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SEXUAL PAIN IN PEOPLE OF ALL GENDERS

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[video transcript]

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Dr Pebble Kranz is a family physician menopause medicine and sexual medicine specialist. She graduated from Brown University's medical school and completed residency with the University of Rochester family medicine residency program with a focus on psychosocial aspects of primary care. After serving as residency faculty and a primary care doctor for the University of Rochester, Dr Krantz pursued additional training in sexual menopause and gender medicine, earning fellowships from the European Committee on Sexual Medicine, the International Society for the Study of women's sexual health certification from the menopause society as an expert menopause medicine practitioner, as well as status as an advanced practitioner in optimal sexual experiences group couples therapy. She served on the board of the scientific network on female sexual health and cancer, and is a consultant to the University of Rochester, Pluta Breast Cancer Center's sexual wellness clinic. She is the founder and medical director of the Rochester center for sexual wellness, providing comprehensive care for sexual relational and gender concerns in Western New York. With all of that, welcome, Dr Kranz. Thank you for being here today. Thank you so much, Jessica. I am delighted to be here so I'm going to dive right in, because I have a lot to cover. These are my disclosures, though they don't have anything to do with any of the material I'll be presenting today. I'm hoping that we're going to cover some prevalence definitions common causes of sexual pain across genders. And then I'm going to introduce to you a process of care for assessment and treatment of sexual pain. And then we're going to learn some first aid for sexual pain. So first overall, what is it that we're talking about? Pain in the genital or pelvic region can be either generalized all the time or provoked having certain triggers. This we're looking at as a chronic issue lasting more than three months, shorter term, more acute issues with pain in the genitals and the pelvis, we are not going to be covering today, and this generalized pelvic pain, as well as sexual pain, has a profound impact on so many areas of a person's life, including their sense of identity, their sense of self. It certainly has sexual pain. Has an impact within relationships. It also has an impact on the relationship with the health care system, because, as we'll see, there is such frustration and difficulty getting diagnosis and effective treatment plans with genital pelvic pain and sexual pain, and it affects how we perceive of ourselves in our many roles, our roles in terms of relationship, our roles in terms of Family, our roles in terms of culture. It's important to note that sexual pain often overlaps with generalized genital pelvic pain. And while this is an issue that's really more commonly identified in people who experience vaginal receiving sexual play, it occurs in people of all genders and across the lifespan, it is thought to affect up to 28% of people. Though prevalence estimates among a variety of genders and communities are variable, and we have a real difficulty in that often this is a problem, particularly with regard to sexual pain that is not reported. So I'm going to start with talking about cisgender women, because this is really the community of people who have sexual pain about who have the highest prevalence, the highest known prevalence, as

well as we have the most information. So it may be surprising to you to learn that a third of people who cisgender women, who experience sexual pain, never seek help at all, and 50% of those who do seek out help are really disappointed with their experience with the health care system leading to people with sexual pain seeing an average of four to seven health care. Providers before they receive an effective and helpful diagnosis and treatment plan, and it is I do need to recognize that the evaluation of sexual pain as well as the management of it really requires a multidisciplinary, collaborative approach. So why are so many people so dissatisfied? Why are they not seeking help? Well, yes, the evaluation can be complex, and it takes some time, and it requires a multi disciplinary approach, but also, we don't ask about sex in health care enough we don't get enough information about sexual pain to assess an adequate diagnosis. Typically, all that may be asked about sexual pain is whether it's at entry or deep, and as we'll discuss, this is only the beginning of what we may need to know about sexual pain to provide an adequate diagnosis and treatment plan, we also reflexively jump to recommendations about using lubrication for sexual play or simply relaxing or having a glass of wine, And I certainly hope at the end of this time, there will be none of you who leave the assessment and treatment plan for sexual pain there. And why is this? Is this because of our overall discomfort culturally about us discussing sexual concerns. Is it that as healthcare providers or as patients, people are not considering this issue important enough to warrant care, or is this reflective of larger cultural messages around women and suffering? In fact, there is a very wise menopause medicine specialist who became famous in the New York for saying in the New York Times that we have a we culturally have a high tolerance for women's suffering in our culture. Or is it because we simply don't know? We haven't had enough training? And the truth is that it's all of these things. And I hope that after today, you'll leave with some more tools and ideas about how to move forward. So general pelvic pain and sexual pain really is under a bigger umbrella there may there's another condition that you may or may not have heard of, called persistent genital arousal disorder. This is an unwanted, disruptive sense of arousal that occurs in a UN, very uncomfortable way, and maybe accompanied by stress, shame, anxiety about this condition. And then we also have other entities that include other sensations in the genitals, like twitching or itching or numbness in the genitals that can be constant or in episodes. And we in the Sexual Medicine world, we put this condition of persistent genital arousal disorder, as well as the variety of genital pelvic pain and sexual pain conditions, under this umbrella of genital pelvic dysesthesia on the on the side of your screen here. This is a cover of a sexual medicine review this. The image is was created by a patient of Dr Irwin Goldstein, dealing with persistent genital arousal disorder, and describes most articulately what this experience is. This is, this is a very difficult condition. The QR code will lead you to an overview of this condition that may be helpful for patients, as well as sort of a general sense of PE gad. So all of this understanding that really has evolved over the last 10 years and continuing to evolve the this is a research area in the Sexual Medicine world that is quite robust. So in 2021 This led to a consensus paper around this issue of genital pelvic dysesthesia, as well as a process of care. And this really provided us with a new way of seeing this condition that. That was really helpful,

