



Women's Sexual Health Journal

Editorial

Spring has reached the North country. The only snow remaining is in shadowed ditches and deep under the pine canopy. Gunflint Lake is now open on the west end, and the remaining ice has turned black. Daffodils and scilla are peeking though the ground. The loons are back and nesting. Our 3-month old female Curly Coated Retriever puppy, Spirit, is exploring a whole new world. Spring is a time of promise and dreams.

TWSHF started several years ago as a result of a conversation between Lisa Martinez and me. Lisa described all of the difficulty she had encountered seeking answers when she experienced FSD following surgery. She had been rebuffed by her surgeon, referred to counseling, and even told to accept it as part of getting older. But she did not give up. Eventually, she found a health care provider who validated her concerns and worked with her to seek solutions. As a result of this quest, Lisa identified a profound problem in women's sexual health: the dearth of information for women and health care professionals. We discussed this at length over a few months. I thought she was crystallizing her thoughts into a plan. Finally, I asked "What is your dream?"

Lisa said "to set up a foundation to provide educational information on the causes, treatments, and latest research in sexual health issues to women and healthcare professionals. But that's silly. I could never do that." I said "Why not?" The rest is history.

In 2003, Lisa started the Foundation. Later, she incorporated it and obtained a 501(c)3 status for it. She worked with a colleague to set up a website. She wanted an advisory panel of prominent, caring persons working in the field of women's sexual health. She got it. She wanted to attend the 2003 annual meeting of the International Society for the Study of Women's Sexual Health (ISSWSH) in Amsterdam. She did. Last summer, we discussed creating a small electronic newsletter to keep

Foundation members informed about current events and research relating to women's sexual health. Some members of the Board of Directors thought it would be very daunting. Not Lisa! Instead of a small, infrequent newsletter, we put together a quarterly journal.

At the ISSWSH meeting in Atlanta in 2004, we brainstormed after dinner one night discussing the papers we had heard that day. Lisa observed that though ISSWSH served scientists well, perhaps it was too esoteric for the public and regular practitioners. So I said "What is your dream?" She said "I want the Foundation to put on a symposium in 2005 that will be targeted at the public and practitioners." Well, one thing led to another. Please see **Announcements** to see the realization of Lisa's dream.

When I was a student, I had a mentor who affected the rest of my life. He would call me into his office whenever I seemed to be flailing around without goals or direction. He would ask "What is your dream?" That always made me think about where I wanted to go and how to get there. Since then, I have used the same phrase to help others find and achieve their dreams. At the beginning, there is promise. It takes dedication and work to turn the promise into a dream realized.

In this volume of the Journal, we have the story of a woman who experienced HSDD after a hysterectomy with oophorectomy. She participated in a clinical trial of Intrinsa, the women's testosterone patch under development by Procter & Gamble. She was so impressed with the promise of this treatment that she even testified at the FDA Advisory Panel meeting reviewing Intrinsa. Although Intrinsa requires more research, it holds promise as potentially the first FDA approved medication for the treatment of a female sexual dysfunction.

We also have an article by Serena Holguin, a graduate student in health education, describing her journey of discovery. She identified women's sexual health education as her dream. Now, she is pursuing that dream through her studies at California State

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Published four times yearly by The Women's Sexual Health Foundation, Cincinnati, Ohio. The Journal (WSHJ) is an educational service to provide valuable information to professional, student, and public members of the Foundation. Founded in April of 2003, and directed by Lisa Martinez, RN, JD, The Women's Sexual Health Foundation (TWSHF) is a nonprofit corporation. TWSHF supports a multidisciplinary approach to the treatment of sexual health issues and serves as an educational resource for both the lay public and healthcare professionals. The Professional Advisory Board: Yitzchak (Irv) M. Binik, PhD, David Ferguson, PhD, MD, FACCP, Jean Fourcroy MD, PhD, 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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University Northridge. We wish her well and hope she fulfills her promise as an educator.

