



Women's Sexual Health Journal

Editorial

I am honored to guest edit this third volume of the Women's Sexual Health Journal. Congratulations are in order to Lisa Martinez, TWSHF founder, and the TWSHF board on becoming the 2005 recipient of the Elaine Boynton Memorial Award (**Announcements**).

Vaginismus, painful intercourse (known by the medical term dyspareunia), and pelvic floor dysfunction are areas that for decades have perplexed health professionals. The classic approach was, that if no clear medical findings, such as infection or disease, were evident to the examining physician, the pain must be "psychological or emotional" and best treated by a psychologist or sex therapist, who may be able to help uncover the underlying cause, be it fear, anxiety, guilt, distrust, or aversion to sex.

As the field of sexual health began to recognize the interdisciplinary nature of sexual function and dysfunction, practitioners began to integrate the medical and psychological approaches. The organic nature of conditions causing painful sex and multiple factors involved, including hormonal, vascular, neurological and muscular, need to be addressed medically. The impact of these conditions on the woman's feeling of sexual self worth, her relationship with her partner, and its effect on her desire and arousal need to be addressed as well by a mental health professional. The interdisciplinary model cited by experts included the primary physician, the gynecologist, a pain specialist, and psychologist, and/or sex therapist.

Missing from this model are additional unique, but crucial, members of the health care team treating sexual dysfunction particularly in the area of pain. Dr. Susan Kellogg-Spadt, a nurse practitioner, exemplifies in her practice the patient care model provided by a nurse practitioner acting as case manager. In her valuable contribution to this edition (**Sexual Medicine Article**), Dr. Kellogg-Spadt

explains the meaning of pelvic floor dysfunction, how it may impact sexuality, and what treatments are available including physical therapy.

The role of physical therapy is explored in this volume as well. The personal story provided by a woman who suffered with vaginismus, describes the ultimately successful treatment she received with physical therapy. In the article in which I am interviewed, I describe the tools provided by physical therapists in the treatment of conditions such as urinary incontinence, vaginismus, and vulvar pain syndromes.

It is important to note that great advances have been made in the past decades elucidating various causes of painful intercourse. In the mid 1980s, the International Society for the Study of Vulvar Diseases identified and named two conditions of vulvar pain affecting sexual intercourse, vulvodynia and vestibulodynia. Vestibulodynia, also known as vulvar vestibulitis, is estimated to affect up to 15% of women of pre-menopausal age, and it is the most common cause of dyspareunia. Organizations such as the National Vulvodynia Association are instrumental in disseminating information about this unfortunate condition to lay people and health professionals.

We hope that the take-home message is that painful intercourse, or inability to have intercourse due to anxiety and/or a physical reaction of muscle contraction, can and should be treated. Well-meaning caveats by physicians such as "you just have to relax" or "it's all in your head" are not to be accepted passively. We hope this helps empower women and couples toward seeking optimum sexual satisfaction and health. *Guest Editor—Talli Rosenbaum, PT*

Vaginismus: a Woman's Story

I first realized I had primary vaginismus about six weeks before I got married. I was idly leafing through a medical dictionary, fell upon a

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

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

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description of vaginismus, and realized that I probably had the condition. My immediate reaction was to inform my fiancé, who told me he wanted to marry me “any way he could get (me).” I then consulted with three other people for a second opinion: first, the church pastor’s wife, who also was in charge of the church counseling program. She largely viewed my vaginismus as the result of some sort of unidentified spiritual curse. We prayed together about things, and I was then referred to another Christian counselor with an international ministry. This lady told me I should get a vibrator and read books such as *The Joy of Sex*. I was also told to get further Christian counseling. My third consultation was with a sex therapist who was well viewed in the local medical community. None of the three advised against marriage, or suggested delaying it. So, as I thought my vaginismus would be largely dealt with after a month or so of marriage, my fiancé and I went ahead and got married.

Nobody, and none of the literature I read, suggested it would take three years of hard work for me to be able to consummate my marriage. I wish, in retrospect, I had been better informed. But, up to then, I had no private access to the internet. We were all totally ignorant about the condition. I was sexually inexperienced prior to marriage because of my Christian convictions. However, I was aware that it was somewhat abnormal not to be able to insert tampons, or to be unable to tolerate being internally examined by a physician. Today, I look back and see further tell-tale signs: cringing when I saw animals copulating, because I viewed the experience as being painful for the female of the species.