because it breaks it down by sources etiologies of this pain and disesthesia that are delineated by these five regions and that are overall influenced by psychosocial contributors and additional CO morbid factors. Now we are not going to go into each of these issues in depth. I'm going to really be focusing on the most common causes of genital pelvic dysesthesia and the things that I see most commonly in my practice largely focus around end organ issues, as well as overactive, hypertonic pelvic floor muscle dysfunction. And these are all things, these end organ issues that contribute to genital pelvic dysesthesia, these pelvis issues that contributed to genital pelvic dysesthesia. These are things that we really can all be providing care for in general medical practice, and as you'll see, this does have influence on how we view sexual pain in people of genders, aside from cisgender women, but this is the structure that was developed for understanding this, primarily with regard to people With vulvas and vaginas. So this just is my my husband gives me a really hard time when I put up a slide like this. I'm I'm not going to go through all of these things. I just want you to get a sense of this process of care, so that if you want to seek it out, you will know that it covers a lot of issues. It also allows us to really focus in on what a history, what history is necessary, what physical exam may be necessary, some testing that may be useful, as well as as of 2021, expert opinion on what treatments should be for these variety of issues. But we're going to talk about this in sort of a boiled down kind of way. So I think about this as sort of a review of systems. When somebody is coming to me for genital pelvic dysesthesia or sexual pain. Is there an issue that has to do with the skin? Is there an issue that has to do with the organ in the pelvis? Is there an issue having to do with the nerves or the nervous system, or is this also a pelvic floor muscle issue, or, independently, a pelvic floor muscle issue? And how does psychosocial concerns influence this pain? I want to take a moment here to emphasize that older ideas of what caused sexual pain, that sexual pain might be caused by trauma or might be caused by anxiety or a history of sexual abuse. We really know more now that sexual pain is always rooted in an experience in the body. It is not something that is generated only from anxiety or trauma or the brain, though, certainly, those aspects of the pain can influence aspects of sexual pain, the information, the basic information that we need every time we're assessing sexual pain includes, where Does the pain occur, exactly, and when does it occur? Exactly what kinds of sexual play are involved, and sometimes it's necessary to really help people understand how to articulate the wide variety of sexual play. If it's somebody who engages in penis, vagina, sexual play, I will say, is this something that occurs only in penis, vagina, sexual play. Is it pain that occurs with any touch of the vulva? Is it pain that occurs with any receiving into the vagina? Is it pain that occurs with anal receiving? Is it pain that occurs with sitting on a hard surface? So we really need to get a lot more information about the pain. Of course, we need to know about the nature of the pain, and it's important to assess when the pain occurs. What is your own response that. Do you have a sense of increased anxiety, worry that this is never going to resolve, a sense of hopelessness. What is your own emotional response? Do you stop sexual engagement completely, or are you attempting to continue to engage in sexual play despite the pain, and then it's also helpful to assess what partners responses are, as we'll discuss a little bit further. I hope partner responses have a large impact

