AOFS NEWSLETTER

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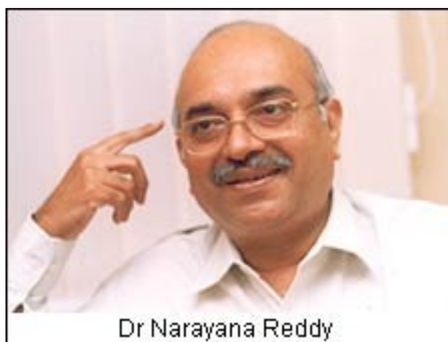
INVITATION TO ALL MEMBERS TO ATTEND THE

15th AOFS CONFERENCE IN CHENNAI, INDIA

Dr Narayana Reddy, President of the 15th AOFS Conference, encourages all members of AOFS to actively participate in their professional organisation's biennial conference.


Dr Narayana Reddy

This is a unique opportunity to present information to like–minded colleagues, share knowledge and therapeutic strategies, educate about cultural differences and make friends across the region.

Come join us at Chennai, India in August 2018. Let us celebrate life with quality academics in sexual health care. Enjoy the academic feast at the 15th Congress of Asia Oceania Federation for Sexology (www.aofs2018.org) and cherish traditional Chennai hospitality.

Vaango Chennai (Vaango means welcome in local language Tamil)

Dr Narayana Reddy

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Editor:

Dr Margaret Redelman OAM

MEASURES FOR SEXUAL HEALTH RECOVERY AFTER PROSTATE CANCER TREATMENT

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Advances in early detection and efficient management of prostate cancer (PCa) have effectively prolonged the post-treatment lifespan for patients in their survivorship.[1] It is therefore, imperative to incorporate measures for improving quality of life (QoL) in general and sexual health in particular to facilitate the survivors' smooth transition to near-normalcy in their cancer journey. Essentially, the sexual rehabilitation in this setting should focus on:
i. general impacts of PCa treatment on the physical, behavioural, psychological and interpersonal aspects[2] as well as
ii. specific impacts such as loss of libido, erectile dysfunction (ED), ejaculatory disorder(s), changes in pleasure perception and/or penile shortening.[3]

Often ED is a single major concern for men following any form of PCa treatment. The average incidence of ED reported in clinical studies following radical prostatectomy (RP) ranges from 70%- 90%. The cavernous nerve-sparing technique reports erectile function recovery rates of 40%-85% post-surgery (better for bilateral compared to unilateral nerve preservation); however as many as 90% of men will experience an initial decline in erectile capacity, which is then followed by recovery over time.[1,4] The mechanism of male sexual dysfunction is multifactorial and is ascribed to one or more of the following[4]:
i. surgical removal (unilateral or bilateral) of the cavernous neurovascular bundles (NVBs)
ii. transection or ligation of accessory internal pudendal arteries leading to decreased arterial inflow, ischemia and an arteriogenic ED
iii. mechanical or thermal injury and damage of the cavernous NVBs (intraoperative)
iv. post-operative inflammation at the surgical site resulting in temporary or permanent damage of the NVBs
v. neuropraxia caused by traction, compression or coagulation leading to Wallerian degeneration of the nerves
vi. decreased nitric oxide production and increased sympathetic tone resulting in an impaired relaxation of the cavernous smooth muscle
vii. hypoxia, increase in inflammatory cytokines, cavernous muscle fibrosis, collagen deposition and apoptosis leading to structural changes viz., reduction in penile length or girth and a Peyronei-like curvature
viii. impaired compressive effect on subtunical venules, corporal veno-occlusive dysfunction, venous leakage and a veno-genic ED.

While the consensus from the International Consultation of Sexual Medicine[5] indicates that it is almost impossible to regain an erectile function "back to baseline" following PCa treatment, the measures for penile rehabilitation are particularly use-ful to help patients achieve forms of physical and emotional closeness with their partners. At the cellular level, the inherent goals of rehabilitative interventions would include improved cavernous oxygenation, endothelial protection and a possible restoration of the structural integrity.