My husband and I attempted intercourse several times during the honeymoon, but penetration was impossible. The penis just wouldn’t go in! My husband was wonderful about it, and insisted we enjoy the honeymoon regardless. I vowed to start sex therapy as soon as I got home. There was a waiting period of several months before we could start the sex therapy. Meanwhile, I managed to get one consultation, during which I was advised to do Kegel exercises in the intervening period.

About six months after we got married, we started weekly counseling sessions with the sex therapist. Her approach was a combination of relationship counseling and sex therapy. We found a small portion of the sex therapy very helpful, but all the relationship counseling counterproductive. I should add that I also had non-existent libido, and I was prescribed sensate-focus exercises for that complaint, with zero success. However, after a year or so of doing Kegel exercises, and getting

accustomed to touching my vulva, I reached the point where I was able to insert a finger up to the second knuckle and then, not too long after, all the way in.

Meanwhile, however, all was not well. The relationship component of the counseling sessions, and the treatment directed at improving my libido, were causing both the sex therapist and us some considerable frustration. One day, to our surprise, the therapist announced she felt she couldn’t continue therapy with us any more. My husband was devastated, and pleaded with her to continue, but she said she felt I was in need of extensive long-term counseling, before I could make any progress on the libido or vaginismus fronts. As she was the expert, we deferred to her greater wisdom, and obediently trotted off to one of the best counseling services we could find in the state.

Once again, there was a waiting period (best part of a year), and in the intervening period, members of the leadership of the church I was in took an interest in my case, and I was severely reprimanded by several of them (or their wives) for the “lack of submission” that summed up, in their view, the entire *raison d’être* for my vaginismus. Other church leaders were more sympathetic, and gently prayed with me, but the prayer sessions turned into full-blown attempts at “exorcising” me. I obediently tolerated the shouting, and what I now view as the insults, trying my level best to get healed of vaginismus. When I wasn’t cured, I was considered “intractably unsubmitive.”

The counseling service advised me, after about three months of counseling, not to present for any more sessions, as I had done well in the counseling, and they didn’t feel I had further need of any counseling. One of the counselors was a female Christian, and she also concluded I needed to submit to my husband and that my being healed of vaginismus was largely a matter of will. I tried, and tried and tried to will my way out of vaginismus, but still the penis wouldn’t go in!

At this point, my husband and I felt that counseling had failed us, both on the vaginismus front, and on the libido front. We purchased a computer, and, through the internet, we started doing our own research. I read about testosterone therapy, and did some research into gynecological therapy, and decided to give both a try. My libido problem was solved after four weeks of testosterone therapy, following tests which showed my levels were below normal. I was able to have intercourse after four and a half months of physical therapy, and I have had intercourse many times since. I still find it painful on occasion, and still need to do dilation exercises in

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advance, but I have come a long way!

My number one tip to women with primary vaginismus is: become active members of a vaginismus support group. [Editor's note: See *Resources*]

Questions and Answers

Q: I cannot believe it, but my doctor told me that I have HPV, and it is a sexually transmitted disease (STD). I thought only younger women got STDs. I am in my mid-forties. What is HPV, and what should I do?

A: HPV is the Human Papilloma Virus and a very common sexually transmitted disease. It is transferred from sexual activity, whether intercourse, heavy petting, or oral sex. There are many different strains of HPV, and depending on the type or strain, a woman could end up with genital warts, a precancerous condition, or even cervical cancer.

It is important to try to stay healthy by minimizing stress, not smoking, eating properly, and exercising. By taking these steps, you can help your immune system to stay healthy, and decrease the attack of an HPV infection.

Chronic HPV infections may turn into cancer. Although generally cervical cancer is slow growing, it is important to have an annual PAP smear. Also, it would be wise to obtain a copy of your PAP smear results. When you receive a copy of your results, verify that the correct patient information is listed: name, birth date, address and any other specific identifiers. If you do not hear from your provider, no news does not mean good news. You need to be your own patient advocate. Sometimes lab results can be misfiled or accidentally lost.

Q: I love to go horseback riding, but I have heard that it can create nerve damage and sexual difficulties. Is that really true?

