



Women's Sexual Health Journal

Editorial

The dictum "Above all else, do no harm" is a cornerstone of medical practice. Every patient who seeks health care comes with questions and doubts, fear and anxiety, faith and hope. In the field of sexual health, providers must address these issues while gathering data, making a diagnosis, and treating the patient. Accurate diagnosis can be difficult because of the psychological, societal, and relational influences on patient and provider candor. Reticence, shame, guilt, and embarrassment (consequences of our Puritan heritage and 20th century Freudian notions) directly interfere with essential communication. Providers must overcome their own issues while assisting patients in overcoming theirs. Making the correct diagnosis is paramount to doing no harm.

In this issue, a compelling account of a husband's struggle with his wife's sexual dysfunction reminds us of how important a thorough search for etiology must be when confronted with patients with sexual difficulties. This couple discovered on their own that there might have been a hormonal basis for her lifelong sexual indifference. No doctor had ever suggested to this couple that there was any possible explanation except her upbringing. With medication prescribed by one of our sexual medicine colleagues, they are now enjoying a sexual relationship for the first time in more than thirty years of marriage. A delayed identification of the source of her dysfunction was certainly harmful. This case also reminds us that patients are usually part of a couple; what impacts the patient, impacts the couple.

Current pharmacologic treatments for female sexual dysfunctions are very limited. Products containing estrogen (and also testosterone in one case) are available for relief of menopausal symptoms including hot flashes and vaginal atrophy/dryness. No prescription product has been approved by the FDA for the specific treatment of any FSD. That may soon

change with the upcoming FDA review of a testosterone patch for women (see **Meetings**). In the meantime, all decisions to prescribe medications for these dysfunctions are based on the literature and extrapolation from use of such products in men. This practice is called off label prescribing. When done by a knowledgeable physician, beneficial outcomes may be expected. When patients obtain medications and self-prescribe without a physician's review, misadventure may occur. There is a thought-provoking article, **Informed Consent, Off Label, and Off Street Drug Use**, in this issue that addresses these concerns and how physicians and patients may minimize harm.

A case presentation (not related to sexual health) summarized from the New York Times is particularly cogent since the gynecologist involved refused to say "it's all in your head" to a woman who presented with baffling signs, symptoms, and tests. His great concern was that once she had been labeled as a psychological case, there would be no more attempt to discover any physical cause for her ailment. In this case, he was right. This is not to say that psychological factors do not cause, impact, or result from sexual dysfunctions. A fascinating case of persistent sexual arousal (PSAS) is described under **Sexual Medicine Article** in this issue. In this patient, a dietary extreme apparently was responsible for her PSAS. What was the psychology underlying her faddish diet? Did she think that a "natural" substance could do no harm? Could she benefit further from psychotherapy? Undoubtedly! Well, that is a topic for another editorial in a future issue.

Throughout this issue, the difficulties met by providers and patients (and partners) revolve around establishing an accurate diagnosis. Sir Arthur Conan Doyle modeled his famous detective Sherlock Holmes after his medical school mentor Joseph Bell. Bell was renowned at Edinburgh and elsewhere as the master of observation and deductive reasoning when searching for a diagnosis. In the articles presented here, we have seen successful deductive reasoning by

(Continued on page 2)

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Articles, letters, and questions may be submitted to the Editor, David Ferguson, at info@twshf.org.

(Continued from page 1)

a patient and her husband, identification of a biliary disorder through dogged perseverance, and elucidation of a dietary contribution to PSAS through careful history taking. These examples should hearten us and spur us on to better patient care. *Editor—David Ferguson*

A Husband's Story

My wife and I have been married for thirty-four years and we have worked together to raise two wonderful adult daughters. Many people have told us we represent an ideal family, and I consider myself a fortunate man to have such a family. This is the account of my experience of living with female sexual dysfunction and its effect on me. A part of me is reluctant to describe this because my wife is truly one of the kindest and most caring people I know, and I am well aware that other men may have reacted differently in similar circumstances.

For the first thirty years of our marriage, we struggled with the effects of what is now known as FSD. In the last few years, we have learned this dysfunction was caused by a lifelong hormonal imbalance that seriously affected not only sexual function but also the perception of oneself as a sexual person.

From the time I became physically mature my sexual longings focused on giving pleasure to a woman, especially bringing her to orgasm in one way or another. I longed for emotional connection as well and could never relate to men who just wanted to have sexual “conquests”. I deeply desired that I would find a woman with the same desire and that our marriage would include a passionate sexual union.

