Independent learning program for GPs

Unit 537 April 2017

Sexual health

www.racgp.org.au/check
The five domains of general practice

- Communication skills and the patient–doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions
ABOUT THIS ACTIVITY

The management of sexual health in Australian general practice includes the patient’s physical, emotional, mental and social wellbeing regarding sexuality. Sexual health presentations are common in Australian general practice, and can range from conditions affecting the genitourinary system to family planning and contraception.¹

It is important for general practitioners (GPs) to know and understand the advantages and disadvantages of the various options for contraception and when this can be stopped when a woman reaches menopause.²

Urethritis involves the inflammation of the urethra and can present as urethral discomfort, discharge and/or dysuria.³

The sexual interests of men and women can be affected by a range of factors, including fatigue⁴ and predictable life stages, including after the birth of a baby or with young children, around menopause⁵ and with increasing age.⁶,⁷

Women aged 25–74 years will soon undertake five-yearly testing for human papillomavirus, which is estimated to reduce the number of cervical cancers by 15%.⁸

Premature ejaculation is one of the most common sexual dysfunctions among men, affecting an estimated 21–31% of Australian men.⁹

This edition of check considers the management of various sexual health conditions in general practice.

LEARNING OUTCOMES

At the end of this activity, participants will be able to:

• provide contraceptive advice for perimenopausal women
• outline the assessment and management of patients with urethritis
• discuss approaches to assessing lack of libido in women
• describe the management of patients with premature ejaculation
• summarise the changes to cervical screening.

AUTHORS

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REFERENCES

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<td>COCP</td>
<td>combined oral contraceptive pill</td>
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<td>CST</td>
<td>cervical screening test</td>
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<td>DMPA</td>
<td>depomedroxyprogesterone acetate</td>
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<td>DSM-5</td>
<td>Diagnostic and statistical manual of mental disorders, fifth edition</td>
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<td>ENG</td>
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<td>follicle stimulating hormone</td>
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<td>high-grade squamous intraepithelial lesion</td>
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<td>IELT</td>
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<td>LDPOC</td>
<td>lower dose progesterone only contraceptives</td>
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<td>LLETZ</td>
<td>large loop excision of the transformation zone</td>
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<td>lack of libido</td>
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<td>low-grade intraepithelial squamous lesion</td>
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<td>male hypoactive sexual desire disorder</td>
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<td>NCSP</td>
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<td>non-gonococcal urethritis</td>
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<td>RACGP</td>
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<td>SSRIs</td>
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<td>Therapeutic Goods Administration</td>
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<td>TOC</td>
<td>test of cure</td>
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<td>UK Medical Eligibility Criteria</td>
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CASE 1

GEMMA COMES TO SEE YOU

Gemma, aged 50 years, comes to see you for advice. She saw her usual general practitioner (GP) about two months ago because her etonogestrel (ENG) implant was due to expire in six weeks. Gemma has been amenorrhoeic since her first implant was inserted almost six years ago. Her GP ordered a follicle stimulating hormone (FSH) blood test, which showed an FSH level of 75 IU/L. He advised her that the implant should be removed and not replaced because she is postmenopausal and the hormones are harmful.

QUESTION 1

What additional history will you elicit?

FURTHER INFORMATION

Gemma tells you that she has no significant past history, is in good health, and takes no other medication. Her alcohol intake is within recommended guidelines but she smokes 12 cigarettes per day and is trying to quit.

Her mother’s menopause was around the age of 51 years. Occasionally, Gemma has hot flushes, but these are not bothersome or persistent.

Gemma’s regular partner, and the father of her daughter, separated six months ago. She has a ‘mate’, a man with whom she had sexual intercourse six weeks ago.

Gemma changed from the combined oral contraceptive pill (COCP) to the ENG implant on the recommendation of her GP as she was older than 40 years of age and continued to smoke. Her current implant is her second one. Gemma is very happy with the ENG implant and is concerned about having it discontinued. Her mother had ‘dreadful’ periods as she approached menopause and Gemma is very happy that she has not has any periods since she started using the ENG implant.