on sexual pain, as well as on many other aspects of sexual function. So we're going to talk first about the surface skin issues. And I just want to make sure we're all on the same page with regard to the kinds of skin we're talking about here when we're talking about people with vulvas. So the vulva is, of course, everything exteriorly to the vaginal canal, and it includes the clitoral head, the outer labia, the inner labia and inside the inner labia, where there is a color change at heart slime. This is a part of the skin called the vestibule. And when it comes to sexual pain, this vulvar vestibule skin is very important. So of course, hormonal shifts of many kinds, related to pregnancy or lactation, related to menopause, related to many medications, can have an impact on the vulvar skin and this vestibule skin medications that cause dryness of all kinds, take Paxil as a mood medication that causes a generalized dryness or antihistamines can also cause skin issues at the surface level of the vulva. Certainly, infections that become recurrent or chronic can have an impact on the skin. And then we have a variety of vulvar Dermatoses, things like lichen sclerosus, lichen erosive plaintiffs, that can affect the vulva and the vestibule skin, and then we also have vaginal skin conditions like desquamative vaginosis and other chronic vaginitis problems, autoimmune problems that cause drying, like shogrens, for example, can affect this skin, as well as pelvic radiation, for any cause, whether or not is it is to the vaginal skin directly, can cause changes to the vulvar and vaginal skin, and sometimes there are skin changes that we have don't have a reason for understanding why skin has changed, but these other things are really quite common. So the first thing we need to do to assess this is examine the vulva. We often treat the vulva as sort of flyover territory when it comes to pelvic exam for somebody with a vulva and a vagina are when we're thinking about a sexual concern, we don't need to see the cervix. It's usually not about that. It is really about examining the vulva closely. And this is Dr Rachel Rubin. She's a urologist who specializes in sexual medicine and people of all genders, she has a wonderful video on how to examine the vulva. I also want to point out for you the fact that Dr Rubin here is using a mirror, and this is something I do in my exams as well, so that we can have a shared conversation about this part of the body, both for educational reasons as well as with regard to treatment. If the if I want a cream to be applied some place, I want my patient to know, both visually and by touch, where that cream is to be applied. So we're going to dive into some first aid for bulbar and vaginal skin. And these are some really simple things that we are just not taught. At least as a person with a vulva, just not taught to take care of this skin. And so one of the things that's important to think about in our culture, where we get really sort of obsessed with hygiene and not having smells and using all kinds of products on the body, it's helpful to remember that. At the skin of the outer labia, the skin of the mons, the skin that's designed by nature with hair and sweat glands. This skin can take soap and scrubbing. The skin of the inner labia, the skin of the clitoral hood, the skin of the vestibule. This is like lip skin and skin just inside the mouth. This is skin that cannot take scrubbing and regular application of soap, particularly when it is delicate. We also, so I tell people, water in a hand, that is all that's necessary to clean those thin skins. We also need to be aware of pads and panty liners worn on a regular basis. These are products that wick moisture away from the skin, and that's exactly what they're going to do. We also need to take care with urine against this skin

chronically, because this too is drying and irritating to the skin. When we have chapped lips, we use a moisture barrier. We use some chapstick. And this is true of that this vulvar thin skin as well, and the vulvar moisture barriers that work the best are actually natural oils, olive oil, coconut oil, same stuff as is in the kitchen, and you're not dousing yourself like a salad, you're just taking a little bit of oil and putting it on those thin skins of the vulva. We also need to, of course, treat vulvar and vestibular conditions that are observed, for instance, genitourinary syndrome of menopause lactation or other kinds of hormone deficiency related to medications or cancer treatments, this must be treated and topical estrogen, which we'll talk about in a minute, is an excellent treatment. And very, very few people should be careful, and mostly people should feel very free to use topical estrogens. We also need to treat vulvar Dermatoses, vulvar skin conditions. We also need to think about vaginal skin care. We've finally gotten the message, no douching, and that is good news. But we also need to treat vaginal pathologies, again, genital urinary syndromes of hormone deficiency as well as chronic infections. Um, now one of the things that I will just share with you, we're going to talk a little bit more about vaginal estrogen in a moment. But what is very important with the use of vaginal estrogen is often we're not starting people with a loading dose where the skin is getting a higher amount of that estrogen initially. So initially, vaginal estrogen should be used every night for two weeks, and then we can spread out to two to three times a week. If somebody has been on vaginal estrogen and has not at a two to three time a week interval and has not found it helpful, it's likely that a loading dose may have a different impact. We, of course, can use vaginal moisturizers that are non hormonal, if one is unable or unwilling to use vaginal estrogen, but again, we need that loading dose, and then we can spread out. It's also important to note, when we're thinking of a vaginal moisturizer, that it needs to be the right pH and osmolality in order to be moisturizing to this skin. The many of the products are pH balanced that are available, but very few have an appropriate osmolality. With an osmolality of above 1200 we can expect that these products are going to be pulling moisture out of these vaginal skin cells, causing vaginal skill to skin disruption and and and apoptosis and so working against so some of the products that are most common out there, like replens, has osmolality of above 2000 so when somebody says to me, I've used replens, I've used a vaginal moisturizer. It doesn't work. I say no kidding. Let's find one that does. So let's talk about vaginal estrogen for a minute. We're talking about topical estrogen, not systemic estrogen. This topical estrogen causes skin regeneration. It increases the rugae, the pleats in the vaginal canal skin. It increases elasticity of skin. It lowers the pH to be that pre menopausal level that is more helpful for preventing infection. It certainly decreases vulvar and vaginal dryness, both generalized as well as in. An arousal situation, it increases one's vibratory sensation, and particularly after pelvic radiation. This is a very useful tool. It's important for you to know when somebody is using vaginal estrogen, it causes increase in in systemic estradiol levels of between four and eight picograms. So the average post menopausal level is less than 30 This is a very small amount. An annual dose of estradiol from a topical product used as directed is equivalent to about one typical birth control pill a year. This is a very, very low amount of systemic estrogen that is being provided. It's important to know that not all topical

