Transcript Details

This is a transcript of an educational program accessible on the ReachMD network. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/video-library/opening-the-door-to-discussing-dyspareunia-with-your-patients/9863/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Opening the Door to Discussing Dyspareunia with Your Patients

Narrator Intro: This is ReachMD. The following activity, titled "Opening the Door to Discussing Dyspareunia with Your Patients" is provided by Omnia Education and supported by an independent educational grant from AMAG Pharmaceuticals.

This short video case study is presented by Dr. Sheryl Kingsberg, Chief of the Division of Behavioral Medicine in the Department of OB/GYN at University Hospitals Cleveland Medical Center and Professor of Reproductive Biology and Psychiatry at Case Western Reserve University School of Medicine in Cleveland, Ohio.

The following is an example of a doctor-patient interaction, which offers strategies to discussing dyspareunia with your patients.

Dr. Kingsberg: Vulvar vaginal atrophy, or VVA, affects about half of the 64 million postmenopausal women in the U.S. VVA stems from the loss of estrogen that occurs as a result of menopause and the impact of this loss on vaginal and vulvar tissue, which can lead to symptoms of dyspareunia - or painful sexual activity. Not surprisingly, painful sex can negatively impact a woman's sexual life and her relationship with a partner as well as negatively impacting her overall quality of life.

The following conversation will discuss strategies you can use to help your patients be comfortable with bringing up their struggles with dyspareunia.

Dr. Kingsberg: Hi Debbie. It's nice to see you back.

Debbie: Hi Dr. Kingsbergingsberg, thanks for seeing me.

Dr. Kingsberg: Alright. So it's been about 5 years since your hysterectomy, and when I did see you last, you said no hot flashes, no night sweats, your sexual function was good, your desire was good, .but I have to tell you, many women after menopause startto notice some sexual changes and vaginal changes or they just have some concerns, so I want to check in on your sexual function or any problems you might be having okay?

Debbie: Well, I guess part of why I came back to see you is because in the last 6 to 12 months I have noticed a lot of changes and I actually am pretty worried about it.

Dr. Kingsberg: Well I'm glad you came. So tell me about those changes?

Debbie: I have not wanted to have sex with Brian. No interest. I just don't like having sex with my husband anymore.

Dr. Kingsberg: Well I'm sorry to hear that, but it's good to talk about this. Healthy sexual function is an important part of overall health and quality of life.

So, when you say you don't enjoy sex with Brian anymore, what would you say has changed? Are you and Brian having any personal problems?

Debbie: Oh no, not at all. I just don't feel like having sex.

Dr. Kingsberg: Alright so let me see if I can figure out with you what those changes in feelings are a little bit more clearly okay? So when I talk about sex with patients, I usually talk about 4 aspects of sexual function okay. There's desire, there's arousal, orgasm, and then pain. So when I talk about desire that's about wanting. That's about wanting to have sex. Whether or not you actually act on it your brain sort of has an appetite for it okay.. Arousal is when your body is able to respond physically to that desire. That is you can lubricate, your vagina gets wet, your vagina swells, and you can feel those sensations as pleasurable. Orgasm, or the ability to

experience orgasm in a variety of ways, manual stimulation, oral sex, penetration, is the release of all that sexual tension experienced as satisfying. And then when we look at pain, we're really looking at whether you're having any pain or discomfort with sexual activity itself okay.

Debbie: Well, I guess I don't want to have sex much because it really hurts every time we try.

Dr. Kingsberg: So can you tell me a little bit more about that hurt or pain?

Debbie: I do lubricate a little myself, but not nearly like I used to, so we use plenty of lube. But even with lube it's painful. I usually have to make him stop. The pain is sharp and tearing and sometimes I notice I'm bleeding a little bit. It's really awful, and Brian feels terrible and guilty for hurting me. I feel guilty for having to make him stop.

Dr. Kingsberg: Alright, so to be sure I'm not missing anything before we address the pain, if you weren't worried about pain with penetration, or having sex at all for that matter, do you have a sense of whether you still have desire—you know like that spontaneous sexual thought, erotic feelings, feeling horny?

Debbie: I still think Brain is attractive and I do get horny, but not as often as I used to. Maybe once a week or so, but as soon as I think about wanting to have sex, I get really anxious about it and I think about the pain and then I decide I don't want to.

Dr. Kingsberg: Are you still able to reach orgasm like you used to?

Debbie: Yes. Not much change there.

Dr. Kingsberg: Alright that's good. So let's head to the exam and make sure there isn't any other infection or any other skin condition that might be affecting your pain and bleeding okay?

Dr. Kingsberg: Debbie I am so glad you decided to come in and talk about your symptoms. So your symptoms are the result of what we call vulvovaginal atrophy, or VVA. And it's a condition where the tissues in the vagina get very thin and they don't have those elastic stretchy properties they had when they had been exposed to those reproductive hormones, or estrogen. So it occurs because of menopause --- yes you are post-menopausal --- and although you stopped having your period 5 years ago when you had your hysterectomy, it's likely your ovaries were still functioning for a while and now they're not and because of the loss of estrogen with the ovaries shutting down, this has resulted in the vulvar and vaginal changes.

Debbie: So we can fix this??

Dr. Kingsberg: We actually have a variety of treatments that we can try to correct the situation, and I think that you and I can choose the best one to start with that you will like. So we generally consider adding a local therapy which means it only increases estrogen in the urogenital area and the vulvar and vaginal area. And we can use vaginal cream, we can use a pill, we can insert an estrogen pill, or even use a ring sort of like a diaphragm that you can leave in for several weeks.

We also have non-estrogen treatments. And one is a suppository, it's like a little pellet, that is DHEA which is considered a PRE-HORMONE and this is called prasterone. So this works inside the cells themselves --- so right inside vaginal cells--- and it converts into estrogen and androgens, both of which are important for healthy vaginal tissue. And another option is an oral pill called ospemiphene which is a Selective Estrogen Receptor Modulator, or a SERM for short, meaning that while it's not an estrogen, it does actually selectively work on some estrogen receptors, like those in the vagina, and doesn't work on other estrogen receptors in other parts of the body.

Debbie: I had no idea what this was or if could even get better! I'm SO relieved!!!

Dr. Kingsberg: I am so glad that you came in. There is no reason you needed to suffer.

Dr. Kingsberg:

Let's take a look at my interaction with Debbie.

The first and probably most important take home from this is that at least 50% of your postmenopausal patients are suffering from VVA and most of them have no clue what it is. They know that menopause is related to hot flashes but not necessarily vaginal atrophy.

Second, patients need YOU to bring up the topic of sexual function, dryness or pain. They are embarrassed and don't know its' ok to bring it up. Do not assume that all your patients will tell you anything they are troubled with because you have such a wonderful rapport with them.

Third, I used open ended questions to draw out her information. ⁻I quickly got to the main problem—pain with sex and that it was not

related to her relationship or to desire problems.

I hope this case scenario reassures you that assessing sexual function and treating VVA in postmenopausal women is simple, efficient and can be done easily in your office visit and results in better health and sexual function for your patient and a satisfying experience of an office visit for both of you.

Narrator Close: This activity was provided by Omnia Education. For more information, visit ReachMD.com/Omnia.

This has been ReachMD: Be part of the knowledge.