A: Pelvic nerves may become injured during horseback riding or even bicycle riding from pressure on the pelvic area and the surrounding nerves. This injury may impact sexual function. It is possible that numbness, or aching may occur from horseback riding or biking. If that occurs, it may be wise to take a break from such activities until the problem resolves. In some cases, a woman will need to discontinue the activity if she wants to prevent further numbness or damage to the pelvic nerves.

Q: Can fibroids impact a woman's sex life?

A: For most women, fibroids do not impact their sex life. However, some women will have pain and discomfort. They may also have cramping during and after orgasm that may last for a few hours. If the fibroids are large or are located towards the lower part of your uterus, deep penetration may be very difficult or painful.

Changing sexual positions may be helpful, especially where the woman is on top. This position enables the woman to control the depth of penetration and possibly decrease any pain she has been having. Also, emptying your bladder before sex may be helpful too.

Interview

Physical Therapy and FSD, Talli Rosenbaum, PT

Q: How can PT help women with FSD or female sexual difficulties?

A: Physical therapists are trained to provide treatment to restore function, improve mobility, relieve pain, and prevent or limit permanent physical disabilities of patients suffering from injuries or disease.

Physical therapists refer to functional activities as ADLs or "activities of daily living." These generally refer to moving about, walking, driving, working, shopping, bathing and so forth. The ability to function sexually is an important part of daily (or nightly) living.

When referring to female sexual difficulties, it is important to note that most difficulties arise from a combination of factors: physiological (hormonal, circulatory, neurological, vascular) and psychosocial, as well as relational. Therefore, a multidisciplinary approach of health care professionals is essential treatment. The physical therapist is an important member of this team.

Q: What types of problems do you see in your patients with sexual difficulties from a PT's perspective?

A: To answer this question, we need to clarify the concept of "sexual problems." Some women have sexual problems, and some have "problems with sex." For example, women with joint pain or fibromyalgia may have no difficulty with arousal and orgasm, but have too much pain to comfortably position themselves for intercourse, and with guidance of a PT, they can overcome that. On the

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other hand, women who have sexual problems, such as decreased arousal and orgasm may also find that learning pelvic floor exercises with a physical therapist can facilitate an increased sexual response.

Q: What is the most prevalent problem?

A: By far the most prevalent problem I see is painful intercourse, known as dyspareunia. Thanks to the work of Irv Binik and his team at McGill in Canada, the world of sexual health is beginning to re-examine the concept of “sexual pain disorders” by reclassifying such conditions as pain disorders that interfere with sex, rather than sexual disorders per se. Thus the underlying pain condition needs to be addressed and treated, as well as attention paid to the emotional and psychological ramifications of this unfortunate condition.

The majority of problems I see in my practice involve women who either have never been able to have sexual intercourse, have severe pain with sexual intercourse, or have vulvar pain and burning which may or may not be related to intercourse. Most of these women have been diagnosed with vaginismus, vulvar vestibulitis, or vulvodynia. Vaginismus has traditionally been defined as reflexive contracture of the vaginal muscles preventing penetration, but there is certainly a component of anxiety and fear of pain involved with that. Vestibulitis refers to pain with contact at the entrance to the vagina and is the most common cause of dyspareunia in premenopausal women. Vulvodynia refers to pain and burning at the vulva and the cause of this is often neuropathic. In addition, I work with women with urinary dysfunction that often have sexual ramifications. For example, patients with interstitial cystitis, a condition of chronic urinary frequency and urgency with pelvic pain often complain of painful intercourse.

Q: How do you treat these problems?

A: By educating the patient about her condition and validating the physical element of her problem. Fairly often, patients arrive after seeing many practitioners. The classic picture is that they are treated by the gynecologist for months with antifungals and antibiotics and when that doesn't help, they are sent for psychological counseling which is often psychodynamic in nature and doesn't always address the functional problem. Even in cases where the patient was referred appropriately to a sex therapist who treated with cognitive behavioral therapy, including, for example, dilator therapy, the therapist

could not always determine the appropriate dilator size or provide specific treatment to address the pain itself.