When my future wife and I began dating seriously, it became clear that sexual awareness was something that did not exist for her, except as something vaguely negative, and this caused me considerable worry. My concerns came to a head when she made a comment that led to a frank and open discussion. I was concerned enough to try to seek help, but was rebuffed by a pastor/counselor whom I approached. (In retrospect I realize he was simply too embarrassed to talk about sex). Unfortunately, the encounter with him left me feeling I had no right to entertain expectations for a sexual relationship.

In spite of my misgivings, I loved my fiancée and remained convinced we should marry. I put my sexual expectations on hold and chose to believe her lack of desire was something that could be “fixed” later. It is clear from our correspondence

that I had no idea there was such a thing as a physical cause for no sexual desire, and I assumed it was probably caused by some emotional trauma or negative influence.

A year or so after our wedding I decided it was time to approach the issue of our lack of sexual connection and spoke directly to her about my frustration. I brought home books, asked that she speak with female friends and suggested counseling. I did not succeed with this approach, and every couple of years or so I would again speak frankly to her about my desires and ask that we seek help. In retrospect, we both realize now that she had not developed a “sexual self” and had no way of understanding what I was attempting to communicate. (She has recently described herself by using the analogy of a person who is born blind and in her youth never spoken to anyone about sight. How would she know what it means to see?)

I now realize that I made many mistakes along the way. I did not do a very good job of clarifying, for myself, what the underlying problem was. At a conscious level, I knew it had nothing to do with me, but at an emotional level I received it as a deep, personal rejection. I did, however, manage to keep my pain mostly to myself so that it did not negatively affect our family environment.

Eventually I decided that I needed to change myself in order that I could live peacefully in our marriage, and so I set about the task of becoming as much of an asexual person as I could in an attempt to reduce my stress. Surprisingly, this worked better than previous attempts for maintaining inner peace, and I remained in that mode for about thirteen years.

Ultimately, however, that was not a healthy choice, and I came to a place of feeling completely undesirable; I believed no woman could possibly desire me. In the process of trying to repress all my sexual urges and thoughts, I slowly came to despise my own basic nature, and that eventually contributed to depression.

Meanwhile, my wife stopped menstruating at an early age and after a few years her doctor suggested she use Prempro to lessen the probability of osteoporosis. During the following year she noticed a bit of sexual arousal that caught us both by surprise. A new thought occurred to us – maybe her lack of interest and desire had something to do with hormones! I decided to reopen the question of a sexual relationship, in spite of a fear of awakening all the old emotional pain, and started to do some research. I discovered that although it is rare for a woman to respond favorably to an estrogen-based HRT like Prempro®, healthy hormone levels are a

(Continued on page 3)

(Continued from page 2)

key component in sexual interest and response. Now my wife was intrigued as well, because she had *felt* something in her own body.

One search led to another, and we found ourselves in the office of one of the foremost experts in sexual medicine at Boston University. It was a relief for both of us to have confirmed by this person of authority that what we had experienced all these years was the result of a significant hormonal imbalance, most likely caused by an enzyme deficiency present from before birth.

What a pleasant change the last two years have brought! The therapy prescribed for my wife, topical AndrolGel® and Vagifem®, has made a dramatic difference in her sexual response as well as for our sexual relationship. In the last year or so she has even become orgasmic with the help of her trusty Magic Wand. That is not a small accomplishment!

I am truly thankful for my wife's willingness to undertake this challenging journey of discovery, and I would strongly encourage other couples who relate to this story to seek out competent medical help.

Questions and Answers

Q - - - My husband has a slightly enlarged prostate, and after his last doctor visit he came home with Viagra. I didn't think we were having problems with sex, and I am irritated with my husband over this. Now he wants sex all the time. I need help in dealing with this. Do you have recommendations?

A - - - Yes. Set some time aside so that you and your husband can talk about this. Do this sooner rather than later. Tell him how all of this makes you feel, and make sure you give him a chance to discuss his concerns. He may be worried about his sexual performance, and thus the change in his behavior.

Q - - - I am certain that I am in peri-menopause. I still want to have sex, but it has become uncomfortable, and almost painful sometimes. I would appreciate suggestions that may help me.