Finally, I have abstracted an important article from the literature: *The metabolic syndrome: a cause of sexual dysfunction in women*, Esposito et al. The metabolic syndrome consists of the constellation of obesity, dyslipidemia, hypertension, insulin resistance, prothrombotic state, and proinflammatory state (elevated C-reactive protein, CRP). At present, the thresholds for meeting each of these criteria are very low as can be seen in the article. The authors compared 120 women with metabolic syndrome to 80 matched controls using a self-report sexual dysfunction questionnaire and an array of laboratory tests. There was no intervention.

The results showed significant sexual dysfunction and elevations of CRP in the women with metabolic syndrome. Although the authors claim metabolic syndrome as a cause of FSD in the title of their article, it should be noted that this was essentially a correlation study of comorbidities. It remains to be seen if metabolic syndrome is causal. Nevertheless, given the prevalence of metabolic syndrome in the general population, this article is an important first step. In men, the presence of erectile dysfunction is now being used as a warning sign of covert cardiovascular disease including metabolic syndrome. It may eventually be revealed that FSD can be a marker for underlying disease in women.

The authors hypothesize that CRP may have a causal role in the development of FSD. If this is so, then there is promise of another approach to treatment. There are many drug development programs directed at reducing CRP. We can dream.
Editor—David Ferguson, Grand Marais, MN

A Woman's Story:

Living with Female Sexual Dysfunction

Based upon numerous magazine articles and surveys, record numbers of women across the country are having more frequent and satisfying sexual encounters than ever before. I am not, on the other hand, among these women. So what is wrong with me? Admitting that you have no desire for sex is not an easy thing to do, even in the enlightened and open age in which we live.

I first became aware of Female Sexual Dysfunction (FSD) several years ago. It was a

disorder of which I was completely unaware. My girlfriends, mother, or aunts never spoke of it. In my world, it just did not exist. I learned, however, through first-hand experience that FSD was very, very real.

The decline in my sexual libido began in 1996. I had a hysterectomy and oophorectomy – surgeries performed far too frequently on thousands of women in the United States on a yearly basis – that robbed me of my sexual desire. The healing process from the surgery is lengthy. I knew there would be a period while my body was healing where there would be no sex. It was only natural. My body would have to heal. I had no idea, however, that my sexual desire would be greatly diminished and never return to what it once was.

After my surgery, many months passed before it dawned on me that it had been some time since my husband and I were sexually intimate. This troubled me, so I approached my husband and voiced my concern. We discussed our intimacy drought – we were both very busy with full-time, demanding jobs; we were parents of a child who was very active and involved in a number of extracurricular activities that left little or no time to us. When we weren't busy with our jobs and childrearing, we were simply mentally and physically exhausted. We came up with very logical and reasonable explanations for lack of intimacy.

My husband assured me that he loved me and everything was all right. But it wasn't. I knew that there was something wrong. I did not have the yearnings or feel the desire that I used to. The thought of sex was the farthest thing from my mind. On those occasions when my husband and I had sex, it was not very satisfying. It was difficult for me to reach an orgasm, and this became a source of frustration. I missed those toe-curling orgasms.

I knew I had to do something to help stimulate my libido. I began to explore different remedies that were advertised as aphrodisiacs and helped women to have more deep and satisfying orgasms. I tried supplements with natural substances such as wild yam root, which contains estrogen precursors and is recommended by herbalists for women's reproductive health. I purchased topical solutions and drank various herbal teas that were said to be sex enhancers and increased sexual responsiveness. For the most part these remedies did very little to improve my libido.

I continued my quest for something that would give me back my sexual desire. I read many articles that suggested testosterone was responsible for a woman's libido. It was also pointed out that

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research has shown women who had their ovaries removed had very low levels of testosterone in their bodies. Low testosterone equals low libido. A light went off in my head!

I finally decided to seek medical help and made an appointment with my gynecologist to discuss my problem with him. Although I had been going to this doctor for many years, he performed my hysterectomy and oophorectomy, and it was not easy for me to broach this subject with him. Our relationship was pleasant enough, but it was not one such that I felt entirely comfortable discussing an intimate matter. However, I summoned my nerve and was very candid with him. The end result of my visit was a prescription for an estrogen and testosterone therapy.

