburn:** So for those who aren't GPs, the 45 to 49-year-old health check is a Medicare-funded health check for people in midlife. And I think, as we've mentioned many times, sexual function impacts on your physical, mental, social, everything health, and also your physical health can impact on your sexual function. So yes.

**Louise Browne:** Yes, put it in there. And I think while we're talking about that, the loss of the two-yearly pap screen is a bit of an issue for some of these questions that you might ask at that time. So we need to, I think clinicians need to find ways to ask women about a whole range of things that they might've done routinely with the pap screen.

**Dr Sara Whitburn:** I think it's thinking midlife health, and so we will still hopefully see people for their cardiovascular checks and their diabetic checks. And just as in your chronic conditions, we are encouraged to think mental health, I think, in midlife and any life really, we should be thinking about sexual life. So I would hope it would just become one, as I keep saying, an open screening, let me just float this question and see where it goes. Obviously I can feel the GPs in the audience go, 'But how can I do this in all this time?' I think it's picking your moments, and perhaps the health checks, but at least flagging that it's something that could be talked about at another time.

**Janetta Webb:** And I think also if there's a particular issue in the area, so if a woman comes along who has incontinence, urinary incontinence, well that's a perfect time to then say, 'And do you have incontinence, are you sexually active?' So to open the questioning, 'Does it happen when you're having sex?' Because quite often they'll say, 'Well actually that's the worst thing of all. I can hide it myself if I leak when I cough or laugh, even though I don't like to have that happen. But the worst time, I'm in a new relationship and I'm really worried that it might happen.'

**Dr Sara Whitburn:** And as Sue said, it has an impact for people who are not in a relationship as well.

**Janetta Webb:** Well, people will often say that they're scared to start a relationship. And the other thing is that, don't make assumptions that just because someone's not in a relationship, they're not sexually active, even if they're a 70-year=old woman.

**Dr Sara Whitburn:** I think that's why the question was important is, 'Are you sexually active?' And some of my questions were even more broad than that saying, 'Sometimes when people have urinary incontinence, it impacts on how they feel sexually.' So I think it's that discussion about all sorts of private bodily functions that women and men in these areas want you to ask, but they find it hard to ask themselves, so you need to put it on the table.

**Louise Browne:** And I think there's studies that show that vaginal dryness, a woman's not going to initiate a discussion about it, but if you ask her, she will tell you, 'Yes, I've got vaginal dryness,' or—

**Assoc Prof Wendy Vanselow:** Many don't think there's anything they can do about it.

**Louise Browne:** They think that's just their lot.

**Dr Sara Whitburn:** And that's where that question, 'This happens to lots of people' or lots of women, can be really good. It's getting a good screening, opening questions.

**Louise Browne:** And I mean it's been such a long time that people have been uncomfortable talking about sex, but the more it comes up as part of a normal consultation, the better it's going to be for everybody, I think.

**Prof Susan Davis:** In the white paper that people can have access to, there are two algorithms, there are two questionnaires, they're both brief. They were developed by an international consensus group I was part of that were published last year in the Mayo Clinic proceedings that we were able to republish. So I'd recommend that people, if they're interested, look at those brief questionnaires because they will actually help you ask the questions we are talking about.

**Louise Browne:** Yeah, it's just about upskilling, isn't it? And there's also another document in the resources that is, it's an English sexual health questionnaire too that we've included. So that might be useful as well. Just thinking about general health and health screening, what would you like to say about lifestyle interventions, in regards to sexual health? Because that has come up as well.

**Dr Sara Whitburn:** Oh, I think Sue mentioned it in her talk about fitness, and Janetta as well. In some ways it is a good cardiovascular workout, and so you need to have good cardiovascular health. So I think any fitness can help. And I think also, it's those flow-on effects of increasing your exercise, which may only be 20 to 30 minutes a day, can impact on how you feel about your body and your body's strength. And I'm not saying lose weight or change your image, but more about the strength and the ownership of your body. So fitness, you've got to eat healthy, if you don't eat healthy that impacts all your functions. And of course we have briefly skirted around diabetes and other chronic conditions, and of course good healthcare helps prevent or manage some of those chronic conditions, and that is going to help your general, including your sexual health.