A - - - This is not an uncommon complaint for women going through peri-menopause. You may want to consider using a vaginal moisturizer such as Replens, or a lubricant such as Astroglide. These may be purchased over-the-counter (no prescription is needed) at your local drug store. Lubricants are designed to be used just during sex. Whereas, vaginal moisturizers last longer and can relieve other symptoms besides dryness, such as irritation and

itching. You may also want to talk to your healthcare provider about a prescription for one of the vaginal estrogens such as Estrace®, which is a vaginal cream; Estring®, which is a 3 month vaginal ring; or Vagifem®, which is a very small tablet inserted vaginally.

Q - - - Help! I am leaking urine during sex. This is so embarrassing. What can I do to prevent this?

A - - - This is more common after childbirth, menopause, and sometimes after certain pelvic surgeries. First, try emptying your bladder before sex. Kegel exercises that strengthen the pelvic floor may help. There are physical therapists trained to teach you how to strengthen your pelvic floor, and you may want to talk to your healthcare provider for a referral. An overactive bladder can also be the cause of leaking urine; certain medications may relieve an overactive bladder. If you are menopausal, your provider may suggest a vaginal estrogen. Surgery for incontinence should be considered the last option, and when appropriate, it can be helpful. Also, some women ejaculate during sex, typically at orgasm. This is called female ejaculation and is normal for women.

Informed Consent, Off Label, and Off Street Drug Use

As a healthcare attorney, I am often asked about the liability and safety risks associated with off label use of medications. Healthcare providers want to know if there is increased legal liability when they prescribe medications for off label use, and patients want to know if off label use is truly a safe option.

The answer to both questions is yes; although the FDA approves medications prescribed for off label use, as well as, the practice of off label prescribing, there can be a slightly increased legal risk for providers as well as increased safety concerns for patients. FDA guidelines exist to ensure patient safety and to direct healthcare providers in safe practices. Any conduct outside of its regulatory review requires close scrutiny and analysis by patients and healthcare providers.

Because off label use of medications is a primary treatment option for patients with sexual dysfunction, providers and patients should minimize their mutual risks by paying particular attention to the informed consent process. Do patients really understand risks, benefits and alternatives of their medications?

(Continued on page 4)

(Continued from page 3)

An equally important concern relates to the public's lack of understanding of the medical and legal risks associated with "off label and off street use." The following example reflects the problems that can arise. It emphasizes medical and legal problems experienced by consumers who self prescribe without legitimate medical intervention.

Lynn and Jacob

Lynn is an attractive thirty-three year old mother of three. She was a second year nursing student in a small southern town when her husband's career took him to California. The marriage was strained at best, and she and her children were not invited to make the trip. A model parent, student, and over-achiever, she successfully finished her second year of school at the top of her class.

It was at that time when her friendly local pharmacist offered her a gift to celebrate her accomplishments: several blister packs of Viagra®. Stunned, she questioned his motivation. He reassured her that the drugs were "extras" and were meant as a surprise to help her celebrate her personal and academic success. He knew that she and her husband were struggling in their marriage, and between her parenting and academic pressures, he felt she needed "a little fun."

Although she was shocked at his personal inferences and professional misconduct, she took the drugs home with her, secretly hoping that some day she would have the opportunity to use it to revive her sex life with her husband. Confiding this interaction to her girlfriends, she was surprised to hear that they envied her; they wished they and their partners used Viagra®. Because Lynn believed the pharmacist's behavior condoned her use of Viagra® for recreational or party use, she extended her good fortune to her friends. Over the next months, she provided the Viagra®, pill by pill, to her girlfriends who reported great delight in its effectiveness.

Six months later, she finished nursing school and moved west to revive her marriage. Unfortunately, this did not come to fruition, and she and her husband parted ways before they resumed sexual intimacy. Within several months of her divorce, she began dating and found Jacob, an exciting and dynamic partner. Their sexual relationship was relatively satisfying with one exception: intercourse frequently lasted longer than an hour and became physically painful for Lynn because of Jacob's delayed ejaculation. He refused to consider her concerns a legitimate sexual complaint and indicated that she should accept his delayed

ejaculation as an indication of his desire to satisfy her and not a sign of sexual dysfunction.

Lynn wasn't convinced and began internet research on sexual health and education. If he was sexually happy, maybe she could do something to make herself happier. She read information indicating FDA approval of off label use of Viagra® in women. Remembering her girlfriends' experiences with Viagra® for their partners, she decided to enhance her own sex life and produced the last of her Viagra® for their mutual pleasure.