I was excited about starting this new therapy and had high hopes that my sex drive would return. After several months of taking this hormone therapy, I did not see any noticeable change. Another hope dashed.

I continued with my search for other options. One day while riding in my car, I heard an advertisement on the radio that piqued my interest. It was appealing to women with low libido to participate in a research study. Hearing the ad brought me to the realization that I was not the only woman having a problem with sexual desire. Needless to say, I called the toll-free number to obtain more information. I wanted to be a volunteer for the clinical trial. Responding to this ad was the beginning of my involvement with research for FSD.

A telephone screening was done to determine if I was a suitable study participant, which I was. An appointment was set for me to visit the local center conducting the research study. The research center was seeking participants for a study to test a drug therapy on low libido in surgically menopausal women.

I took a series of psychological tests and underwent extensive medical tests to qualify me further for the study. An in-depth discussion was held with the clinical director. My questions were answered, concerns addressed, and my fears about risks eased. I was very excited about my involvement in this research and the hoped for results of this new therapy to replace the testosterone my body was no longer producing.

My participation in this study opened my eyes in more ways than one. I was aware of research for cancer, heart disease, and other things. However, I had no idea that there were research clinics devoted specifically to women's health issues.

After all the preliminary paperwork and tests

were done, there was a period of several weeks before any medication was dispensed. During this time, I completed weekly questionnaires designed to gauge my physical and mental well-being.

Once I began use of the Intrinsa testosterone transdermal patch, follow-up visits to the center were scheduled at regular intervals throughout the course of the study. Taking vital signs, blood tests, and completing questionnaires were a routine part of each visit.

My experience in the study was an excellent one. I did not grow a mustache or beard or develop large muscles. My voice did not deepen nor did I grow large amounts of hair on my chest. I felt absolutely great! I had an overall sense of well being. More importantly, there was a noticeable increase in my libido. There was hope.

I had first hand experience with the positive effects of the testosterone transdermal patch, and I want to experience those feelings again. Clinical studies have shown this drug therapy is effective in raising the levels of testosterone in a woman's body with little or no side affects. I was very disappointed the patch did not receive FDA approval. It is my hope the FDA will ultimately approve Intrinsa after the additional studies they have requested are completed.

It is frequently stated that women are much more complicated than men. In a lot of cases, our libido is directly linked to our emotions and mental state of mind. But this is not always the case. Physical factors like a hysterectomy can affect libido.

I know that a healthy and satisfying sex life is important to my physical and mental well being. There are countless numbers of women like me who are seeking a solution to our sexual dysfunction. Until the medical profession takes note and devotes as much time and money as they have done with male sexual dysfunction to aggressively seek a solution to FSD, I and others like me will continue to suffer in silence and be deprived of a vitally important part of our lives.

Roslyn G. Washington
Silver Spring, Maryland

A Student's Story

Health Education can be defined as "a social science that draws from the biological, environmental, psychological, social, physical and medical sciences to develop individual, group,

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institutional, community and systemic strategies to improve health knowledge and attitudes as well as skills and behavior”, (Northern California Society for Public Health Education, 2003). As a result, health educators can be employed in a variety of settings in the public and private sector.

When completing my undergraduate degree in Psychology at the University of Texas-El Paso, I was at the crossroads of deciding what I was going to do post graduation. At that point in time, the media was grabbing a hold of a new term called “female sexual dysfunction.” Through web surfing and book reading I learned more about this term and the various elements that impact a woman’s sexuality. At this point, I knew I wanted to be involved in some aspect of women’s sexual health.

Aristotle once said “Where your talents and the needs of the world cross, lies your vocation.” I found the need, but what was my talent? Although my background is in psychology, there was no faculty at the time with research interest in human sexuality. After more researching and networking, I became familiar with the field of health education, and given the above stated components of health education, I figured this would be the best format for me to pursue a career in women’s sexual health. Not only do each of the multidimensional factors of the health education definition contribute to female sexuality, but a healthy nurturing sex life can benefit each of those multi-dimensions of health.

