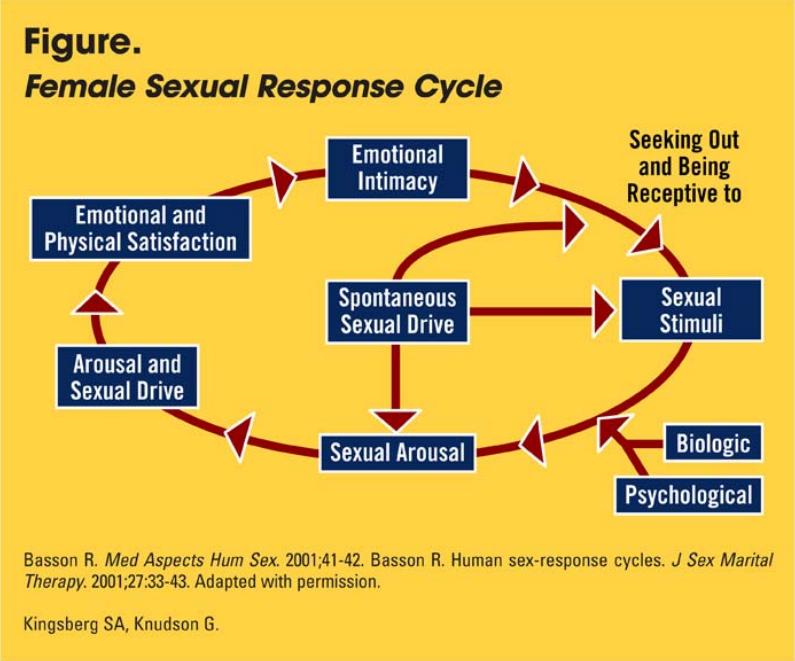
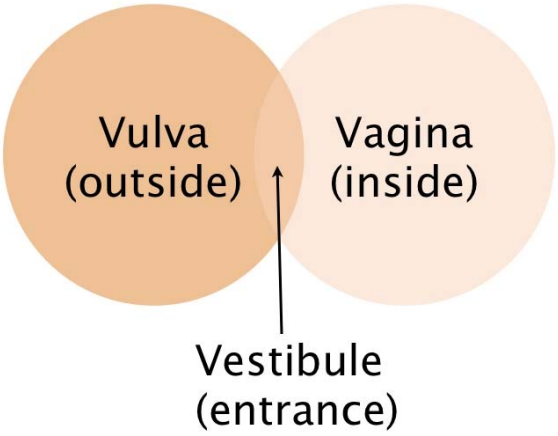
How to have sex in a canoe: Canoe maintenance and troubleshooting handout (Dr. F. Garcia April 2019 – SRPC)

Fast facts



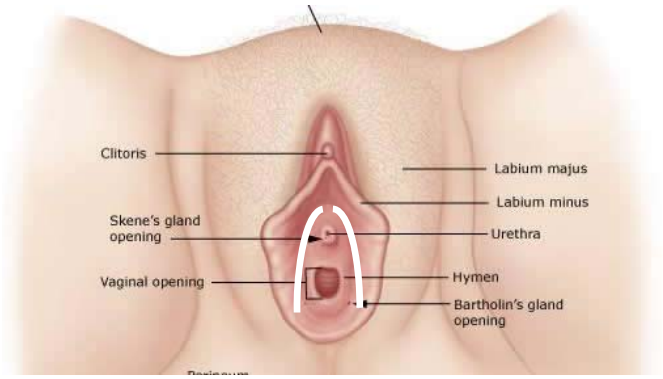
- Female Sexual Dysfunction (FSD) is more prevalent than previously thought and estimated between 7-10% of women
- FSD appears to be highest in the perimenopausal age group
- The female sexual response cycle is both circular with multiple inputs, and directions without multiple different resolutions
- Domains of FSD: Desire, Arousal, Orgasm and Pain
- Antidepressant sexual dysfunction correlates with serotonergic activity
- Pain/Dyspareunia has a large differential diagnosis, however the vestibule is a common source that has been historically ignored
    - Hormonally mediated vestibulodynia can be diagnosed on physical examination and requires local +/- topical hormone therapy
    - Neuroproliferative vestibulodynias can be difficult to treat, but confirming the diagnosis can be critical
- OCPs can contribute to hormonally mediated sexual side effects by altering Sex Hormone Binding Globulin levels
- Pelvic floor certified physiotherapists are critical to FSD assessment and treatment
- Hypoactive sexual desire disorder (HSDD) may be primary or secondary. Hormonal and non-hormonal options exist.
- Testosterone is an important hormone for all women.
- Testosterone dependent tissues in women: Clitoris, Vestibular glands, periurethral glands (prostate)
- Testosterone replacement in women is not endorsed by any society, but has lots of clinical support via experts.
- Testosterone replacement in women is targeted at approximately 1/10th the levels in men.
- Addyi © (Flibanserin) is an effective non-hormonal therapy for HSDD
- HSDD is a disorder of excess inhibition and low excitation