estrogens are the same. We have a wide variety of ways to provide topical estrogen, and when and where and how it's applied is going to have an impact on absorption so on the vulvar skin, which is usually the place that sexual pain is most notable, there is a very, very little systemic absorption. And the impact of treating genital urinary syndrome of menopause or other low hormone states is profound, not only in terms of comfort and sex, but in terms of preventing recurrent UTIs and even preventing urosepsis. There is evidence that it has an impact on mortality, but we have this 2003 black box warning on every estrogen product that it causes uterine cancer, strokes, blood clots, heart attacks, dementia, breast cancer. And for most people, when they open a package insert without a warning, they're terrified. But we have loads and loads of data that indicates this is not the case, especially for topical estrogen. So we do have a campaign to attempt to remove this black box warning from these topical products, and if you are interested in being a part of this really important change, not only for the well being of people with vulvas and vagina vaginas, but also mortality. Scan the QR code and consider adding your name to this campaign. Certainly, moisture for sex, lubrication is important, and what I tell people is, use it often and use plenty and nothing fancy, no sparkles, heating, cooling. There are all kinds of different types of lubricants for sexual play, and somebody may want a variety of types for a variety of different settings. Water Based should be appropriate. PH and osmolality still a cone. Ones are the only caution is that they shouldn't be used with silicone sexual aids and oil based there's some concern about its use with condom and we don't use oils in the vagina on a regular basis as a moisturizer, for example, because it can contribute to the creation of a biofilm in the vaginal canal. Here's another point for first aid. Arousal is healing, arousal of any kind, and there are all kinds of ways to bring blood flow to the vulvar and the vaginal skin vibrators, simply by the act of vibration, are helpful, as well as any other kind of sexual aid. Both solo and partner play are helpful, but we must caution people to avoid the painful sexual play, because as we'll discuss, that can lead us into other problems. Now we're going to talk about some other contributors to sexual pain that are not as common but can be quite impactful, and one of these is the use of anti androgens and oral contraceptives that are including both estrogens and progesterones and their impact on vulvar vestibule skin, we have some evidence that the age of starting oral contraceptive can increase the risk for vulvar vestibule pain, with people who are started earlier in life having a somewhat higher risk, and this is more common with anti androgenic oral contraceptives, think Yaz and Yasmin and low dose oral contraceptives. And it's also seen with very commonly used anti androgenic. Medications, for instance, pironolactone, given out sort of like candy in dermatology practices. And it's important for you to know that this vulvar vestibule depends on androgens. This is not just an estrogen dependent skin. This skin has a large number of androgen receptors because of its embryonic origin. And so what we see is that some people this on on the side here is healthy vestibule skin, and here in the red the reddened area is a vestibule that has been impacted by an anti androgenic environment with redness around vestibular glands and on either side of the urethra. These are particularly androgen dependent tissues, and what we see is that some people are prone to this, and some people may need more androgen than other people. Um, so