Currently, I am a Master in Public Health student in health education at California State University Northridge. When I began my studies as a graduate student in health education, I immediately tried to link the topic to women’s sexual health. I was most successful in doing this through my electives. One of my elective courses was in sexual dysfunction that was taken in the sociology department. In this class, we reviewed case studies of various male and female sexual dysfunctions and their possible treatments. Although I do not intend to go the clinical route on female sexuality, I felt it was important to have a basis of the treatments and theories.

Another way I took advantage of this was in a more applicable structure: peer education. On the campus of California State University Northridge, there is a peer education program EROS (education and resources on sexuality), that educates the campus on sexual issues such as contraception and sexually transmitted diseases. From this, I have acquired a wealth of knowledge and a satisfaction in knowing I am passing on essential information to young adults.

One road block I have encountered is faculty

relaying to me that they do not see female sexual dysfunction as a topic of interest in health education. It cannot be denied that it is a public health issue with Lauman, Paik, and Rosen (1999) stating it to be a public health problem and with the sexual side effects of various medications being well known. For a woman to be diagnosed with sexual dysfunction, she must state that it causes her personal distress, therefore her quality of life is affected, which many other 21st century health problems share with sexual dysfunctions.

Many still believe that female sexuality belongs in the psychological realm not realizing that the medical field is taking note of the many facets that encompass a woman’s sexuality. Therefore where does health education fit in?

Health educators who are certified by the National Commission for Health Education Credentialing, Inc. (NCHEC), are held to a set of responsibilities, competencies, and sub-competencies, three of which are:

- Investigate physical, social, emotional, and intellectual factors influencing health behaviors
- Identify behaviors that tend to promote or compromise health
- Recognize the role of learning and affective experience in shaping patterns of health behavior

Given that health is such an expansive term, one could insert sexual health in the above sub-competencies, and the competency criteria would not be lost. Granted, health educators do not have the training to treat sexual dysfunctions due to psychological, physiological, or combined factors, but health educators do have the skills to deal with behavioral, attitudinal, and educational factors. Behavioral, attitudinal, and educational factors of sexual health and dysfunction can encompass safer sex practices, information on contraceptives, competency on reproductive anatomy, and knowledge of skills and techniques that can enhance the sexual experience. Acquiring knowledge in these areas could be seen as preventative measures towards a life without sexual difficulties.

Currently, I am at the critical point in the masters program where a thesis topic needs to be decided. I am interested in doing a project involving Natural Family Planning/Fertility Awareness. What interests me and why I feel there is a need for it, is that these methods are considered to be viable options for birth control, yet very few women are aware of these methods. The benefit to these methods is that a woman’s hormonal make-up is not manipulated.

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Although the research is not extensive, some of it concludes that hormonal contraception can lead to inhibited sexual desire and arousal in some women (Martin-Loeches M., Ortí R.M., Monfort M., Ortega E., Rius J, 2003). In addition, women who wish to be sexual during their fertile period but avoid intercourse to prevent pregnancy, can explore other activities and options to express their sexuality. The acquisition of knowledge of her body that a woman will receive from learning about fertility awareness, may also help her communicate more freely with her physicians about any sexual health problems she may have.

To conclude, the profession of health education can play a critical role in women's sexual health and dysfunction through the dissemination of information and by keeping the public abreast of the research findings in this area. I hope to make this a goal as I embark on a new profession.

Serena Holguin
El Segundo, CA

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Laumann EL, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. *JAMA* 1999;10: 537-545.

Northern Society for Public Health Education 2003: <http://www.ncsophe.org/healthedef.htm>

National Commission for Health Education Credentialing, Inc. 2002: <http://www.nchec.org/aboutnchec/rc.htm>

Martin-Loeches M., Ortí R.M., Monfort M., Ortega E., Rius J. A comparative analysis of the modification of sexual desire of users of oral hormonal contraceptives and intrauterine contraceptive devices. *The European Journal of Contraception and Reproductive Health Care* 2003; 8 (3): 129-134.

Questions and Answers

Q: We just had our first baby, and I have been breast feeding. However, I am about as interested in having sex as I would be in going to the dentist to have a cavity filled. What is going on, and is this normal? Plus, I have heard of women having orgasms while breast feeding. Is this really true?