There are various treatment tools available depending on the condition. I generally treat by educating the woman about her anatomy, using a mirror, and assisting her to understand how she is able to control her pelvic floor muscles in order to allow penetration. I also treat with various hands-on techniques designed to stretch and mobilize tight muscles and connective tissue in the pelvis and vulvar area. I also use biofeedback, which is a tool that allows the woman to view the muscle activity of her pelvic floor during rest and work, thus teaching her how to properly relax, strengthen and stabilize the muscles.

Q: How long does it take to see results? Does that depend on the type of problem?

A: Results can take from three to nine months depending on the nature and severity of the problem. In some cases, success is achieved after only a number of visits, and this is often true when the underlying problem is a lack of education or self awareness combined with anxiety about penetration.

Q: How new is physical therapy in the area of FSD?

A: There is not a lot of documented literature on physical therapy for sexual function disorders much before the late 1970s. Pioneering physical therapists in the field of childbirth education, such as Pamela Shrock in South Africa and Elizabeth Noble in the United States, did much to promote awareness of the importance of the pelvic floor in the childbearing years and as physical therapists began to treat pelvic floor dysfunction, the issues of sexuality naturally began to emerge.

Sex therapists have traditionally been verbally instructing patients in pelvic floor exercises to enhance the sexual response. Because physical therapists evaluate and treat by doing a physical examination, which includes internally examining the vagina to assess pelvic floor muscle tone, they are in the best position to effectively teach patients pelvic floor exercises. In fact some studies have shown that when provided with only verbal instruction, only 50% of women actually perform these exercises properly.

Q: Do you use a multi-disciplinary approach to treatment? Do you work with other specialists while

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treating your patients, for example psychologists, etc?

A: Absolutely. It is sometimes believed that the multidisciplinary model is being utilized when a patient is seeing a number of various practitioners, however, if she sees them in isolation of each other, and there is no communication between the disciplines, the results could even be harmful, particularly if the patient is given contradictory advice. The multidisciplinary approach requires communication between the various practitioners regarding treatment.

Q: What sexual problems are most difficult from a physical therapy viewpoint?

A: I can't answer for all physical therapists, but I would say that the most challenging problem for us is probably the same as for all sexual health practitioners, and that is lack of libido.

Q: What signs and symptoms should alert primary care providers to the possibility that physical therapy may be valuable in the patient's treatment plan?

A: The most obvious indication would be the inability of the primary care physician or gynecologist to adequately physically examine the woman due to her anxiety or inability to allow penetration. When performing a vulvar and vaginal exam, the finding of tenderness due to episiotomy scars is a good indication for physical therapy, for example. The presence of pain at points along the vulvar vestibule indicating vestibulitis is a good indication for referral. Any indication of pelvic floor dysfunction, either hypertonus, where the muscles are tight and contracted, or weakness, are important indications for physical therapy. Any other condition, such as pain with arousal and orgasm, which may have a neuromuscular or musculoskeletal component would be an appropriate referral. Concurrent urinary symptoms, such as urgency, frequency, or incontinence is certainly treatable with pelvic floor exercise, biofeedback, and behavioral therapy, such as bladder training.

Q: What FSDs are not appropriate for physical therapy?

A: I would rephrase that question to what FSDs are not appropriate for physical therapy alone? Physical therapists need to ask the appropriate questions and be aware of situations requiring concurrent therapy. Situations of sexual abuse and relationship problems, for example, usually require psychological

intervention. When there is depression, severe anxiety, eating disorders, or even OCD, the patient should be followed by a psychiatrist as well. Conditions of severe, chronic neuropathic pain often necessitate referral to a pain specialist.

Q: Can women with disabilities such as diabetic neuropathy, MS, or spinal cord injuries benefit sexually from physical therapy?

A: Definitely. In the case of diabetes, techniques to increase circulation and decrease pain, with modalities such as TENS (Transcutaneous Electrical Nerve Stimulation), for example, can be very helpful. Patients with MS often have bladder issues due to neurogenic bladder, and physical therapists have been working with this patient population for ages. We need to widen the scope of our rehabilitation philosophy to include intervention in the area of sexual function.