not everybody who goes on an anti androgenic oral contraceptive or Spironolactone is going to have this problem, but there are some who will. How do we deal with this? Well, we remove those anti androgenic medications, if it's possible, and then we have some FDA approved alternatives, which would include, first a trial of estradiol. But as you might be thinking, if this is an androgen dependent tissue, it is unlikely to respond to estradiol alone. And we do have a DHEA suppository prosterone, which is FDA approved for introidal dyspareunia, that will provide both the substrate for the estrogens and the androgens that are needed. Also sometimes expert opinion in sexual medicine circles, we will use a testosterone, estrogen compounded cream. We don't have a an FDA approved product that includes topical testosterone appropriate for vulvar skin, and this is a very low, low dose both estrogen and testosterone used on that vulvar vestibule skin. We typically see improvements in about three months, but some people take a longer time to improve, and this is thought to be because there's some down regulation of androgen receptors in this tissue that takes some time to allow the skin to respond to the testosterone or the DHEA. I want to bring to your attention clitoral pain. This is often described as a grain of sand. It can feel like hypersensitivity of the clitoris or a sense of persistent arousal. And this can be caused by keratin pearls, these tiny nodules of sloughed skin and adhesions of the clitoral hood to the clitoral head skin. And this, of course, examines require, requires examination of the clitoral skin in order to assess. And there are some, increasingly some good articles about clitoral adhesion, sort of grading them, and some indications for releasing clitoral adhesions and removing of of these keratin pearls. And at a first stage, when there are mild clitoral heat adhesions, when about 75% of the glands of the clitoris is visualized, then sometimes retraction with a steroid or a hormone cream can be useful. But if it's more moderate or severe, clitoral adhesions, as you can see in these two lower pictures, then there may be consideration of a lysis of adhesions procedure. This is an office procedure that doesn't involve any cutting, but it's important before somebody has this procedure that their vulvar skin is in as good condition as possible, and sometimes it's necessary to create a dorsal slit in order to free the clitoral glands, then we have nerve issues that can contribute to sexual pain. So nerves that go to the vulva or the genitals can become injured or compressed. For instance, in pudendal neuralgia, or some people develop more nerves, they develop neuroproliferation on the skin of the vulva. This is sometimes congenital, or it's sometimes related to chronic inflammation. So inflammation leaves. To neurogenesis and nerve proliferation. We've seen it in a number of different inflammatory conditions, and this, as I was saying, is a divided and congenital and acquired. Acquired causes of this neuroproliferation are thought to be chronic infections, chronic allergic reactions, vaginal there, there may be vaginal discharge, there may not be and what we see on pathology is increased inflammatory markers, increased mast cells. Now the treatments for this, there are no FDA approved products. These are all experimental or expert opinion treatments. Antifungals have pluses and minuses because oftentimes people have an in while they're having an effective response at decreasing the yeast burden, they may be having an inflammatory response to some of the other components of these anti fungal topical creams. There have been, there's been investigation of interferon, of Montelukast, and of other mast cell

stabilizers and antihistamines, and we have in the falsetto lab at the University of Rochester, some really exciting research on inflammatory markers, of these specialized pro resolving mediators that may be a key to dealing with this neuroproliferation associated vulvar vestibule pain. Those people who have vulvar vestibule pain from the time of birth, what we see on pathology is increased C afferent nociceptors, and interestingly, 60% of the folks with that are determined To have congenital neuroproliferative vestibulodynia may have umbilical hypersensitivity. Again, all of these treatments are expert opinion, topical gabapentin, capsaicin and a vestibulectomy, which is a surgery, topical lidocaine. I have very mixed feelings about when it comes to sexual play, because one of the things that we want to do is to allow for pleasure, and if we're numbing that skin, we may be able to accomplish vaginal receiving, but we may be inhibiting pleasure. I just want to touch on very briefly, these scent. There's some central nervous system causes of genital pelvic dysesthesia, with a particular attention to connective tissue disorders. Your patients with Ehlers, danlos or marfans have a very high rate of pelvic pain, as well as a very high rate of sexual pain as compared to their peers. Now, we of course, have some organ causes of genital pelvic pain, endometriosis, we're going to talk a little bit about, but also things that have to do with the bladder have to do with the pelvis overall, as well as bowel diseases. Endometriosis and sexual pain is a complicated relationship. 79% of those with endometriosis have dyspareunia, typically thought of as deep dyspareunia, but they may have superficial dyspareunia as well, and this endometriosis can be anywhere and causing all kinds of pain related to overall restriction of movement within the pelvis or implants throughout the pelvis, and can contribute to other pain syndromes as well. So we need to think about the fact that chronic pain of endometriosis can cause secondary pelvic pelvic pain issues, myofascial pelvic pain that contributes to sexual pain. And the treatments that we use for endometriosis can be hormone deficiency medications causing other kinds of surface layer sexual pain. So we need to think, is the endometriosis directly causing the pain? Is it an indirect causing, the cause of the pain, or is it an innocent bystander? I also want to note that among trans masculine folks, we do, we have a data that shows a higher prevalence than among cisgender women with a prevalence of endometriosis of about 10% among cisgender women with 25% among cisgen among transgender men. And this is complicated, because often we think when testosterone. People are amenorrhea, but there are some who have heavy menses and dysmenorrhea, and we don't have evidence that testosterone therapy always leads to decreased endometrial growth. Ovarian function is not entirely suppressed. We have and we have aromatization of testosterone to estrogen, which can create endometrial proliferation. We also see this very high rate of pelvic pain, both cyclic and constant among trans masculine folks, and real problems with diagnosis. There are delays in care for this, certainly access issues with regard to not having gender affirming resources to and practices to have this dealt with. And this has led to a recommendation that for anybody who does have a gender affirming hysterectomy, which, as you know, is not every trans masculine person, they should have a careful assessment of the entire abdominal cavity for endometrial endometriosis implants. Now, how do we address pain with endometriosis? Well, first off, the endometriosis needs to be