Gemma tells you that it is very important for her not to get pregnant as she is currently unemployed and is hoping to get a job. She is also helping to care for her mother, who has breast cancer, and provides support for her daughter, who is a single parent.

Gemma’s only child was born vaginally 21 years ago after an uncomplicated pregnancy. Cervical screening and mammograms are up-to-date and have always been normal.

On examination, Gemma’s blood pressure is 125/80 mmHg and her body mass index (BMI) is 24 kg/m².

QUESTION 2

In view of Gemma’s sexual history, what additional information and testing may be indicated?

FURTHER INFORMATION

Gemma has never used intravenous drugs. To her knowledge, neither of her partners has used intravenous drugs, had sex with men or come from a high-risk country. Gemma has no symptoms of sexually transmissible infections (STIs), but has had no testing for STIs.

From her history, you recommend chlamydia screening. Gemma elects first-void urine collection in preference to a self-collected vaginal swab. The results are normal; she decides to use condoms in the future.

QUESTION 3

Gemma’s usual GP has stated that her hormonal contraceptive is ‘harmful’. Is he correct?
QUESTION 4
Is Gemma postmenopausal?

FURTHER INFORMATION
As Gemma is amenorrhoeic and her FSH level, when tested previously, 75 IU/L, you requested a second FSH test. She returns to see you a week later for the result, which is 4 IU/L.

QUESTION 5
Is Gemma menopausal?

FURTHER INFORMATION
Gemma would like to continue using the ENG implant for contraception and cycle control, and you proceed to remove the old implant and insert a new one. She is now six weeks overdue for the changeover, but has not had intercourse in more than a week before the old device expired.

QUESTION 7
In view of the delay in inserting the new implant, what recommendation would you give in relation to the onset of effective contraception?
CASE 1

ANSWER 1
Additional history that you will need includes:
- a general medical history, including allergies, medications, smoking, alcohol and other drugs, family history, systems review, social history
- a sexual history, including parity, relationship status and sexual partners, whether Gemma is up to date with screening (cervical screening, breast screening), STIs (if indicated), menopausal symptoms (if any)
- ideas, concerns and expectations for her healthcare.

ANSWER 2
Gemma has had two male partners in the past year, one in the past three months. Additional questions to ask include:
- Has she had any symptoms of STIs?
- Has she ever been tested for STIs?
- Has she ever used intravenous drugs?
- Have her partners had sex with other men, used intravenous drugs or come from a high-risk area for STIs?
Practitioners should not assume that sexual risk-taking is confined to younger patients. Many older people enter new relationships after coming out of longer term monogamous relationships and may need to consider STI screening and use of (male or female) condoms for the prevention of STIs, even when they no longer need contraception.

ANSWER 3
Progestogen-only contraceptives are well studied and there is no conclusive evidence of a link between this type of contraceptive and breast cancer.1,2
Lower dose progesterone-only contraceptives (LDPOCs), including the ENG implant and progestogen-only pill (POP), but not depomedroxyprogesterone acetate (DMPA), do not have a significant impact on lipids or cardiovascular risk and, on age alone, are UK Medical Eligibility Criteria (UKMEC)3 category 1. This means there is no restriction on the use of the contraceptive method on the basis of age alone. However, other medications or conditions, if present, may alter Gemma’s risk category for that contraceptive.1,3
On the basis of age alone, the COCP, which contains both oestrogen and progesterone is UKMEC category 2 from the age of 40 years.3
DMPA is UKMEC category 2 from the age of 45 years because of the theoretical fracture risk associated with reduced bone density from DMPA. Although DMPA may reduce bone density, there is no evidence of increased fracture incidence. Remember that even if a contraceptive is classed as category 2 for a particular characteristic (eg age, weight, medication, condition), this means the benefits still outweigh the risks, and the use under those circumstances in not contraindicated and may be helpful.3
Bone density is sustained when using the other progesterone-only contraceptives,3-5 as they do not suppress oestrogen levels to the same extent as DMPA.