Editor's Note: Talli Yehuda Rosenbaum is a private practice physical therapist, researcher and lecturer, specializing in urogynecological and pelvic floor rehabilitation. She serves on the board of the Women's Health Section of the Israel Physiotherapy Society and is a member of the International Society for the Study of Women's Sexual Health. She has presented posters and papers at international conferences on the subject of vulvar pain and treatment of painful sexual intercourse and has written for the National Vulvodynia Association Newsletter. She recently co-founded the Institute For Marital Enrichment which provides sexual education and therapy for Orthodox Jewish couples in Israel. For further information you may e-mail Talli Rosenbaum at: tallir@netvision.net.il

Sexual Medicine Article

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The Good News about the Female Pelvic Floor, Susan Kellogg-Spadt, PhD, CRNP

Women with vaginismus and other disorders of the pelvic floor have historically been subject to misdiagnosis and misunderstanding by the healthcare community to whom they turned for help in dealing with painful and frustrating symptoms associated with sexual intercourse. The good news is that the climate for adequate healthcare for women with these disorders is finally changing. Unlike healthcare providers of the past, many of today's physicians, nurse practitioners, and physical therapists (particularly those who specialize in sexual health) understand the specialized anatomy and physiology of the female pelvic floor, in terms of muscular support, physiology, restoration of function, effects of pharmacologic interventions, and relationship to sexual functioning. In the last ten years, there has been a dramatic expansion in the scope of female healthcare with the emergence of medical specialties such as urogynecology, pelvic floor reconstruction, and pelvic floor physiotherapy such that disorders that affect any aspect of the pelvic floor, including the "front" compartment, e.g. bladder dysfunction; the "middle" compartment, e.g. genital/sexual dysfunction; and/or the "rear" compartment, e.g. bowel dysfunction; can be addressed in a comprehensive fashion.

Normal function of the pelvic floor musculature is essential in maintaining appropriate function of the pelvic organs, as well as appropriate sexual functioning. Abnormal function of this musculature is seen in an estimated 70% of women with genitourinary, bowel, and sexual disorders. The term/diagnosis "Pelvic Floor Dysfunction" (PFD) refers to a number of conditions in which the pelvic floor muscular support system is functioning suboptimally. The muscles, which are responsible for supporting most of the organs within the lower abdomen as well as providing secondary postural support of the human skeleton, are integral to proper functioning of urination, defecation, and sexual activity. The support that they provide to the body can be altered if they are either too relaxed (laxity) or too tight (spasticity).

Hypotonus of the pelvic floor or pelvic floor laxity is termed "low tone pelvic floor dysfunction" and abbreviated LT-PFD. It is a familiar term in most medical and lay literature because of the relationship of the poorly toned pelvic floor muscles to urinary and fecal incontinence as well as pelvic organ prolapse. LT-PFD is often associated with vaginal

childbirth, obesity, trauma to the muscles, and/or aging. It can contribute to pelvic organ "dropping" or relaxation, urinary leakage with coughing, sneezing, lifting, and/or during orgasm, vaginal laxity, and decreased sensation with intercourse, thrusting dyspareunia, and poor control of gas (flatus) and/or fecal matter during or outside of intercourse.

Hypertonus of the pelvic floor or pelvic floor muscle spasm, abbreviated HT-PFD, is a newer term, although the concept has been documented for many years in specialized medical literature (such as colorectal and psychiatry texts) where it has been referred to as "tension myalgia of the pelvic floor" and "levator ani syndrome." HT-PFD can result from vaginal childbirth, postural stressors, micro- or macro trauma to the pelvic floor muscles, infection, urinary or genital inflammation with sustained guarding reflex, adhesions, surgical trauma, and/or fear associated with perceived threat to the pelvic floor area. HT-PFD can contribute to symptoms of urinary frequency, urgency, burning with urination, urinary retention, constipation, fecal retention, and pain/spasm with penetration and/or thrusting in the vagina (vaginismus).

Assessment of tone in the pelvic floor muscles is performed to determine a woman's ability to isolate, contract, and relax the pelvic floor muscles. While conducting a digital exam exerting light pressure on the lower and side walls of the vagina, the woman is asked to squeeze the examining finger and to "lift" the pelvic floor, without simultaneously tightening the abdominal, buttocks, or thigh muscle groups. If the patient is unable to produce sufficient muscle strength to "squeeze" the finger or to sustain that squeeze for a period of 5 seconds, she may be exhibiting a LT-PFD pattern. If, conversely, the woman experiences muscle tenderness or pain when pressure is applied to the lateral (side) vaginal wall or during an attempted squeeze against resistance, she may be exhibiting a spastic or HT-PFD pattern. Results of the simple digital exam can be verified by the placement of a measurement tool such as a perineometer or an EMG probe, designed to measure muscle activity.