That being said, understanding the PCa survivors' perspectives of their intervention needs would guide the development of a conceptual care model under the comprehensive umbrella of penile health recovery. This formed the basis of our pilot study conducted in a small cohort of PCa survivors attending the Singapore Cancer Society Rehabilitation Centre. The sub-jects included 13 men (mean age: 67.54y; SD: 17.1) with a presenting history of prostate cancer; newly diagnosed were 30.8% (n=4) while the rest (15.4% with stage IV lesion) had completed treatment in the last 3 years. A majority underwent radical prostatectomy (77.7%); 22.3% had radio- and chemo- therapy and 44.4% were on hormone ablation. Extent of base-line comorbidities for ED such as type 2 diabetes, dyslipidaemia, hypertension, coronary heart disease, smoking, excessive drinking, and/or obesity were evaluated and any changes in sexual life quality assessed through semi-structured interviews. The presenting level of erectile disorder was estimated using the International Index of Erectile Function – IIEF 5 items' scale, the sexual health inventory for men (SHIM). Pre-operatively, 18.1% had erectile and/or relationship problems with a menopause history in 92.3% of cohort's partners. Overall, 76.9% were distressed with the post-treatment impacts on their sexual intimacy. Severe ED was reported by 66.7%, together with loss of libido and performance anxiety in all. In spite of partners' (88.9%) acceptance of changes in relational dynamics, a majority was concerned with sexual health loss and delayed functional recovery.

Our study findings confirmed that ED is a distressing survivorship-care requirement. Nevertheless, given the inevitable impacts of PCa treatment, majority appeared to benefit from realistic recommendations for reinitiating (erection-independent) forms of physical and emotional intimacy, with a wider sexual repertoire. Where possible, measures of early penile rehabilitation using clinical interventions were advocated for an optimal restoration of structural integrity as well as functional capability. The following customized bio-psychosocial model[5,6] was useful in the clinical algorithm and should be considered not only to meet the PCa survivors' intervention needs but also for a holistic QoL recovery in the cancer journey.

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Customized Bio-Psychosocial Model of Sexual Health Rehabilitation

Clinical Interventions
First line: oral PDE-Is – low daily dosing or on-demand; started early (at catheter removal to 4 months); limited efficacy if the cavernous NVBs are removed or damaged
Second line: intracavernous injection of PGE_1; possibility of painful erections if started early – an ideal starting time is at least 3 months after RP; works in the absence of functional NVBs
Second line: intraurethral or topical PGE1; available or approved in some countries
Second line: vacuum erection device; daily or on-demand, helps to improve cavernous oximetry; useful in the absence of functional NVBs
Third line: penile prosthesis – surgical implant when all other measures are ineffective
Psychosexual Counselling and Sex Therapy
Cognitive behavioural therapy
Mindfulness-based psychotherapy
Sex therapy – viz., sensate focus, PLISSIT measures
Psychosexual counselling
Measures to Address Barriers and Challenges
Intervene early (from the time of catheter removal) with some form of treatment for erectile function recovery
Be persistent in continuing with the treatment (for about 1 to 1.5 years)
Normalise the level of erectile impairment as an expected post-treatment impact
Address anxiety or fears related to sexual performance inadequacy
Encourage attempts of sexual activity in spite of lack of desire or loss of libido

PROFESSIONAL SEXUAL BOUNDARIES

The Harvey Weinstein saga and the continuing exposure of bad behaviour (or maybe just behaviour considered inappropriate in our time) has made many conscious of how we now want behaviour between men and women (and health professionals and patients/clients) to be conducted.

I have summarised segments from the Medical Board of Australia website that I thought important for all of us to consider. The document was published 28.10.2011 and is titled: Sexual Boundaries: guidelines for doctors. I have not heard much discussion at our conferences on this aspect of practice and I think we need to be proactive rather than reactive, to protect the good name of our specialization. The whole section on the website makes good reading. http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx

These guidelines complement “Good Medical Practice: A Code of Conduct for Doctors in Australia” and provide specific guidance on sexual boundaries in the doctor-patient (therapist–client) relationship.

Good Medical Practice states:

“Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy.”

“Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.”

