



# Women's Sexual Health Journal

## Editorial

Launching a new journal is akin to the birth of a baby. This was conceived casually, but then there was passion. Over the course of time, imagination ran wild. What will it look like? How big will it be? What features will it have? Who will love it? Who will take care of it? How fast will it grow? These questions taunted yet guided us at TWSHF while preparing this first issue.

I volunteered to be the editor with some trepidation. Could I find enough material for the first issue? Expanding on that thought, will there be sufficient material to sustain future issues every three months? Lisa Martinez and I brainstormed frequently about audience, features, content, and tone. We decided we wanted to produce a journal for foundation members, both lay public and professionals. Ideally, the articles should have sufficient substance to be useful to healthcare practitioners, yet have high readability for those members who are not immersed in medical jargon.

One feature we both agreed on immediately was a story column. This would feature the experience of a woman or her partner coping with a sexual health issue. We have heard numerous stories that are heart wrenching; some, however, reached successful conclusions. Both public and professionals will learn much from these stories. Authors may send their stories to me at [info@twshf.org](mailto:info@twshf.org) with the understanding that their anonymity will be preserved unless they request otherwise.

Another feature will be an original article in sexual medicine or women's health. The professional Advisory Board of TWSHF and additional colleagues will be solicited for submissions. These articles may be edited for size and readability. Coupled with this, I will summarize important papers from the literature

from time to time. These may be either classic or current papers.

Each issue will have a question and answer feature, resources, meeting postings, and information about donations and membership. Letters to the Editor may be published if they have informative value. Guest columnists are encouraged to contact me. Please join me in wishing this new venture well. *Editor—David Ferguson*

## A Woman's Story

### *If I had only known!*

I am a 58 year old registered nurse. Although I have not actively practiced nursing at the bedside for many years, I am a strong advocate for living healthy lifestyles, and being compliant with medical care, especially when it comes to preventative care. I also choose good providers of care and put my trust in them.

So when I found myself sitting in a urologist's office one sunny morning in April of 2002 and was told that I most likely had ovarian cancer after an ultrasound, I was in total disbelief. The urologist was seeing me that morning because I spent several hours in the emergency room the previous evening. I could not void and had to have an indwelling catheter inserted into my urinary bladder due to a large mass obstructing the flow of urine. I was shocked to hear that I had a large mass on my ovary, because within the previous six weeks I had had a normal check up with my gynecologist.

With tears streaming down my face and as I pondered how I was going to tell my husband this devastating news, I went for blood work and an MRI. I kept praying for strength and acceptance as I lay still under the MRI machine.

*(Continued on page 2)*

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**Articles, letters, and questions may be submitted to the Editor, David Ferguson, at [info@twshf.org](mailto:info@twshf.org).**

*(Continued from page 1)*

Later that afternoon I saw my gynecologist. With my husband now at my side, I was relieved to hear that the mass first seen by the urologist was actually intrauterine with other large masses surrounding my ovaries. I was told that I needed to have a hysterectomy.

Quite honestly, I was so relieved to hear that I most likely did not have cancer, I was ready to go to surgery that day. I kept asking why my doctor did not feel these masses when I saw him only a few months earlier. He had no answer except to say that my uterus was tilted “backwards” and it was difficult to feel. I thought that this was strange, since I had such dramatic symptoms of not being able to urinate for at least four weeks, the last time requiring a visit to the ER.

When my gynecologist gave me informed consent, he skipped over the risks and alternatives but focused on the benefits. He said that I knew all about this since I was a nurse. I never knew that there could be any alternatives, and just wanted to be free of the masses that were causing all the pressure on my bladder, and to finally know if there were any possibilities of malignancy.

Within a few days I had a total hysterectomy which included removing my ovaries. Prior to surgery, I was still having menstrual periods at age 56. I had no hormone levels taken and had no idea of the radical changes that began to affect my body post operatively.

Following a six week recovery period from major abdominal surgery, I began to feel stronger but was tired. I know that it takes time to heal. But what surprised me the most was the major push for hormone replacement therapy by my doctor. I have fibrocystic breast disease and within four weeks of a hormone patch, I was feeling some breast lumps, so I took myself off the hormones. I went back to the office with these complaints and was again offered another hormone alternative. I asked for blood work to see where my hormone levels were at, but was told those tests were not reliable.