She saw no problem with her plan. She was in relatively good health. Chronic problems for which she received regular medical care included depression, anxiety and symptomatic MVP. She was encouraged to exercise regularly and took no cardiac medications, and for several years her depression and anxiety were controlled with medications.

Jacob was delighted to try the Viagra. He denied any medical problems. At fifty-eight, he ran marathons and maintained a high profile legal practice, active in his community affairs. Although he didn't need the Viagra®, he had read reports about men like him- virile and without diagnosed sexual dysfunction- who used it for recreation. It seemed a perfect aphrodisiac.

Believing that sharing is the essence of good sex, Lynn and Jacob enjoyed a bottle of wine and half a dose of Viagra®. The drug was everything she expected and more. It produced what she described as feelings of excitement and great arousal. Finally, she could match Jacob's ardor. She was quite satisfied with her discovery until she suddenly and simultaneously experienced a severe headache, heart palpitations, and what she described as hypotension and dizziness. The symptoms were significant and unexpected. Something felt wrong and she began to panic. Although her health probably would not have precluded a prescription for off label use of Viagra®, neither she nor her partner could be sure at the time. Yet, it wasn't too late to get medical help. She requested that Jacob transport her to the local emergency room for treatment. She was stunned when he refused. Asking her to "ride it out" he distracted her with the following questions and observations; all very good- if untimely.

1. Should Lynn have taken a drug so obviously designed with men in mind?
2. Was her research adequate and reliable?
3. He had not seen the medicine packaging and now, in light of Lynn's unexpected response he speculated that they had taken "imported" drugs, mislabeled or misrepresented as

(Continued on page 5)

(Continued from page 4)

- Viagra. What was in it anyway? Could it have been damaged or expired and thus produce unexpected complications?
4. The pharmacist offered Lynn the Viagra without a prescription. Wasn't this illegal behavior by the pharmacist?
 5. When his partner accepted the drug, was she committing a crime?
 6. Was it a crime for Lynn to share the drug with her friends and their husbands? What about when she gave it to him?
 7. If they reported this to the emergency room staff, would he and Lynn be charged with trafficking and illegal drug use?
 8. Could using prescription drugs without a prescription involve investigations by other agencies?
 9. As a prominent attorney, he had a community reputation to uphold. Not only was he terribly embarrassed about the sequence of events, could his wife discover his relationship with Lynn if he created a paper trail at the emergency room or had to deal with the police?

The symptoms subsided after several hours, only to be replaced by anger, relief, embarrassment, frustration, and an end to the relationship. He never received the answers to his questions. But the issues he raised are significantly important to a public that needs to recognize the difference between legal and illegal use of prescriptive drugs.

Off Label Prescriptions

Patients recognize that drugs are approved by the FDA for a specific set of purposes. They know the FDA requires extensive research and clinical studies before a medication is approved for treatment of particular medical conditions. They expect these medications to be safe, effective, and with recognized side effects. What patients don't realize is that with years of experience, healthcare providers have discovered many drugs whose secondary effects have benefited their patients. These secondary effects were not recognized or were not part of the original research submitted to the FDA when it analyzed the manufacturer's request for drug approval.

When physicians prescribe these medications for the secondary benefits it is known as "off label" prescribing. Although off label prescribing escapes the initial rigorous clinical testing required by the FDA, the practice of prescribing medications for

off label use is well established in the medical community and no laws have been written to prohibit its practice. Because the FDA recognized that off label prescribing is a significant and valuable part of physician healthcare practice, but not without some risk to patients, in 1997 it addressed the issue in the Food and Drug Administration Modernization Act, Pub.L.105-115. This act included recommendations and guidelines for off label use and sharing of information about medications that accumulates after initial approval.

However, medical and legal complications can occur, and when they do, courts make new rules and new law. At this time, at least one court is reviewing a malpractice claim alleging negligence and lack of informed consent by a physician who prescribed medications for off label use. At issue in this case is the appropriate selection of the off label medication for the patient's condition, and whether the patient participated in a valid informed consent process. Eventually, a jury will make a determination about the physician's decision to prescribe the medication, relying on testimony from physician experts to support or refute his medical choices, the validity of the information he relied upon when making his decision, and evaluating whether the patient participated in a valid informed consent.

What is informed consent?