Conservative therapy for PFD is aimed at muscle reeducation. A manual physical therapist that specializes in the pelvic floor can be a valuable asset to the treatment team, designing a pelvic floor rehabilitation program aimed at facilitating sexual comfort and pleasure for patients. Such a program often involves first rehabilitating the outer abdominal and pelvic support muscles through strength training, postural support, and stretching exercises. The pelvic floor muscles can then be rehabilitated through the

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use of Kegel exercises and directed sling massage (sometimes referred to as “Thiele massage”) of the pelvic floor to elongate shortened muscles and decrease high tone spasm for a woman with vaginismus. Early work by Thiele suggested that 19 of 31 patients with pelvic floor related pain (61.3%) were “cured” and 17 of 31 (35.5%) were “improved” after a series of directed massage of the pelvic floor muscles, a technique also practiced by physical therapy specialists in pelvic pain.

Pelvic floor massage can also be taught to partners of women with HT-PFD as well as to the women themselves so that they can become active participants in their healthcare. Pelvic floor muscle massage often precedes and facilitates the gradual introduction of dilators and movement toward sexual penetration for women with vaginismus. Pelvic floor muscle rehabilitation can also be augmented with biofeedback and/ or electrical stimulation techniques

A woman’s sense of well-being is closely tied to the quality of her affiliative relationships, including her intimate physical relationships. By taking the time to properly diagnose and rehabilitate the pelvic floor musculature, health care providers can now, better than ever before, assist women with vaginismus and other pelvic floor disorders to reclaim a sense of themselves as sexually competent women capable of intimacy.

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*Note: Dr.
Kellogg-
received*

her PhD in Human Sexuality at The University Pennsylvania, her MSN as a Maternal-Child Clinical Specialist from Loyola University in Chicago and her post-masters certificate as an OB/GYN Nurse Practitioner from The University of Pennsylvania’s Center for Professional Development. She is the co-founder of the Pelvic Floor Institute at Graduate Hospital in Philadelphia where she has been The Director of Sexual Medicine for 7 years. In this capacity, Dr. Kellogg-Spadt performs direct patient care and consultative services as a vulvovaginal specialist, colposcopist, researcher and sexual dysfunction consultant.

Dr. Kellogg-Spadt is an assistant professor of Obstetrics and Gynecology at Robert Wood

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Johnson Medical School of The University of Medicine and Dentistry of New Jersey and is a frequent lecturer at The University of Pennsylvania and The Planned Parenthood Federation. She has published in several peer-reviewed journals and lectures on female sexual dysfunction to professional audiences, nationally and internationally. Dr. Kellogg-Spadt is a frequent guest on radio and television programs discussing women's sexuality.

Announcements

TWSHF Receives Award

The Women's Sexual Health Foundation is the 2005 recipient of the **Elaine Boynton Memorial Award** which is given annually by *Speaking of Women's Health*, a national women's foundation, to an organization that improves the lives, health and well-being of women. A grant will also accompany this award to help advance the mission of the Foundation.

The **Elaine Boynton Memorial Award** was created in memory of Elaine Boynton, who passed away in 1997 after a four-year battle with breast cancer. She founded the Breast and Cervical Health Network of Southwest Ohio to help slow the occurrence of breast cancer through early detection.

The Women's Sexual Health Foundation improves the lives, health and well-being of women through its mission:

1. Providing educational information on the causes, treatments, and latest research in sexual health issues to women and to healthcare professionals.
2. Supporting a multidisciplinary approach in treating women's sexual health concerns.
3. Offering resources for women experiencing sexual health difficulties as well as for their partners, family, and friends.
4. Advocating funding for research to advance knowledge in sexual medicine.
5. Increasing worldwide awareness on the subject of women's sexual health.

The *Women's Sexual Health Foundation* would like to thank the support of its professional advisory board and volunteers in helping to attain this award.