Vestibule: From hymenal ring to Hart's line (base of labia minora)

Vestibulodynia: Pain confined to vestibule (generally no pain inside the vagina

Vagina (*Mesoderm*), Vestibule (*Endoderm*), Vulva (*Ectoderm*)



Types of Vestibulodynia

Pain throughout entire vestibule

Hormonally Mediated Vestibulodynia
- Pain began while:
  - •Taking hormonal OCP or other meds that affect hormones such as meds for endometriosis, breast cancer, acne, infertility
  - •After surgical menopause
  - •During breast feeding or menopause, or lack of regular menstrual cycle
- There is low calculated free testosterone
- •May be associated with decreased libido, arousal, energy and depression

Congenital Neuroproliferative Vestibulodynia
- There has always been pain (since first tampon insertion or coitarche)
- •There has never been completely pain-free sex
- •There may be sensitivity (or pain) when pushing in on the umbilicus as compared to rest of abdomen (radiates towards vagina)

Acquired Neuroproliferative Vestibulodynia
- The pain began after:
  - •Severe allergic reaction to topical medications
  - •Severe yeast infection
  - •Local trauma
- •Women with a history of atopy (sensitive skin) may be predisposed

Pain is much worse at 4, 6 and 8 o'clock of vestibule (and minimal to no pain on either side of urethra
May be tenderness with deep pressure to perineum

Hypertonic Pelvic Floor dysfunction
- Muscles of pelvic floor are tight and tender (on exam)
- •There is abnormal EMG of pelvic floor muscles

Ulcers or erosions that may be confined to the vestibule but also may occur on labia and perineum

Lichen planus
- Ulceration in a vestibule that can have "fern-like" or violet borders
- •The erosions can extend into the vagina and can also affect the mouth
- •Very significant scarring of the vulva and vagina is possible

Lichen Sclerosus
- Ulcerations in the vestibule and on the labia but not in the vagina
- •Thick, white itchy skin with very significant scarring

Pain is mainly in vestibule but there is irritation, redness and (possibly) fissures on the perineum or in the interlabial sulci

Vaginitis
- Inflammation that includes vestibule and vaginal mucosa.
- •Vaginal mucosa typically looks inflammed and there is frequently yellowish discharge
- •BV does not cause enough inflammation to cause vestibulodynia

Desquamative Inflammation Vaginitis
- •Thick, yellowish d/c that dries like glue, ruins underwear
- •pH > 5.0, many WBC and parabasal cells on wet mount

Candidiasis
- Recurrent: Culture positive yeast infections that do not respond to three doses of fluconazole

Allergic Vaginitis
- •Latex or spermicide allergy: swollen and inflamed vagina and vestibule, only occurs if condoms are used
- •Semen allergy – sweollen and inflamed vagina and vestibule, does not happen if condom used

Treatments

- HMV
  - d/c hormone medications as appropriate
  - If appropriate, replace deficient hormones
  - Intravag DHEA, Estrace cream topically, systemic testosterone, etc.
- Cong/Acq neuroproliferative
  - If caught early – INF-alpha injections can work
  - Topical anesthetics/lubricants/capsaicin
  - Antidepressants and Antiseizure drugs
  - Vulvar nerve blocks – if successful, can consider vestibulectomy
- HPFD (or levator ani syndrome)
  - PT, Biofeedback, heat therapy, vag supp diazepam, botox
- Vagnitis
  - DIV – Cleogel, Metrogel +/- Steroids
  - Candidiasis – other antifungals, vag supp, prolonged treatment
  - Allergic – avoidance
  - Infection specific treatments (herpetic, syphilitic, BV, etc)
- Lichen Planus/Sclerosis
  - Clobetasol, topical calcineurin inhibitors, other dermatologic tx

Decreased Sexual Desire Screener

To be discussed with your health care provider.

Each question is answered Yes or No.

1. In the past, was your level of sexual desire or interest good and satisfying to you?
2. Has there been a decrease in your level of sexual desire or interest?
3. Are you bothered by your decreased level of sexual desire or interest?
4. Would you like your level of sexual desire or interest to increase?
5. Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest:
   a. An operation, depression, injuries, or other medical condition
   b. Medications, drugs, or alcohol you are currently taking
   c. Pregnancy, recent childbirth, or menopausal symptoms
   d. Other sexual issues you may be having (pain, decreased arousal, or orgasm)
   e. Your partner's sexual problems
   f. Dissatisfaction with your relationship or partner
   g. Stress or fatigue

Desire dysfunction

- HSDD (Hypoactive Sexual Desire Disorder)
  - Absent/reduced sexual desire
  - Absent/reduced response to normal sexual cues
  - Loss of sexual fantasy
  - Avoidance of situations that may lead to sexual activity
  - Loss of initiation of activity
  - Associated with feelings of loss, inadequacy, sorrow, worry etc
  - Can be lifelong or acquired – should be generalized
  - Situation is not HSDD