So the compliant person that I usually am decided to not go along with more hormones. I used diet, black cohosh, and reduced my caffeine intake to control the hot flashes and leg cramping. I am not sure if the herbal approach works or not, but if in my mind I feel better, I will continue to take it.

My most disturbing symptom post-hysterectomy has been my absolute lack of libido. I am tired a lot and have blamed this lack of energy and passion on work, grandchildren, and overseeing the care of elderly parents. But I am beginning to realize that since surgery, I have much less stamina physically. I also have very little desire for physical intimacy.

At first I thought I was at fault. My husband could not understand what was wrong with me. I thought it had to be something I was doing. I tried all kinds of things, like romantic evenings, weekends away, etc. Try as I might, I just did not feel like making love to the man I am so in love with. This has placed a strain on our marriage. My husband feels rejected. I feel guilty. It takes patience, trust, and understanding on both our parts to deal with this situation.

A few months ago a friend of mine suggested that I ask my gynecologist for Premarin vaginal cream, which I did. He willingly gave me a prescription, and I have noticed some slight improvement. But what is so disconcerting to me is that no one ever told me that losing my cervix, uterus, and ovaries would cause such dramatic changes in my body. And what is even more phenomenal is that other women are telling the same stories.

I always heard that you feel so much better after this surgery. Well, I do not. I am angry that the life I had has been changed. I know that I can and do have the ability for physical intimacy with my husband, but I wish I would have been given the alternatives to surgery and certainly a better explanation of the risks following the procedure. I don't think that I would have felt so alone with my symptoms “if I had only known.”

## Questions and Answers

**Q** - - - Are there tests that can assist in determining if my testosterone is low especially as it relates to low desire/libido, etc? My doctor has told me no such lab tests exist.

**A** - - - Total and free testosterone levels in healthy young women are about one tenth those of men. Although these lower levels are more difficult to measure accurately, there is a test appropriate for use in women: the equilibrium dialysis method. Two commercial laboratories that offer this test are Quest and Mayo. Your doctor should order total and free testosterone and sex hormone binding globulin

*(Continued on page 3)*

*(Continued from page 2)*

(SHBG). This latter substance can sequester testosterone reducing the amount of free testosterone available to affect the body. SHBG can be elevated by hormone replacement therapy and birth control pills. The sexual medicine article in this issue discusses the relationship between testosterone and low desire in women.

**Q** - - - While my husband and I were making love and as he was bringing me to orgasm manually, I suddenly developed a severe (almost migraine-like) headache that also caused me to be nauseated. I have had this happen one other time, but this time was more painful and lasted much longer. The headache lasted a couple of hours. It scared us both. We thought I was having a stroke. What is this?

**A** - - - Coital headaches are not uncommon. They are more common in men than women. Although there is no specific information as to the cause, a current theory is that the vasodilation associated with sexual arousal that leads to engorgement of the genitals, nipples, and nasal mucosa, as well as the flushing of the chest and face, may become generalized and lead to dilation of the cerebral blood vessels, causing headache. Prevention of these headaches may be accomplished in some cases by taking an analgesic prior to sexual activity. Other preventatives may include caffeine and calcium (doses similar to those used for prevention of osteoporosis). If caffeine is used, it may retard or even prevent orgasm.

Interestingly, people who are prone to coital headaches are also more likely to develop headaches when using Viagra. This is consistent with the theory described above.

A website that has some information about this phenomenon: <http://headaches.about.com/library/weekly/aa061901a.htm>

**Q** - - - What medications may be responsible for loss of libido?

**A** - - - Although the list of possible offenders is enormous, as seen in some pharmacy compendia, most of those reports are anecdotal and not scientifically proven. For women, the medications most often associated with loss of libido are oral contraceptives, antidepressants (particularly the SSRI class), and certain blood pressure drugs. Fortunately, there are effective alternatives in most cases. Contraceptive patches are believed to have little negative effect on libido. Bupropion (Wellbutrin®) is

an antidepressant that has been shown to relieve low desire in depressed patients who were switched from SSRI antidepressants. Among antihypertensive medications, diuretics and beta blockers are very frequently the cause of reduced libido. Most patients can achieve good control of their blood pressure without the loss of libido by switching to an angiotensin 2 blocker. Women who believe they may be experiencing a loss of desire due to medications should speak to their physician before making any changes.