It is the Doctors/ Health Professionals role to:

- maintain professional boundaries
- never use the professional position to establish or pursue a sexual, exploitative or other inappropriate relationship with anybody under care. This includes those close to the patient, such as their carer, guardian or spouse or the parent of a child patient
- avoid expressing personal beliefs to patients in ways that exploit their vulnerability or that are likely to cause them distress.”

It is always unethical and unprofessional for a Health Professional to breach this trust by entering into a sexual relationship with a patient, regardless of whether the patient has consented to the relationship. It may also be unethical and unprofessional for a doctor to enter into a sexual relationship with a former patient.

Sexual Misconduct

Sexualised behaviour includes any words or actions that might reasonably be interpreted as being designed or intended to arouse or gratify the Health Professional's sexual desire. This covers a range of inappropriate professional behaviours including:

1 Sexual harassment

- Making an unsolicited demand or request, whether directly or by implication, for sexual favours
- Irrelevant mention of a patient’s or doctor’s sexual practices, problems or orientation
- Ridicule of a patient’s sexual preferences or orientation
- Comments about sexual history that are not relevant to the clinical issue
- Requesting details of sexual history or sexual preferences not relevant to the clinical issue
- Conversations about the sexual problems or fantasies of the doctor
- Making suggestive comments about a patient’s appearance or body.
- Inappropriate disrobing or inadequate draping for a physical examination, and conducting intimate examinations without adequate prior explanation (and thus without informed consent) may be considered a breach of sexual boundaries

Sexual assault

●ranges from physical touching (or examination without consent) to rape.

A sexual relationship describes the totality of the relationship between two people, when the relationship has some sexual element, including any sexual activity between a Health Professional and their patient. This is the case whether or not the sexual relationship was initiated by the patient. A sexual relationship, even if the patient is a consenting adult, may impair the Health Professional’s judgement and compromise the patient’s care.

A Health Professional's unconscious or unintentional sexual behaviours do not minimise the seriousness of the behaviour.

The Health Professional-patient relationship is inherently unequal. The patient is often vulnerable. In many clinical situations, the patient may depend emotionally on the Health Professional. It is an abuse of this power imbalance for a Health Professional to enter into a sexual relationship with a patient for their own sexual gratification or any other emotional needs.

Health Professionals (and not patients) are responsible for establishing and maintaining boundaries. To summarise, a Health Professional should not:

- enter into a sexual relationship with a patient even with the patient’s consent
- discuss his or her own sexual problems or fantasies
- make unnecessary comments about a patient’s body or clothing or make other sexually suggestive comments
- ask questions about a patient’s sexual history or preferences unless this is relevant to the patient’s problem and the Health Professional has explained why it is necessary to discuss the matter.

Good communication

Good communication is critical in helping patients understand why certain personal and sexual questions are being asked and why specific examinations required. Good, clear communication is the most effective way to avoid misunderstandings. The use of a chaperone may be appropriate. A Health Professional should ensure the patient does not feel compromised or pressured into proceeding with an examination.

A sexual relationship

The beginning of a sexual relationship between a Health Professional and a patient may not always be immediately obvious to either of them. It is the Health Professionals responsibility to be alert to warning signs that indicate that boundaries may be being crossed. Warning signs include:

- patients requesting or receiving non-urgent appointments at unusual hours or locations, especially when other staff are not present
- inviting each other out socially
- a doctor revealing intimate details of his or her life, especially personal crises or sexual desires or practices, to patients during a professional consultation
- patients asking personal questions, using sexually explicit language or being overly affectionate
- patients attempting to give expensive gifts.

If a Health Professional senses any of these warning signs he/she should seek advice from an experienced and trusted colleague or a professional indemnity insurer on how to best manage the situation.

It may be appropriate for AOFS to discuss and publish a position statement on Sexual Boundaries that we feel are appropriate and sensitive to the cultural values of our region.

Commentary and personal and regional experiences would be welcome.

SAME-SEX MARRIAGE LEGLISED IN AUSTRALIA

The right to marry has been the one significant difference between the legal treatment of same-sex and heterosexual relationships in Australia and has been a controversial issue for many years. However, with a shift in community and political opinions the movement towards the legalisation of the right to marry for same-sex couples was inevitable. Also, the conversation around the issue of same-sex marriage in Australia occurred within the context of developments overseas. A growing number of countries had already legislated for same sex marriage such as New Zealand, the Republic of Ireland, most parts of the UK and Canada. Only thirteen years earlier the Australian Marriage Act was changed to explicitly forbid same-sex unions.