Neither the COCP nor DMPA should be used beyond the age of 50 years, but the LDPOCs can continue to be used until 55 years of age (or beyond).3
Remember also that Gemma probably derived significant benefit from her implant beyond contraception, in terms of limiting menstrual problems in the perimenopausal period.
As Gemma has no other health conditions, the ENG implant is UK MEC Category 1 and can safely be continued.1

ANSWER 4
Menopause is a retrospective diagnosis, confirmed after 12 months of amenorrhoea.6,7 A woman’s age and bleeding patterns, rather than hormone levels, are the most useful factors in determining the likelihood of menopause, unless bleeding patterns are altered by hormonal contraception, such as in this case.
For women on hormonal contraceptives that can produce amenorrhoea, lab testing may have some value in determining when contraception can be stopped. It is possible to measure FSH levels while using progesterone-only methods of contraception, but not COCP, even if measured during the hormone-free interval.7
Because of day-to-day fluctuations in gonadotropin levels and to reduce the amount of unnecessary testing, consider restricting testing to women who are both older than 50 years of age and amenorrhoeic. FSH testing should be repeated twice to allow for fluctuations.
Fortunately, the diagnosis of menopause need not be made precisely; as we have seen, it is safe to continue contraceptives other than DMPA and COCP past 50 years of age.3

ANSWER 5
Amenorrhoea alone is not a reliable indicator of menopause as it can result from ENG implant use. A single FSH measurement is also not useful for determining menopause, because of hormonal fluctuations, and there are no alternative hormone tests indicated to confidently make the diagnosis. In Gemma’s case, the repeat measurement of 4 IU/L indicates that she is not menopausal.
Women older than 50 years of age who are amenorrhoeic and using the ENG implant, POP or intrauterine system (IUS) can have their FSH levels checked if confirming likely menopausal status will influence management. If the level is ≥30 IU/L, the FSH should be repeated after six weeks. If the second level is also ≥30 IU/L, contraception can be stopped after one year or at 55 years of age,5 when natural loss of fertility can be assumed for most women. Another approach, for women who are amenorrhoeic and using implants, POP or IUS, could be to forego FSH testing altogether and simply continue contraception until 55 years of age.5
ANSWER 6
Gemma should be advised to continue using contraception for a further 12 months. Another ENG implant can safely be inserted. There is no urgency about removing the implant when 12 months is completed. The probability of menstruation (and possibly ovulation) after one year of amenorrhea for women older than 45 years of age has been estimated by the World Health Organization (WHO) to be 2–10%. The risk of pregnancy after 50 years of age is estimated to be less than 1:100, or similar to the effectiveness of the long-acting reversible contraceptives or sterilisation, but some women do remain fertile into their 50s. A pregnancy in an older woman is more likely to end in abortion or fetal abnormality, and is associated with increased maternal morbidity. While there is very little evidence available regarding when to discontinue contraceptive use, the recommended practice is for contraception to be used for 12 months from the onset of menopause if that is at 50 years of age or older, and two years if menopause occurs before the age of 50 years.

ANSWER 7
Gemma’s ENG implant requires seven days after insertion to become effective. She should be advised to either abstain from vaginal intercourse or use condoms for contraception for seven days after insertion of this new implant.