## Sexual Medicine Article

Evidence Based Management of Androgen Insufficiency in Women with Female Sexual Dysfunction (FSD), André T Guay MD, FACP, FACE, Director, Center for Sexual Function / Endocrinology, Lahey Clinic Northshore, Peabody, Massachusetts USA, 2004.

In 2000, the International Consensus Development Conference on Female Sexual Dysfunction<sup>1</sup> defined Sexual Desire Disorder as a persistent or recurrent deficiency of sexual fantasies or thoughts, and/or desire or receptivity to sexual activity accompanied by personal distress. The most severe form of this is sexual aversion disorder. The hallmark epidemiological study was done by Laumann<sup>2</sup> and reported in J.A.M.A. in 1999. In all, 43% of women ages 18 to 59 years, suffer from some form of sexual dysfunction. The incidence of decreased libido remained constant in all decades studied at about 30-32%. How many of these women have decreased androgens is unknown. In a study in the UK, Dunn<sup>3</sup> determined by postal questionnaire that 41% of women 18 to 75 years old had some form of sexual dysfunction.

As in men, decreased libido in women has been linked to decreased testosterone levels. Decreased sexual desire is multifaceted and often multiple causes are found in any single individual. Anxiety and depression have traditionally been linked to decreased libido, as well as relationship disorders. Acute and chronic illnesses, along with various medications have been implicated. Decreased sexual desire has been often noted to accompany the menopausal transition, and estrogen deficiency has been studied along with androgen deficiency.

*(Continued on page 4)*

*(Continued from page 3)*

The Princeton Consensus Conference<sup>4</sup> in 2002 defined female androgen deficiency as consisting of a pattern of clinical symptoms in the presence of decreased bioavailable testosterone and normal estrogen status. Besides decreased libido, changes in sexual function include decreased sexual receptivity and pleasure. As in men, decreased androgens may cause a diminished sense of well-being and unexplained fatigue and loss of energy. Vasomotor instability and decreased lubrication can occur even if the patient is adequately estrogenized. Decreased muscle strength and bone loss may also occur.

In men, androgens are made primarily in the Leydig cells of the testicles. In women, half of the androgens and androgen precursors are produced in the ovary with the other half being derived from the adrenal glands. Also, half of the active androgens are produced by the peripheral conversion of precursors in various tissues. Therefore, damage to the pituitary gland, ovaries or adrenal glands will produce a deficiency. Also, blocking the function of these organs will impede their androgen production. Examples of this are cortisone, birth control pills, or even perimenopausal hormone replacement.

Androgens have been given during menopause for many years. Greenblatt<sup>5</sup> compared the effect of various combinations of androgens and estrogens during the menopause in 1950. The combination resulted in improved well-being and libido when compared to estrogen alone. Sherwin<sup>6</sup>, recently in 2002, summarized a number of randomized clinical trials showing that adding androgens to the standard estrogen replacement had added benefit to well-being, sexual desire and interest, frequency of intercourse, and frequency of orgasm.

There are problems in considering the use of androgens in women. The use of testosterone for androgen replacement is not approved for use in the United States and in many other countries. There is a lack of knowledge on the exact normal range for testosterone by age, although we know that androgen precursors and testosterone decrease with age in both men and women. This is compounded by the lack of sensitive and specific testosterone assays in women. Because of this a free androgen index or a calculated free testosterone value is felt to be more precise.

Zumoff<sup>7</sup>, in 1995, published a curve showing decreasing testosterone levels in women from ages 20 to 50. There were only 33 women and none were screened for sexual difficulties. The mean

testosterone levels declined from approximately 38 ng/dL at age 20 to approximately 12 ng/dL at age 50. There was no sudden decline associated with the menopausal years. Guay<sup>8</sup> and colleagues recently presented the androgens values in 60 women for the same 30-year period, and these women were screened for sexual dysfunction, especially decreased libido. In doing this, and presumably eliminating some women with low testosterone from the normal pool, the normal range increases substantially. In this study, total testosterone ranged from 46 to 58 ng/dL for women aged 20-29 (n=17), 28 to 40 ng/dL for women aged 30-39 (n=23), and 27 to 39 ng/dL for women aged 40-49 (n=20). More normal range studies are needed with many more women to verify this finding.