A: Prolactin, which is a hormone that helps you
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produce milk, could be decreasing your desire for sex. Prolactin can also diminish sensation and may make it difficult to have an orgasm. Estrogen levels may be lower when a woman breast feeds. This can cause dryness and painful intercourse. If this is the case, you may want to use a lubricant. Also, some women have orgasms when they breast feed because of nipple stimulation, and this is normal.

Q: I have been diagnosed with cancer of the vulva. Will this impact my sexual response?

A: With cancer of the vulva, part of the vulva may be removed or even the labia, mons, and possibly all of the clitoris. Some women are concerned about their self image post-operatively because of the change in the appearance of the vulva area. Scarring is possible from the surgery at the opening of the vagina. This may make intercourse painful. Also your vulvar area may feel numb. If the clitoris is removed, it may or may not impact a woman's ability to have an orgasm. Your doctor may recommend using vaginal dilators to help prevent scarring. It would be wise to speak with your doctor about your concerns.

Q: I am a little embarrassed to ask this but I am in my seventies, and I am planning on getting married soon. My first husband died over 4 years ago. I have not had sex with my fiancé, and I am worried that when we do, it may be painful. You see, I have not had sex since before my husband died. What should I do?

A: Congratulations on your upcoming marriage. We would advise that you talk to your doctor about your concerns. She or he may prescribe vaginal estrogen. This would help to decrease irritation and/ or dryness. Also you may want to consider a lubricant such as Astroglide or some of the silicone lubricants that are on the market. These are available over the counter at drugstores or through the internet.

Q: Can having hypothyroidism or low levels of thyroid affect sexual desire?

A: Yes, hypothyroidism can be associated with decrease desire, and it can be detected with a simple blood test which your healthcare provider can order.

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Sexual Medicine Article

The metabolic syndrome: a cause of sexual dysfunction in women, K. Esposito, M. Cotola, R. Marfella, D. Di Tommaso, L. Cobellis, and D. Giugliano. *Int J Impot Res* 2005; 17: 1-3.

Obesity, hypertension, dyslipidemia, and diabetes mellitus are important risk factors for male erectile dysfunction. This constellation, once known as one of the two Syndromes X, is now called the metabolic syndrome. In this paper, Esposito et al assess the prevalence of sexual dysfunction in premenopausal women with metabolic syndrome as compared to the general population of women. Editor.

Materials and Methods

Women 20 to 48 years were recruited from outpatients visiting the metabolic department of the University of Naples. Enrollment criteria included premenopausal state, regular periods, no oral contraceptives, no gynecologic disease, and no other endocrine disease. To qualify as having metabolic syndrome, they had to present with three or more of the diagnostic criteria: (1) waist circumference > 88 cm; (2) HDL-cholesterol < 50 mg/dL; (3) triglycerides \geq 150 mg/dL; (4) blood pressure \geq 130/85 mmHg; (5) fasting glucose \geq 110 mg/dL. Exclusions were frank diabetes or impaired glucose tolerance, pelvic trauma, urinary incontinence, lower urinary tract symptoms, cardiovascular disease, psychiatric problems, use of drugs, or alcohol abuse. An approximately equal number of women matched for age, weight, tobacco use, and other inclusion/exclusion criteria were recruited.

Sexual function was determined by patients completing the Female Sexual Function Index (FSFI), a validated, 19 question self-report instrument which consists of six domains: desire, arousal, lubrication, orgasm, satisfaction, and pain. Domain scores and total scores were measured. The authors set sexual function as "good" if the total FSFI score was \geq 30, "intermediate" between 23 and 29, and "poor" if below 23.

Laboratory evaluations included serum total and HDL-cholesterol, triglycerides, glucose, and C-reactive protein (CRP). Conventional statistical tests were used to analyze the data.

Results

The metabolic syndrome group (n=120) and the matched control group (n=80) did not differ significantly for age, body mass index, menopausal status, glucose, triglycerides, or HDL-cholesterol. Total FSFI scores were significantly lower for the metabolic syndrome group (23.2 ± 5.4 vs 30.1 ± 4.7 , $P < 0.001$). CRP was significantly ($P = 0.01$) for the metabolic syndrome group.