adequately treated. And the gold standard for treatment, of course, is ablation, but sometimes progestin can be used to stabilize endometrial implants, implants the use of selective estrogen receptor modulators or aromatase inhibitors and GnRH agonists. But it's the key thing is that endometriosis must be controlled. We need to address the sexual side effects of the treatments for endometriosis, and always include pelvic floor physical therapy in the treatment here, when that's acceptable to a patient, pain, education is important, really dealing with the thoughts about pain and expansion of the sexual script, really moving beyond just for a heterosexual or a vaginal receiving sexual for vaginal Receiving sexual play to the wide variety of sexual play that is possible, and then this on the screen, here you see a very helpful tool, vaginal bumpers. This is a set of stretchy silicon rings that can be placed over the base of an penis or the base of a toy and limits the depth of receiving and this is an incredibly helpful tool to know about. Now it's important to recognize that most sexual pain is multi layered, and we may have these skin issues and these deeper pain from organs or this nerve issue, and then that may be complicated by those pain issues contributing to myofascial pelvic floor muscle pain or tightness, the pelvic floor muscles in people of all genders have an anterior compartment here that's more superficial, and a posterior compartment that's deeper. These are the muscles that hold up everything in the pelvis and go from the tailbone to the pubic bone and hip to hip. These are busy muscles. They have a lot to do in addition to supporting the pelvic organs. They control our bladder and bowel function. They control our elimination. They have to do with sex and people in all people who have a pelvic floor, which is all, pretty much all of us, and it's involved in breathing, the the little video on the side of the screen shows you how the pelvic floor muscles move with an inspiration and with expiration. And of course, they have a role in pregnancy and childbirth. So myofascial, pelvic pain, hypertonic pelvic floor pain, also called levator ani syndrome, sometimes these this has a variety of consequences, including pain with vaginal receiving, persistent unwanted arousal like P gad or decreased arousal or soreness after vaginal receiving or after having orgasm. And what we see is that these things are in a relationship. One can have a myofascial pelvic floor pain that leads to sexual pain, but then re experiencing sexual pain leads to more guarding and myofascial pelvic floor pain the. Diagnosis for this is with a single digit examination via the vagina and a close history. And this is a kind of exam, this palpation of the individual pelvic floor muscles that often we aren't taught in general care, pelvic care. But this is an important kind of exam to learn. I also just want to give a flash here to the really critical importance, particularly with people who have genital pelvic pain or sexual pain, that a trauma informed pelvic exam is critical with a real assessment of past trauma with pelvic exams or past trauma with medical care, a shared understanding of what happens when the person who is having the pelvic exam has anxiety, the mental aspects of it. Do they become dizzy and foggy, or do they pass out and the somatic aspects of it? Do they have guarding? Do they have stomach pain? Do they have chest pain and palpitations, and then working together, before the exam begins, to establish tools for dealing with this anxiety and stress before the exam occurs, and planning for the emergence of trauma responses during a pelvic exam, I say to people you, if you do anything to advocate for yourself during this pelvic exam, I will applaud