Products are being developed to deliver testosterone to deficient women. Shiffren et al<sup>9</sup> studied women with impaired sexual function who were menopausal after oophorectomy. Testosterone or placebo was administered by transdermal patch to the women who were receiving standard estrogen replacement. The total testosterone was raised above the normal range despite the SHBG decreasing, but the free and bioavailable testosterone remained within the normal range. Sexual frequency and orgasm increased significantly with the testosterone, along with an increase in well-being and mood. No adverse effects on skin and lipids were noted but the study did have a high placebo response as well as possible supraphysiological levels of total testosterone and dihydrotestosterone at the higher treatment dose level. The study did confirm that testosterone therapy augmented the standard estrogen replacement in menopause and actually did have added benefits, especially in the area of sexual function.

Very few studies have been done in premenopausal women complaining of sexual dysfunction. Guay et al<sup>10</sup> studied women, ages 20-49, who appeared healthy but who complained of sexual dysfunction. They, and an age-matched group of women with no sexual complaints, had regular menses and were taking no medications or birth control pills. The two groups were separated significantly by a sexual function questionnaire. The women complaining of sexual dysfunction had significantly lower adrenal androgen precursors and testosterone levels than their age-matched controls. This included decreased levels of pregnenolone, 17-OH pregnenolone, DHEA-S, total testosterone and free testosterone. The cortisol part of adrenal gland function remained quite normal.

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(Continued from page 4)

Goldstat, et al<sup>11</sup>, also studied premenopausal women complaining of decreased libido. They were found to have testosterone levels in the lower third of the presumed normal range for young women. These women received testosterone cream or placebo for 12 weeks. The women on testosterone therapy had significantly increased well-being as well as increased sexual desire and activity. The mean decrease in a depression inventory score approached significance. Androgens play an important role in general well-being and energy as well as in sexual function, but more research is needed in developing the data and tools needed to outline androgen deficiency more precisely.

### References

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3. Dunn KM, Croft PR, Hackett GL. Sexual problems: a study of the prevalence and need for health care in the general population. *Family Practice* 1998; 15: 519-524.
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8. Guay A, Munarriz R, Jacobson J, et al. Serum androgen levels in women aged 20-49 years with no complaints of sexual dysfunction. *Int. J. Imp. Res.* 2004; 16: 112-120.
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10. Guay A, Jacobson J, Munarriz R, et al. Serum androgen and androgen precursor hormone levels in women with and without sexual dysfunction. *Int. J. Imp. Res.: J. Sex. Med.* 2004; 16: 121-129.
11. Goldstat R, Briganti E, Tran J, et al. Transdermal testosterone therapy improves well-being, mood and sexual function in pre-menopausal women. *Menopause* 2003; 10: 390-398.

## Meetings

**1st Annual Symposium on Sexual dysfunction in Women and Men**, Wright State University School of Medicine, Dayton Ohio. October 9, 2004.

**The International Society for Sexual and Impotence Research (ISSIR)** will host its 11th World Congress in Buenos Aires on October 17th to 21st, 2004.

**International Society for the Study of Women's Sexual Health (ISSWSH)** Annual Meeting will be held in Atlanta, Georgia on October 28-31, 2004.

**The Society for the Scientific Study of Sexuality** Annual Meeting will be held in Orlando, Florida on November 4 - 7, 2004.

**American Association of Sex Educators, Counselors, and Therapists** Annual Meeting will be held May 11-15, 2005 in Portland, Oregon.

**World Congress of Sexology** Annual Meeting will be held July 10-15, 2005 in Montreal.

## Resources

### Books:

*For Women Only: A Revolutionary Guide to overcoming Sexual Dysfunction and Reclaiming Your Sex Life.* Berman, Jennifer, Laura Berman & Elisabeth Bumiller. 2001. New York: Owl Books.

*What Your Mother Never Told You About Sex* Hutcherson, Hilda. 2002. New York: Putnam.