**Louise Browne:** Okay. I've got another question here where we've had someone ask, some women experience a UTI every time or almost every time they have penetrative sex. These women follow advice about voiding UTIs. How would you approach this, basically?

**Assoc Prof Wendy Vanselow:** Oh, I felt we'd covered that to a large extent. But yeah, voiding before and after, making sure—

**Louise Browne:** Checking, checking too—

**Assoc Prof Wendy Vanselow:** Checking that it is a UTI and maybe getting examined, as I said, for urethral irritation, from urethral prolapse, that type of thing.

**Janetta Webb:** Also ,too, talking to the woman about appropriate vulval skincare. A lot of women are washing before they have sex washing after they have sex. There's lots of washing and scrubbing with soaps, and it's not necessary. So, washing the vulva purely with water, or some of the washes that Sara mentioned before—

**Assoc Prof Wendy Vanselow:** And wipes.

**Janetta Webb:** That are often, yes, and not using wipes because they contain preservatives and fragrance. Not using vaginal sprays and deodorants and those sorts of things.

**Prof Susan Davis:** And vaginal steaming, I don't if many people are aware, but there's a lot of promotion of this vaginal steaming that, again, I think it's a bit like everything. Ask patients what they are doing. You might be surprised.

**Assoc Prof Wendy Vanselow:** Yeah, the vagina is self-cleaning.

**Louise Browne:** Jean Hailes does have a good vulval booklet, too, for consumers. So that can be ordered through Jean Hailes and you can download it. So that's something I'd recommend, because it does talk a lot about vulval skincare. I've got another question here. 'I recently saw a patient who's experiencing trouble with penetration with her new partner. Libido is normal. Symptoms are not suggestive of vaginismus. She has no vaginal dryness.' What do you think, team?

**Assoc Prof Wendy Vanselow:** So just to clarify the word 'vaginismus', that is a tensing of the pelvic floor muscles with penetration, which can be pap smears, doing a vaginal examination, or sex. So I think the first things I'd be thinking are, what's happening in that relationship? Does she actually want to be having sex? So maybe more Wendy's areas of expertise, but does she want to have sex? Is she actually getting aroused? But then examining her and checking her skin for any skin conditions, reassuring her, they'd probably be the first things that I would look at. And even though she may not give a history that's suggestive of vaginismus, of course as a pelvic floor physio, if she were happy for me to, I would like to check that, to reassure her. But if there is some overactivity of the pelvic floor, then to help her to self-manage that or possibly to have treatment if need be.

So I'd examine early, that's for sure. Some conditions are silent, such as lichen sclerosus, and planus even, which can narrow the opening. And also vaginismus is something that some people are not conscious of until—

**Janetta Webb:** Most people are not conscious of.

**Louise Browne:** So examination's crucial. I'm afraid I'm going to have to cut us off because we have our take home points, which I think are really crucial to wrap up. We've had so many questions, so apologies if we didn't get to yours, but I think we've covered a fair bit of ground. So starting off with Sara, I'm going to do the slide. I'm not passing it down. Sara, hit us with your take-home message.

**Dr Sara Whitburn:** I think I've hit everyone over the head with my take-home point throughout the talk, giving patients, women, men, whoever you are seeing, and yourself permission to talk about their sexual history. Using open, broad questions which make you comfortable, make them comfortable, and feeling comfortable to try and explore these histories more. And I think doing it little and often and practicing, and then it'll become second nature.