Informed consent refers to the legally binding discussions between a healthcare provider and a patient wherein the patient's history, diagnosis, prognosis and treatment options are analyzed, discussed, and agreed upon. Patients should receive information about treatment options including the risks, the benefits, and the alternatives available. Their consent to treatment can be made verbally, with the physician entering notes about the discussion in the medical record. Alternatively, the patient may receive written materials that detail the information and require a signature.

How do physicians decide which risks are most important to discuss? The legal analysis of informed consent provides the most guidance in this area. Risk is determined as material (important) if a reasonable person would consider the information a significant factor that could influence their personal decision to accept or reject the proposed medical treatment. Knowledge of a patient's education, religious, cultural preferences, and previous healthcare experiences is vital to ensure an adequate informed consent. Informed consent is the basis of quality care and because of the slightly increased risk

(Continued on page 6)

(Continued from page 5)

associated with off label use, both physicians and patients must assume responsibility for ensuring mutual understanding and satisfaction.

Recommendations for Physicians

1. Be knowledgeable about off label risks and benefits: Be sure your decision to prescribe medications for off label use is supported by medical literature. Identify credible sources that establish the off label use as within the standard of care. Monitor patient responses carefully and detail them in the medical record.

2. Follow specific guidelines to obtain adequate consent for off label use: Remain mindful of the elements required to obtain a valid informed consent. Discussions should be factual, free of medical jargon, objective and candid. Although verbal consent can be obtained from the patient, the medical record should document the discussion between the provider and patient in clear detail. A discussion of the risks, benefits and alternatives should occur with each treatment change.

If off label prescriptions are in the best interest of the patient, the provider should be well informed about the scientific rationale and medical benefits and discuss these with the patient. The physician should discuss her reasons for using off label products: why she selected it for the patient, its efficacy, and her plan to monitor the patient for complications or adverse effects.

The physician should tell the patient that the drug is not formally FDA approved for the particular indication or secondary benefit, but that the FDA has acknowledged that physicians may use their discretion when patients may benefit from the off label use. In addition, physicians should tell patients that the risks and benefits of off label use may not be clearly identified or known.

Patients often consider their physicians as their advocate and thus the best decision maker. Even if the patient decides “not to decide” on a treatment, the physician should prompt the discussions with questions that help them analyze how they will react to possible risks and complications.

3. Document discussions and treatment in the record: Documenting the patient’s complaints, history and physical, and the contents of discussions is critical in preventing allegations that a patient did not engage in a valid consent process. A written and signed consent form that details the scope of the discussion and any literature the patient received is an

ideal way to jog a patient’s memory and to limit exposure to litigation. Include copies or references to any literature provided to the patient. Allegations that the physician acted carelessly will fail when the physician has clearly established the standard of care and can provide published literature to support off label use of the drug.

Monitor patient response to the drug and document positive as well as negative effects. Off label use requires closer scrutiny of the patient and written documentation of the patient’s subjective and objective response decreases liability. Always remember, consent is not just a one time agreement but an ongoing process. This documentation must be repeated with each change in treatment.

Recommendations for the Patient

As described earlier, the legal elements of a patient’s informed consent include discussion of the patient’s condition, the diagnosis, the treatment options and their risks, benefits, and alternatives. Patients come to physicians seeking their wisdom, knowledge, and understanding in order to regain control of their lives. Their desire and need for the physician’s successful interpretation and treatment of their problem makes them passive and less willing to question the physician’s advice. In addition, their physical, mental, and emotional capabilities are less than optimal. Understandably, their ability to retain information and analyze treatment options may be undermined. Yet, they can, and must, assume responsibility for the care they receive. By following the recommendations below, patients can facilitate a more favorable experience and healthier outcome.

1. Provide the physician with a brief written record of your health history: You should keep a written record of your health and care you receive. Include the names and addresses or phone numbers of physicians who have cared for you, past and present. What was your problem, and how was it treated? Identify medications you take, how much and how often. Do you have side effects with them? If so, what are they, and how long do they last? If you do not keep a personal journal with this information, then contact your new healthcare providers’ office well before your visit in order to obtain health history forms that are usually completed in the physician office. Take your time and detail the information.