*Getting the Sex You Want: A Woman's Guide to Becoming Proud, Passionate and Pleased in Bed.* Leiblum, Sandra, & Judith Sacks. 2002. New York:

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Crown Pub.

Becoming Orgasmic: A Sexual and Personal Growth Program For Women. Heiman, J and J. LoPiccolo. 1988. New York: Prentice Hall.

Women's Bodies, Women's Wisdom. Northrup, Christiane. 1998. New York: Bantam.

The Wisdom of Menopause. Northrup, Christiane. 2001. New York: Bantam, Doubleday & Dell.

Hysterectomy & Ovary Removal: What ALL Women Need to KNOW. Plourde, Elizabeth. 2002. Irvine: New Voice.

Hysterectomy: The Best or Worst Thing that Ever Happened to Me? Plourde, Elizabeth. 2003. Irvine: New Voice.

The Hormone of Desire: The Truth About Testosterone, Sexuality, and Menopause. Rako, Susan. 1999. New York: Three Rivers Press.

I'm Not in the Mood: What Every Woman Should Know About Improving Her Libido. Reichman, Judith. 1999. New York: Quill.

Misinformed Consent: Women's Stories About Unnecessary Hysterectomy. Cloutier-Steele, Lise. 2003. Chester, NJ: Next Decade, Inc.

What Your Doctor May Not Tell You About Fibroids: New Techniques and Therapies--Including Breakthrough Alternatives to Hysterectomy. Goodwin, Scott C, MD & Broder, Michael, MD. 2003. New York: Warner Books.

#### **Internet Links:**

American Association of Sex Educators, Counselors, and Therapists: [www.aasect.org](http://www.aasect.org)

FSDInfo- Information on Female Sexual Dysfunction [www.fsdinfo.org](http://www.fsdinfo.org)

International Society for the Study of Women's Sexual Health: [www.isswsh.org](http://www.isswsh.org)

The Kinsey Institute  
<http://www.indiana.edu/~kinsey/>

National Foundation for Sexual Health Medicine, Inc.  
[www.nfshm.org](http://www.nfshm.org)

National Vulvodynia Association  
[www.nva.org](http://www.nva.org)

The National Uterine Fibroids Foundation  
[www.nuff.org](http://www.nuff.org)

The North American Menopause Society  
[www.menopause.org](http://www.menopause.org)

The Society for the Scientific Study of Sexuality  
<http://www.sexscience.org/>

Society for Sex Therapy and Research  
[www.sstarnet.org](http://www.sstarnet.org)

Vaginismus Support Group  
<http://health.groups.yahoo.com/group/1vaginismus/>

#### **Government**

National Institutes of Health: [www.nlm.nih.gov/medlineplus/femalesexualdysfunction.html](http://www.nlm.nih.gov/medlineplus/femalesexualdysfunction.html)

#### **General Sexual Health and Related Links**

Endometriosis Association  
[www.endo-online.org](http://www.endo-online.org)

Go Ask Alice  
[www.goaskalice.com](http://www.goaskalice.com)

Hormones, hormone studies:  
<http://www.nih.gov/PHTindex.htm>

The Interstitial Cystitis Network  
<http://www.ic-network.com/>

The Sexual Health Network  
[www.sexualhealth.com](http://www.sexualhealth.com)

Vulvar Health  
[www.vulvarhealth.org](http://www.vulvarhealth.org)

The Alexander Foundation for Women's Health  
[www.afwh.org](http://www.afwh.org)

The Menopause Web Reference  
[www.womanlab.com](http://www.womanlab.com) (sponsored by the European

(Continued on page 7)

(Continued from page 6)  
 community. Information at this website is available in many different languages.)

## Membership

### Professional , student, and public members

For a professional membership, you must be a professional working in the field of women’s health or a healthcare related field. For a student membership, you must be at least 18 years of age and currently a student in a healthcare related field. Annual membership for the public is \$10. If the annual membership fee will be a hardship, please contact TWSHF at [info@TWSHF.org](mailto:info@TWSHF.org) so that you will still be able to receive these benefits. TWSHF does not intend for the public membership fee to be a barrier to receiving sexual health information. For a \$50.00 annual professional membership fee or a \$10.00 annual student or public membership fee, you will receive the following benefits:

### Women’s Sexual Health Journal

TWSHF publishes its e-journal four times per year. The journal contains articles written by experts in the field of female sexual medicine and health, summaries from the literature, patient stories, Q&A, and resources. Specifically, the newsletter serves to educate the lay public and healthcare provider about the current research, diagnosis and treatment of female sexual health difficulties. It will also include announcements for conferences and seminars on female sexual health topics, and summaries of conferences attended by TWSHF staff and advisory board members. The journal will be available only to members at the TWSHF website.