and bend over backward to make it happen. And this is a really important piece we really need to support agency empowerment and really think about our attitude when it comes to a pelvic exam. It's always got to be about the patient's comfort, not ours as medical providers. So there are all kinds of treatment options for myofascial sexual pain. We try to avoid triggers as one is able. Dilators, vaginal inserts and pelvic floor physical therapy are incredibly useful for anybody who desires receptive vaginal sex, but everybody else too. People need specific dilator instructions, simply saying, giving a suggestion to use dilators is not adequate, though many of the companies that produce dilators have some very good videos online. It's important for people to know that they may require pelvic floor PT and dilator use in the long term, that if they go a period of time without attending to their pelvic floor muscles, even after they've gotten back to comfortable sexual play and no pelvic floor hypertonia, they may take a step back and need to get back into care. It's important for use of dilators to not be painful. This process is giving evidence to the body as well as the mind, that something in the vagina is comfortable and it's also stretching muscles, but that evidence for the body and mind is important. As medical providers, we need really need to master the art of the pelvic floor PT referral. People need to be prepared that pelvic floor PT is an excellent resource with an additional layer of expertise beyond general physical therapy and that there is an external evaluation and when the patient is comfortable, an internal evaluation as well. Most pelvic floor PT providers use a careful, trauma informed approach, which is important for you to know, medications can be used as adjuncts for pelvic floor PT. When things aren't moving along, muscle relaxes, either as suppositories or orally or injections, Botox injections, trigger point injections, these can be helpful if pelvic floor PT doesn't seem to be moving along the way that it might. Among trans men, we have a very high prevalence of vulvovaginal sexual pain. In some articles, up to 60% experience vulvovaginal sexual pain. Other data indicate that between 23 and 72% of assigned female at birth transgender folks experience pelvic pain. This is related in part, to testosterone use, though it can have. Other causes. Testosterone, of course, has a wide variety of positive sexual impact for trans masculine individuals, more interest in sexual activity, easier to orgasm for many, but also more vaginal pain or discomfort during sexual play. So we need to think about testosterone induced changes to the skin, pelvic floor, muscle dysfunction, as we discussed before, endometriosis and then also psychosocial contributors that can that can have an influence on this as well. Our overall approach is similar to among cis women, with the advice for topical moisturizing and lubricants, as well as the use of topical estrogens. Externally, estradiol can be used or conjugated equine estrogens, Premarin, as well as internally, depending on the kind of sexual play that they're doing, as well as the where they're having pain, prosterone, also the DHEA suppository can be very helpful. And then, of course, we need adequate treatment of endometriosis among trans women. We also see a pretty high prevalence of sexual pain among those who have had no treatment, among those who have had hormone therapy, as well as among those who have had vaginoplasty, and sometimes for those simply on hormone therapy, scrotal pain can be related to tucking pain can be traumatic, mechanical or related to nerve function, and we can advise shorter periods of tucking or looser looser binding

equipment and consideration of orchiectomy and other bottom surgeries. If this is a really important driver of dysphoria for a person, we do see some genital pain related to the onset of estrogen. This is of unknown etiology. It's generally benign. It generally improves spontaneously. Vaginoplasty is can be challenging. The this is a very medicalized part of the body. They can't have any sexual play in the vagina or even oral sex for at least minimum of three months post op, and the dilation schedule required is demanding and time intensive, with a lot of discomfort, stress and pain, and very rarely are people provided with resources to help bridge the gap between dilation and sexual function pelvic floor. PT, here is an amazing tool, and we need to remember that the vaginal canal, Neo vaginal canal, is not a mucosal surface, and its needs are different from a natal vagina with some different flora and discharge, maybe due to other causes and lubricant is really critical. And the thing here to remember is that with a NEO vagina, water based lubricant is the lubricant that one should be using for vaginal sexual play, not silicone, because a non mucosal surface is not going to allow that silicone to slough away the way that It does in a natal vagina. So we have causes of chronic sexual pain in people with penises too, beyond those in trans women, there can be a variety of symptoms here. The prevalence is thought to be less than 5% but this, among these people, this causes a lot of distress. And my approach to this is sort of a similar assessment. I'm thinking of skin and organs and muscles and nerves and psychosocial contributors. I we have chronic prostatitis, chronic pelvic pain syndrome, as well as peronis disease, which is a disruption of the Tunica, albuginea and the fascia of the penile shaft, certainly other skin issues, phymosis, ballets, paraphymosis can have an impact on sexual pain as well as anything going on in the pelvis, including hernias, scar tissue related to chronic inflammatory bowel disease or pelvic floor dysfunction, just like we have in people with vulvas and vaginas, there is newly recognized issue called Hard flaccid syndrome among the urology community. Though this is newly understood, this is. Pretty of the closest correlate of P Gad and genital pelvic dysesthesia. What happens is there is a shortened, sort of a turtled penile shaft that is non compressible, hard and tender, where there can be loss of sensation, especially in the glands as well as Ed and dysuria. The way to approach this is similar. So I also have some information here about receptive anal intercourse, because penises and vaginas are not the only places we have sex and the only places we can have sexual pain, but I'm not going to go into this, except to say that analgesparuni is as pretty prevalent, as well as anal intercourse being prevalent. And we have some new information about an understanding of the kinds of painful sensation people feel and the kinds of pleasurable sensation that people feel with anal intercourse, our treatment for anal dyspareunia really involves addressing anal skin concerns, use of adequate and right kind of lube, addressing a pelvic Floor issues with dilators or PT and reducing anxiety. I am going to skip these next few slides, except for these, some tips that it's helpful for us to really think about expanding the sexual script, working on enhancing sexual flexibility, rather than goal oriented sex, really allowing people to focus on enjoyment and pleasure, and allowing receiving or penetration of any kind only when the receiving partner is sexually aroused Enough. It's also important to note that we must stop having painful sexual play, because when we engage in a repeated painful sexual play, this may increase our anxiety,