2. Research your problem from reliable sources before the visit: This information can help you shape your questions and supplement your analysis of

(Continued on page 7)

(Continued from page 6)

treatment options. Although you may wish to bring this information with you to discuss, do not assume the physician will read each report (or any of them). These are often general in scope and may not be applicable to your specific situation. You should feel comfortable highlighting the most important references you think apply to your situation. Your physician may agree, disagree, or even point you to more specific data for you to review.

3. Make a list of the questions you wish to discuss:

Often, office personnel will give you the opportunity to raise the questions prior to the physician interview. Do not hesitate to offer them the list; they are there to facilitate your care. Your questions can be basic. Here is my problem; what is the cause? Why or how did this happen to me? What is my diagnosis-my prognosis-my treatment options?

4. Express preferences when discussing treatment options:

If you know that your beliefs or previous experiences will prohibit you from accepting a treatment option, state it immediately. Remember; know the risk, benefits, and alternatives of every planned treatment. Ask for literature that can help you understand and anticipate benefits and possible complications. You have the legal obligation to understand the information before agreeing to it.

5. Record your conversations and specifics of the treatment plan:

Patients do have access to information within their medical record, but this can be complicated to obtain. You should record instructions and information obtained during office visits in a journal. It is a reminder of the specifics of your treatment plan and should include your specific responses to treatment. It should include plans for follow up care. The journal can create the foundation for your health history and is a valuable reference to you and your providers.

6. Withdrawing Consent: Remember, informed consent can be withdrawn at any time. All you need to do is to notify the physician. Unless it is an emergency, never stop a medication without discussing the appropriate way to do so. Just as there are risks and benefits to beginning a treatment, there are also implications for its discontinuance. You are responsible for obtaining the information you need.

Conclusion

Off label use of medications is beneficial to patients and an acceptable treatment modality for

physicians. Although it carries a slightly increased risk for both patients and physicians, this risk is easily managed when both parties follow these simple guidelines to improve communication and understanding.

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Case Presentation

[The case presented below was summarized by D. Ferguson from an article in the New York Times, September 26, 2004 by Lisa Sanders, MD]

A 26-year-old woman returned after 3 months to her gynecologist, Stanley Ottinger, MD, complaining "Maybe I am crazy. All I know is that I throw up whenever I eat, but all the tests say that nothing is wrong. I just don't know anymore." At her previous visit, she had nausea in spite of having removed her birth control ring several weeks earlier. Her physical exam findings were remarkable only for right upper quadrant tenderness, Murphy's sign. An ultrasound failed to reveal any gallstones. At this visit, she reports that eating anything induces nausea and vomiting every day, but she does not have pain or diarrhea.

Prior to this visit, she had been seen by her primary care provider, a gastroenterologist, and a surgeon. Multiple medications had been prescribed without relief. Multiple tests ruled out pregnancy, biliary blockage, cholelithiasis, pancreatitis, liver disease, ulcer, and even *H. pylori*. "I'm losing my faith in doctors," she said. "It seems like everyone's attitude is: 'I don't know what it is. Try this pill and call me next week.' They think it's all in my head. Do you?"

Dr. Ottinger noted that she had a history of seizures and migraines that were well controlled by medication. Her physical exam indicated dehydration: dry skin, cracked lips, and tachycardia. The doctor hospitalized her to restore her fluid status while he considered the possibility that she might have a psychological reaction to stress or an eating disorder. But the continued presence of Murphy's sign bothered him. Was he missing a physical explanation for her problem?

(Continued on page 8)

(Continued from page 7)

In the hospital, more specialists were consulted; more tests were conducted. Ottinger continued to suspect the gallbladder. Blood work, ultrasound, gastroscopy, and a HIDA scan (a test of gall bladder function) were all negative, yet the young woman's nausea and vomiting continued. The doctor reassured her, "We're going to keep you here until you get better, or we find out why you're not." He was perplexed and wondered if it really was "all in her head." He said, "I didn't believe it, didn't want to believe it, but ultimately I had to consider it." An extensive psychiatric consult failed to reveal evidence of psychiatric disorders. Ottinger continued to suspect the gall bladder, entertaining the possibility of biliary dyskinesia. A repeat HIDA scan was performed with a positive result. The gall bladder was not emptying properly! The woman's gall bladder was removed, and she went home feeling well the following day.

Dr. Ottinger reflected afterward, "Even when it's not clear what a patient has, you've got to give her the benefit of the doubt and do your best to make sure there is no disease before you say it's a psychiatric problem. Because once you label a patient like that, chances are no one will look for the cause of her problem again."