### Education Opportunities

TWSHF has a list of available preceptorships in sexual medicine and health for those professionals interested in advancing their education in this area.

### Education Brochures

As a member you will have access to print the brochures listed at [www.TWSHF.org](http://www.TWSHF.org) for your office, or for other professional purposes such as seminars.

If you prefer to order pre-printed brochures in bulk, you will receive a discount on these orders by

contacting [info@TWSHF.org](mailto:info@TWSHF.org) and requesting pre-printed brochures. Please make sure you mention that you are a member.

### E-Newsletter

E-newsletters will be sent to our members when there is news breaking in the area of female sexual medicine and health.

### Answers to your questions

Some of our advisory board members are willing to assist with answering questions you may have in the area of female sexual medicine and health. The frequently asked questions and answers will be posted for members only to review.

## Membership Application

If you wish to join TWSHF, please provide the information shown below and make your \$10.00 or \$50.00 check payable to The Women’s Sexual Health Foundation. If you live outside of the USA, TWSHF can only accept a US money order. Please mail your application and payment to:

**TWSHF**  
**PO Box 40603**  
**Cincinnati, Ohio 45240-0603**

<b>Membership</b>	Public <input type="checkbox"/> Professional <input type="checkbox"/> Student <input type="checkbox"/>
<b>Name:</b>	
<b>Address:</b>	
<b>City:</b>	
<b>State:</b>	
<b>Zip:</b>	
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<b>Home Phone :</b>	
<b>Work Phone :</b>	
<b>E-mail (required):</b>	

(Continued from page 7)

## Donations

Thank you for your interest in supporting the work of The Women's Sexual Health Foundation. A woman's sexual health can be impacted anytime throughout her life. The mission of the Women's Sexual Health Foundation is to provide support in the following ways:

- Providing educational information on the causes, treatments, and latest research in sexual health issues to women and to healthcare professionals
- Supporting a multidisciplinary approach in treating women's sexual health concerns
- Offering resources for women experiencing sexual health difficulties as well as for their partners, family, and friends
- Advocating funding for research to advance knowledge in sexual medicine

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 non-federal 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:

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## Instructions for Authors

Manuscripts, guest editorials, questions, stories, and letters to the editor may be submitted by e-mail to David Ferguson at [info@twshf.org](mailto:info@twshf.org). Microsoft Word

is the preferred word processing program. Manuscripts should be 3,000 words or less. Illustrations or figures should be submitted as bitmaps and must have sufficient clarity and resolution to be legible when printed in a single column of the Journal. Photographs must be scanned at a minimum of 300 dpi and submitted as bitmaps, TIFF, or jpg files. All authors must be listed with first and last names and affiliations. Sponsorship (if any) should be indicated. Format should follow standard scientific style for an original piece of research or a review article. References should follow the format shown in the Sexual Medicine article in this issue.

Manuscripts and guest editorials must be in English, with spelling and phrasing consistent throughout the paper, conforming to either standard English or American usage. In order for a manuscript to be considered for publication all named authors must agree 1) to its submission, 2) that it is not currently being considered for publication by another journal, and 3) if accepted the paper will not subsequently be published in the same or similar form in any language without the written consent of the publisher.

Questions may be submitted by anyone and may be directed to a member of the Advisory Board or simply to the editor. The Editor may need to clarify the question prior to publication, so the author must provide contact information. Authorship of a question will be published unless a specific request is made.

Personal stories should be 1,000 words or less. The Editor may need to edit the story prior to publication, so the author must provide contact information. Each story will be published anonymously unless a specific request by the author is made.

Letters to the editor should be 500 words or less with full contact information and affiliation provided. The Editor may work with the author to refine the letter prior to publication. The Editor will decide whether a letter will be published. Authorship of a letter will be published unless a specific request is made.

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

Thank you.