**Louise Browne:** Yeah, getting better and better at it. Thanks, Sara. Physio, you have to be quick. You've got a lot.

**Janetta Webb:** So don't ignore the pelvic floor. Often overactivity, underactivity, weak pelvic floor muscles. Always take care with language that you're using as a GP or a nurse if you're doing pap smears or vaginal examinations. If there's any discomfort, do consider that it could be related to the pelvic floor. And ideally all women should have access to information about pelvic floor muscle training. And we've got some resources for you on a slide at the end, I think.

**Louise Browne:** If you haven't already downloaded the slides, please do so now because they won't be available. So there's lots and lots of information that we've got on the slides. So if you go into the 'resource library' folder, I can't remember what the name of it is, you should be able to see it on the screen. Please download the slides. You can see them later on on the Jean Hale's website. But if you want to look in more detail, because we've given you lots to take on board, so I encourage you to get the slides, get a copy of them. Alright, Wendy?

**Assoc Prof Wendy Vanselow:** Well, I've thought about using genograms a lot because I do that with pretty much everyone I see, to get an idea of current and past family structure and relationships, because I think it tells you a lot more than what meets the eye in the first instance. I won't talk more about hormones. We think that they're generally safe. I do like to use them transdermally, if I'm using systemic hormones. And sex education, I utilise a lot. I help women to help themselves, and there's some resources in the notes. And I also teach assertive communication and sexuality so that women can take control.

**Louise Browne:** Yeah, I think it's never too early to be talking and educating. We were in country Victoria recently talking to year 8 girls about terminology for their genital region, and I think, they're year 8, they're probably 12 and 13. But that education can start young. Not talking about sexual function necessarily, but just talking about things so that people feel comfortable naming what they're talking about. Identifying what they're talking about. Finish up with you, Sue.

**Prof Susan Davis:** So my point is not on the slide. You can read that yourselves. The advances in this area have suggested that there are two biochemical things going on in the brain that some people truly have no or low desire, and they're poor responders to arousal stimuli. The other thought is that there are women and men who are hypervigilant when they're sexually active. So they're constantly subconsciously monitoring their response to the experience, and hyper aware of how they're responding, which may well apply to the question about the vaginal, the inability to have penetrative sex, because that person may simply be hypervigilant of how their body might be responding. So I think talking to your patients and trying to tease out whether they simply have this dead low libido, lack of endogenous arousal, or whether they're hyper aware of as to how they should be performing. And I think that's an important thing to try and unravel.

**Louise Browne:** And it is hard to do that in short consultations.

**Prof Susan Davis:** But there's something to think about, at least.

**Louise Browne:** Something to think about as you go into the consultation.

**Prof Susan Davis:** And If you think that a person's troubled, then refer them.

**Dr Sara Whitburn:** I think it's just being aware. So yeah, I mean it would be great if we could all work together in a very long consultation, but it's being aware and, as I said, these things can often take time, or use your team. This is not so something you, this is not something that you do on your own. And even if you're in a place which doesn't have these resources, I would hope there's always phone a friend or online resources, and the resources that are at the back, like Rosie King, are books that you can have yourself in your clinic. In fact, I do have copies in my clinic to show people. And so it's adapting what we've said to the location that you're in, and you don't have to do it all in one appointment.

**Louise Browne:** And we do appreciate that we've got clinicians from all over Australia, so it's not always as easy. But if you can get to know the people who are in your area that you can work with, I think that's ideal. So the resources you will find on the end of the slides that also, as I said, there's resources that'll be in the Jean Hailes library when the webinar is up next week.

So there's lots of information. Oh, that was what I wanted to mention earlier. There's a really good article by Edwards and Panay, which is around vaginal lubricant and moisturiser, and the things that might be important to consider in a woman who's menopausal. So we have got to the end. It's nine o'clock, we need to finish. Thanks so much for being part of the webinar tonight. Remember, we'll send you an email next week about the recording. If you want to do the, if you want CPD points for an evaluation, you need to complete the evaluation when it comes up shortly. Thanks again to our fantastic panel. I think it's been a really great discussion, and I hope you've all taken something away. Thanks very much. See you next time.

End of transcript

Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

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