decrease arousal, increase muscle tension, cause more pain and cause more both anticipation of pain and avoidance of pleasurable sexual play, which is an important component. Multidisciplinary care is critical here, and you may need to involve pain specialists, sexual medicine specialists, behavioral health specialists of a variety of kind, as well as our pelvic floor PT partners. These are some selected resources for further exploration. And I am so honored to have had a chance to talk with you today. I hope we have a few minutes for questions. Thanks so much. Thank

57:57
you very much. Dr Krantz, that was really comprehensive. You had a lot of comments and questions coming in, some of them you've already addressed, like after the comment came in, but I just want to bring up a couple. One was when you talked about olive oil and coconut oil. Could this lead to yeast infections or BV? And that was, you were referring to vulvar skin.

58:21
That's right, yes. So on that vulvar skin not associated with with infection, not not as associated with creating a biofilm as it can be within the vaginal canal, because it's likely to get friction. It's likely to be rubbed off, and it's not going to be there for a long time,

58:48
right? And then you refer to a number of creams, and someone's asked, Are these over the counter or by prescription only?

58:57
Are we talking about like estrogen creams?

59:00
I think that's when it came

59:04
these are, these are, these are prescription creams. All the hormonal creams are prescription creams.

59:14
And then going to the bottom of the chat, someone brings up they have a gender diverse patients who would benefit from pelvic floor therapy, but it's very hard to find therapists. So I don't know if on your resources here, if there's something that you could direct people to specifically looking for pelvic floor therapy. So

59:35
this is a hard thing. I have had this. You know, in my own community, I know my pelvic floor PTS who are trans affirming, and because I've talked to them all, and I, you know, I sort of vet them for my clients. And I've had situations where I have a client moving to Atlanta, and I don't know who the. A trans, affirming pelvic floor PTS are in that other community. It really requires finding somebody who is you know, you can look for people in W path who are pelvic floor pts. There are a number of pelvic floor PTS who are members of W path. You can look on the the International Society for the Study of women's sexual health list a number of pelvic floor PTS on this list, but I would advise vetting them for your clients, or encouraging you to reach out to those folks to know who your trans affirming PTS are, because this is, this is a challenging kind of treatment to engage in for a lot of gender diverse folks, Very can be very gender dysphoric,

1:01:02
and then the same question they referred they've heard of telemedicine options for pelvic floor therapy. The question how beneficial that might be, right?

1:01:11
So, so there are some online options, and some, actually some pretty good YouTube videos for some of the stretches, but unless it is, unless you are having a pelvic floor PT do the internal work to help muscles release, as well as identifying trigger points that One can then use tools at home, like pelvic wands to release it is, it is challenging. I always tell people, you know, I can, I can give you online resources. It's just not going to work as well. And I'm having a menopausal brain moment. There's pelvic sense, this is largely focused at cisgender women. And then there's, I think there's still pelvic gym, which is also pretty much folks focused on cisgender women. Not many that I know of. I would love to know if you know of online gender affirming pelvic floor PT programs, please, please, let me know.

1:02:28
Maybe we'll take one more. You referenced many women wear pads or panty liners for urine leaks, and if this can cause dryness, do you have another suggestion?

1:02:42
Yeah, so I suggest bringing an extra pair of cotton underwear around with you, wherever you go and not, and trying not to use those, those pads and panty liners, if somebody is using pads and panty liners, then I am going to encourage them hard to use a moisture barrier, because this can help and sometimes applying it several times a day. Somebody mentioned in the chat I just looked at, mentioned Heather Howard's work, as she is a sex educator, and her her resources online are are truly excellent, marvelous. Thank you so much for the opportunity. I appreciate you all for caring about this.

1:03:39
Okay, thanks so much. Thank you, everyone.

[End Transcript]