TWSHF At FDA Hearing

On December 2, 2004, TWSHF Executive Director, Lisa Martinez RN/JD testified at the meeting of the public Advisory Committee for Reproductive Health Drugs of the FDA.

The Advisory Committee discussed the new drug application (NDA) 21-769, Testosterone Transdermal System (proposed tradename, Intrinsa) by Procter and Gamble, indicated for the treatment of hypoactive sexual desire disorder in surgically menopausal women receiving concomitant estrogen therapy.

Hypoactive sexual desire disorder (HSDD) is the persistent or recurrent deficiency or absence of sexual thoughts, fantasies, and/or desire for or receptivity for sexual activity, which causes personal distress or interpersonal difficulties. Low sexual desire may be associated with low sexual activity, sexual arousal problems or orgasm difficulty.

At this day long meeting, Procter and Gamble representatives and experts presented to the Advisory Committee during the morning. This was followed by an hour of presentations by various public representatives. The afternoon session consisted of questions by the FDA Advisory Committee to Procter and Gamble representatives.

Below is a portion of Ms. Martinez's presentation. For the transcript of the entire day's proceedings go to: <http://www.fda.gov/ohrms/dockets/ac/04/transcripts/2004-4082T1.htm>.

"Good morning. I'm Lisa Martinez, a nurse and an attorney, and the executive director of the Women's Sexual Health Foundation, an international non-profit organization based in the U.S. Our primary mission is to educate the public and health care professionals in the area of female sexual health, including FSD.

We have heard from many women and their partners relating to female sexual health problems. These stories are heart-wrenching, and have a common theme: women are devastated, suffer in silence, feel very much alone in their journey to find the right answers, care and treatment; and wish that their sexual health would be taken seriously.

For women in relationships, this impacts not only them but their partners, who often feel equally helpless and devastated. Sexual problems are not an easy subject to discuss. Women may feel embarrassed, and yet they don't give up. Some have gone for years looking for help from various providers, sometimes with success and sometimes not. It's not unusual for us to hear that women have

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been told by their provider that their problems are all in their head, or that a hysterectomy or bilateral oophorectomy could never be the physical cause of sexual health difficulties, and that any such problem would be purely psychological.

The Foundation believes that a multi-disciplinary approach should be used to address sexual health problems. This would include both physical and emotional assessments. As part of this complete approach to women's sexual health complaints, a serious effort must be made to determine if there are physical causes, such as hormone insufficiencies. Health care providers need to follow well-recognized workups that will leave no stone unturned, so that treatment plans are specifically targeted at the underlying causes of sexual dysfunction. Consideration should be given to pharmacologic and counseling [therapies].

Currently, there are no FDA-approved treatments for FSD, and providers are using off-label medications that have not been studied in women under FDA oversight. There is a need for such treatment, including testosterone. But, more importantly, FSD is a serious health issue, and not just a lifestyle issue. Thank you."

Resources

Vaginismus:

To join a support group for women with vaginismus you may go to:

<http://health.groups.yahoo.com/group/vaginismus/>

To join a support group for vaginismus that is open to everyone, including healthcare professionals, go to:

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

Vulvodynia:

Vulvar Health
www.vulvarhealth.org

National Vulvodynia Association
www.nva.org

Uterine Fibroids:

The National Uterine Fibroids Foundation

www.nuff.org

Books:

Private Pain: It's About Life, Not Just Sex ... Understanding Vaginismus & Dyspareunia, Ditz Katz, Ross Lynn Tabisel, Women's Therapy Center, 2002.

Meetings

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

World Congress of Sexology The biennial meeting will be held July 10-15, 2005 in Montreal. www.montrealsex.com

American Pain Society 24th Annual Scientific Meeting March 30 – April 2, 2005, Boston, Massachusetts. www.ampainsoc.org

Comprehensive Review of Sexual Medicine 2005, April 14-16, 2005, Toronto, Ontario, Canada. www.venuewest.com/2005/crsm/index.cfm

The New Vulvovaginal Diseases (American Society for Colposcopy and Cervical Pathology), April 28 – May 1, 2005, Bethesda, Maryland. www.asccp.org/meetings/future.shtml

American College of Obstetricians and Gynecologists 53rd Annual Clinical Meeting May 7-11, 2005, San Francisco, California, www.acog.org/ACM2005/

Information

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

Disclaimer

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