Some early developments such as the Hague Convention requiring signatory countries (Australia is one) encouraged countries to recognise overseas same-sex marriages and this was almost enacted in 2013. However, following increasing public agitation. Australia has now become the 26th country to legalise marriage with the overwhelming backing of the Federal Parliament. It followed the resolution of the Australian public in the Australian Marriage Law Postal Survey to support same-sex marriage – 61.6% voted in favour of change. The new bill introduced to amend the definition of “marriage” in the Act, omitted the words “man and woman” and replaced these words with the gender neutral term of “two people”.

The bill was resoundingly passed in the Senate and the House of Representatives on 7th December 2017. It received royal assent from the Governor-General and came into effect the following day. As a result, the definition of marriage in Australia is:

Marriage means the union of two people to the exclusion of all others, voluntarily entered into for life.

When the vote was declared, the public galleries burst into spontaneous, rapturous cheers and applause for several minutes and burst into a rendition of “I am, You are, We are Australian”, while MPs crossed the floor of the Chamber to embrace each other. While there were scenes of great jubilation and relief on the floor of the Houses of Parliament there were also joyful celebrations throughout the country.

“Australia has done it. What a day for love, for equality, for respect,” declared a jubilant Prime minister, Malcolm Turnbull, who punched the air as he called it an historic day for the nation…

This belongs to us all. This is Australia – fair, diverse, loving and filled with respect for every one of us. This has been a great, unifying day in our history.” Later Mr Turnbull put the momentous social reform in the same category as the 1967 referendum to count Indigenous people in the census and said he was proud it occurred under his leadership.

The first same sex marriages took place on the 16th December 2017.

Margaret McLelland (Australia)

REPRESENTATION OF WOMEN IN SOCIETY

Although men can also be sexualised and treated badly it is women who have historically been used and abused for their sexuality.

The issue of using attractive scantily clad women, often in sexually provocative poses, has also been raised recently within male dominated and macho image sports in Western countries. Managements are axing roles such as hostesses, cheerleaders, podium girls etc. citing that these embellishments are no longer in keeping with societal expectations of how women should be viewed.

There is possibly a change in public sentiment taking place in Western culture with perhaps a decrease in sex and female sensuality selling everything from toothpaste to sport.

Where the balance will be reached between appreciation of aesthetics and beauty , and “correctness” of behaviour between the sexes only time will tell.

A Population Based Epidemiologic Study of Female Sexual Dysfunction Risk in Mainland China: Prevalence and Predictors

Zhang C, Tong J, Zhu L, et al.
The Journal Of Sexual Medicine [J Sex Med] 2017 Nov; Vol. 14 (11), pp. 1348-1356.
DOI:10.1016/j.jsxm.2017.08.012, PMID: 29110805