The qualitative distribution (%) of total FSFI scores was significantly different ($P < 0.01$) between the groups.

Group	Good	Intermediate	Poor
Metabolic	56	37	9
Control	79	19	2

The metabolic syndrome group's individual domain scores were significantly lower ($P < 0.01$) for arousal, lubrication, orgasm, and satisfaction. In the metabolic syndrome group, total FSFI scores correlated inversely with the number of diagnostic criteria present ($P < 0.01$). Similarly, CRP was inversely correlated with total FSFI scores ($P = 0.02$).

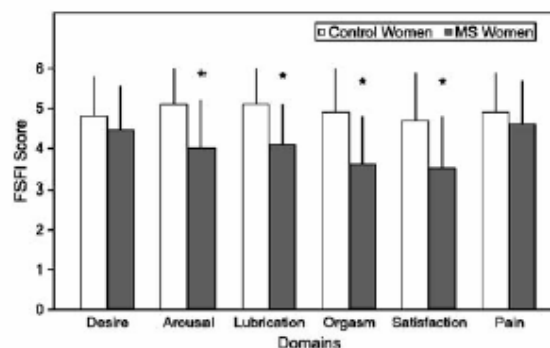


Figure 1 Comparison of the individual domains of the FSFI scores between women with the metabolic syndrome (N=120) and matched control women (N=80). *Significant differences between women ($P < 0.01$).

Discussion

This study demonstrates women with metabolic syndrome have an increased prevalence of sexual dysfunctions as compared to matched controls. The inverse relations among FSFI scores, diagnostic criteria frequency, and CRP are noteworthy. It is

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hypothesized that CRP inhibits nitric oxide synthesis, promotes vascular inflammation, and thus may play a role in the FSD associated with the metabolic syndrome in women.

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Announcements

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS & SURGEONS, DEPARTMENT OF UROLOGY and THE WOMEN'S SEXUAL HEALTH FOUNDATION

PRESENT: FEMALE SEXUAL DYSFUNCTION 2005, A MULTIDISCIPLINARY UPDATE

Saturday, April 23, 2005 at Columbia University Medical Center, New York, New York

FACULTY: Ridwan Shabsigh, M.D., Course Director, David M. Ferguson, Ph.D., M.D., Andre T. Guay, M.D., Hilda Hutcherson, M.D., Rogerio A. Lobo, M.D., Lisa Martinez, R.N., J.D., and Michael A. Perelman, Ph.D.

PROGRAM:

- Practitioners' FSD Survey
- Sexual Response Cycle and Taking a Sexual History
- Epidemiology of Female Sexual Dysfunction
- Definitions and Classifications of Female Sexual Dysfunctions between Clinical Trials and Clinical Practice
- FSD: The Patient Perspective
- The Physical Exam: A Gynecologic Perspective
- The Physiology of Androgens in Female Sexual Function
- Menopause and Sexual Dysfunction
- Diagnosis and Treatment of Dyspareunia
- Pharmacotherapy of FSD
- Androgen Therapy of FSD
- FSD and Urinary Incontinence and Other Urologic Conditions
- Integration of Sex Therapy and Pharmacological Therapy in FSD
- Panel Discussion

FOR REGISTRATION INFORMATION :GO TO

<http://ColumbiaCME.org>

(click Calendar & Brochure Request Form and scroll down to click on April 23, 2005).

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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, Ditzka 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

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/

Donations

As a nonprofit organization, The Women's Sexual Health Foundation is supported through individual donations, memberships, and in a small measure, by the bulk sales of TWSHF brochures and the Journal. We are currently seeking to finance research projects through grants from government agencies and 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:

TWSHF
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Cincinnati, Ohio 45240-0603

Information

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

Editor's Note

The July 2005 issue of the Journal is in preparation. The Editor welcomes articles, letters, meeting notices, pertinent internet websites, breaking news, information on support groups, and publications that may be of interest to the readers.

Disclaimer

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