Sexual Medicine Article

Abstract: *Persistent Sexual Arousal Syndrome and Menometrorrhagia Associated with Increased Soy Intake.* Amsterdam, A., Abu-Rustum, N., and Krychman, M., Memorial Sloan-Kettering Cancer Center, NY, NY, presented at the Annual Meeting of the International Society for the Study of Women's Sexual Health, Atlanta, October, 2004. [Reprinted with permission from author]

Introduction: Persistent sexual arousal syndrome (PSAS) is a rare sexual complaint that can impact a patient's activities of daily living. Patients with PSAS can be distressed by the escalation of tension in the pelvic region and the prevailing necessity to diminish the pressure by self-stimulation to orgasm. Patients frequently suffer from guilt or shame and often do not seek medical care. There are many potential causes of this disorder, however a definitive etiology has yet to be elucidated.

Case Presentation: The patient is a 44-year-old, gravida 9, para 5 female who presented to her gynecologist for evaluation of dysmenorrhea and menometrorrhagia. She has a history of high-grade cervical dysplasia that had been treated with a cone biopsy eight years earlier. During the review of

systems, the patient reported increased pelvic tension, not associated with an increase in desire that required her to self-stimulate to orgasm approximately 15 times daily. To "relieve the tension in (her) pelvic region," she had to interrupt her activities mid-task several times. Upon further inquiry, the patient disclosed that her dietary regimen included soy intake in excess of four pounds per day. She was distressed with her sexual behaviors because they were impacting her employment and studies. Thus, she desired treatment, but did not want an intervention that would "fix her too much." Physical examination was unremarkable other than a fifteen-week sized fibroid uterus. Data review included a recent negative Pap smear, endometrial biopsy with normal secretory endometrium, and a hormonal profile that was within normal limits. Treatment consisted of supportive counseling and dietary modification with limited soy products. Although pharmacologic and surgical interventions were offered to treat her leiomyomatous uterus, the patient declined therapy because she was concerned about their potential impacts on her sexual functioning. At the 3 month follow-up visit, the patient's menstrual difficulties resolved, and she reported that pelvic congestion and throbbing had decreased and that she presently engaged in sexual activity only two times each day.

Conclusion: To the best of our knowledge, this is the first case of PSAS that has been successfully treated with dietary modification. Hormonal and/or dietary factors have not been historically identified to cause PSAS. Although it has yet to be demonstrated scientifically with randomized controlled trials, it can be hypothesized that exogenous factors, such as phytoestrogens found in soy, can bind and stimulate estrogen receptors. Consequently, vasocongestion can occur and vessel integrity may be influenced.

Announcement

Dr. Beverly Whipple (a TWSHF Professional Advisor) was awarded the Society for the Scientific Study of Sexuality (SSSS) Public Service Award on November 6, 2004. The award states "In Appreciation For Her Outstanding Achievement In Promoting Public Awareness Of Sexual Issues Throughout Her Distinguished Career As An Educator, Researcher, Practitioner and Advocate." Dr. Whipple is a Professor Emerita at Rutgers, The State University of New Jersey and the Vice-president of the World Association for Sexology

[Congratulations, Dr. Whipple]

(Continued on page 9)

(Continued from page 8)

Meetings

FDA: ADVISORY COMMITTEE FOR REPRODUCTIVE HEALTH DRUGS, December 2, 8:00 am, Hilton, The Ballrooms, 620 Perry Pkwy., Gaithersburg, MD, Teresa Watkins, Center for Drug Evaluation and Research, 301-827-7001. The committee will discuss new drug application (NDA), Testosterone Transdermal System by Procter and Gamble, indicated for the treatment of hypoactive sexual desire disorder in surgically menopausal women receiving concomitant estrogen therapy.

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: See Women's Sexual Health Journal, Vol. I, August, 2004 for previous listings.

Making Love the Way We Used to . . . or Better: Secrets to Satisfying Midlife Sexuality by Alan Altman, MD and Laurie Ashner, 2001, McGraw-Hill.

The G Spot : And Other Discoveries About Human Sexuality by Alice Kahn Ladas, Beverly Whipple, and John D. Perry, 1982, Random House.

Internet Links: See www.twshf.org for listings.

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Manuscripts, guest editorials, questions, stories, and letters to the editor may be submitted by e-mail to David

Ferguson at 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 Volume I.

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.

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