Abstract:
Background: Epidemiologic data on female sexual dysfunction in China are sparse.
Aim: To assess the prevalence of risk of female sexual dysfunction in mainland China and its regional and sociodemographic variations and physiologic, pathologic, and behavioral risk factors.
Methods: A survey of the general female population was conducted in mainland China from February 2014 through January 2016. Women were randomly selected using multistage, stratified, cluster sampling. The prevalence rate of sexual dysfunction, as measured by the Female Sexual Function Index and ascore lower than 23.45 as the cutoff threshold, was determined. Multivariate logistical regression models were used to examine the effects of sociodemographic, physiologic, pathologic, and behavioral factors on women's risk of experiencing sexual dysfunction and domain-specific sexualproblems.
Outcomes: The questionnaire on sexual dysfunction was completed by 25,446 women 20 to 70 years old.
Results: The prevalence of sexual dysfunction in women 20 to 70 years old in mainland China was estimated at 29.7% (99% CI = 28.9-30.4), with large regional variations. The prevalence rates of potential domain-specific sexual problems were 21.6% (99% CI = 20.9-22.2) for low desire, 21.5 (99% CI = 20.8-22.2) for arousal disorder, 18.9% (99% CI = 18.3-19.6) for lubrication disorder, 27.9% (99% CI = 27.2-28.7) for orgasm disorder, and 14.1% (99% CI = 13.6-14.7) for sexual pain. Higher educational attainment and urban residency were associated with a decreased risk of sexual dysfunction. Women of ethnic minorities (or non-Han ethnicity) had fewer reports of sexual dysfunction than women of Han ethnicity (odds ratio = 0.67, 99% CI = 0.47-0.97). Diabetes, cancers, pelvic inflammatory disease, and pelvic organ prolapse significantly increased the reports of sexual dysfunction.
Clinical Translation: This survey provided the prevalence and risk factors of female sexual dysfunction in China, information that could be useful for potential prevention and clinical treatment.
Strengths and Limitations: This is the first large-scale, nationally based epidemiologic study of female sexual dysfunction in mainland China. The limitations of the study design included an overpowered study caused by the large sample, the under-representation of younger and unmarried women, and no information on the women's partners, their values and knowledge, and detailed medical conditions.
Conclusions: The prevalence rate of female sexual dysfunction in mainland China was modest overall, although variations existed across regions and social groups.

Newly diagnosed major depressive disorder and the risk of erectile dysfunction: a population-based cohort study in Taiwan

Huang SS, Lin CH, Chan CH et al
Psychiatry Research [Psychiatry Res] 2013 Dec 15; Vol. 210 (2), pp. 601-6. *Date of Electronic Publication:* 2013 Jul 11.
DOI: 10.1016/j.psychres.2013.06.012, **PMID:** 23850431

Abstract:
Introduction: The primary aim of this study was to explore the incidence rate of erectile dysfunction (ED) among major depressive disorder (MDD) patients in an Asian country. The second aim was to compare the risk of ED in MDD patients that were treated using antidepressants with a high risk-ED, antidepressants with a low risk-ED, or without treatment.
Methods: We identified 4339 male patients with newly diagnosed MDD using the National Health Database. Four matched controls per case were selected for the study.
Results: The mean age of the participants was 42.3 ± 16.9. A higher crude HR of 3.6 (95% CI: 2.8-4.6) was seen in the male patients with MDD. After adjusting for obesity, monthly income, urbanization level, and comorbidity, the MDD patients had a 3.2-fold higher HR for an ED diagnosis than the controls. Patients with untreated depression had the highest risk of ED, compared to the control group (HR=3.9). Patients treated with IHiRA had a medium risk of developing ED (HR=3.6), and patients treated with ILoRA had the lowest risk of ED (HR: 2.5).
Conclusion: This prospective cohort study found an association between ED and prior MDD. Patients with untreated depression may have the highest risk of developing ED.

Invitation to participate

Our region, Asia covers a wide area and many diverse cultures. In order to achieve our goals of increasing the sexual well-being of our region we need to unite through networking, education and participation in joint ventures. This Newsletter is one way for us to work together in sharing information on activities happening in the region and what individual sexual health professionals are doing.

We ask that all members of AOFS contribute to this newsletter by submitting their country's Sexology Conference and educational meetings information, information on special education/professional development programs, outcomes of sexological or education programs, acknowledgement awards given to members of AOFS, fun activities held by members and anything else that you feel would be of interest to other members of AOFS. Photos are welcome. We are planning 3 editions per year.

Please send contributions to the Newsletter to Margaret Redelman at:

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Warm regards

Dr Margaret Redelman,OAM

Australia

Editor

Attention all AOFS members attending the ESSM/ISSM Conference in Lisbon

This is an opportunity for AOFS members to meet and form professional relationships.

Please let me know if there is an interest in formally getting together during one of the conference days or going out for dinner together as a group.

I am happy to co-ordinate if people email me their details.

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THE AOFS CONFERENCE IS 'OUR' CONFERENCE.

FOR US TO MEET WITH EACH OTHER TO SHARE KNOWLEDGE AND HIGHLIGHT WHAT IS HAPPENING IN OUR REGION.

PLEASE PARTICIPATE ACTIVELY BY SUBMITTING ABSTRACTS TO PRESENT YOUR WORK .