RESOURCES FOR PATIENTS AND DOCTORS

- www.true.org.au OR the Family Planning website in your state

RESOURCES FOR DOCTORS

- UK Medical Eligibility Criteria for Contraceptive Use, Faculty of Sexual and Reproductive Healthcare, UK
- Dr Terri Foran’s video, Hormonal contraception – Ask the experts, provides information about contraception at menopause, and the use of the COCP and LARCs in the perimenopause, https://vimeo.com/146055005

REFERENCES

3. Faculty of Sexual and Reproductive Healthcare, UK medical eligibility criteria for contraceptive use. London: Faculty of Sexual and Reproductive Healthcare, 2016.
CASE 2

KIEREN PRESENTS WITH URETHRAL DISCHARGE

Kieren, aged 24 years, consults you for the first time. He presents with a five-day history of dysuria and urethral discharge.

QUESTION 1
What further information is important on history?

FURTHER INFORMATION
Kieren reports a ‘small amount’ of clear urethral discharge, which he noticed on his underwear. The dysuria began around the same time and seems to be worsening over time. There is no urinary frequency or lower abdominal discomfort, and he feels systemically well. When asked about his sexual history, Kieren reports he only has sex with females and has a regular girlfriend of three years. However, he reports having three other female casual partners in the preceding 12 months. His last sexual contact with a casual female partner was two weeks ago when he was on a business trip to Thailand. He always uses condoms for vaginal sex with his casual partners but no condoms for receiving oral sex. Kieren reports having condomless vaginal sex two to three times a week with his regular partner. His last sexually transmissible infection (STI) test, a urine test for chlamydia, was approximately 12 months ago and the result was negative. He has been vaccinated against hepatitis B and has never been tested for human immunodeficiency virus (HIV).

QUESTION 2
What are potential causes of urethritis?

FURTHER INFORMATION
On examination, Kieren looks well. You notice scant mucoid urethral discharge. There is no associated metritis or inguinal lymphadenopathy. His testes are non-tender. There is no genital rash or ulcers.

QUESTION 3
What investigations will you order?

QUESTION 4
What management would you offer Kieren?

FURTHER INFORMATION
You see Kieren one week later and his results have come back negative: first-pass urine was negative for chlamydia and gonorrhea, and his mid-stream urine was unremarkable. Kieren tells you that his symptoms are much improved.

QUESTION 5
What is your advice for Kieren’s sexual partners?

———
QUESTION 6 📞
What is the prognosis for Kieren’s urethritis?

ANSWER 1
First, more information is needed about Kieren’s presenting complaint. Specifically, the description of the urethral discharge may help suggest a pathogen: purulent discharge is often associated with gonococcal urethritis, whereas a clear or mucoid discharge may be associated with non-gonococcal urethritis (NGU). On the other hand, severe dysuria with marked urethritis tends to be associated with a viral cause such as adenovirus or herpes.¹

A sexual history will be important, including asking Kieren about the gender of his sexual partners, any recent new partners, the consistency of condom use, types of sexual activity, last sexual contact and his past history of STIs and STI testing.

ANSWER 2
Urethritis is defined as inflammation of the urethra and can present as urethral discomfort, discharge and/or dysuria.

Most cases of urethritis are caused by an infection. Infectious causes of urethritis can be classified as either gonococcal (caused by Neisseria gonorrhoea) or non-gonococcal urethritis (NGU). NGU can be caused by a variety of agents such as Chlamydia trachomatis, Mycoplasma genitalium and other less common pathogens such as Herpes simplex virus, Trichomonas vaginalis, or adenoviruses.¹ If an STI pathogen is not identified (in 32–61% of cases),¹⁻³ this is termed idiopathic or pathogen-negative NGU. Organisms that are not sexually transmitted, such as Escherichia coli, can cause urinary tract infections and can also be a cause of urethritis. Non-infectious causes of urethritis include physical injury or chemical irritants (eg soap, deodorants).

ANSWER 3
Kieren should have a first-pass urine test for C. trachomatis and N. gonorrhoea. Taking a swab for gonococcal culture on an appropriate medium (eg Thayer Martin or check with your laboratory for the correct transport medium), if there is suspicion of gonorrhea, would be useful for microbial sensitivities. If available, a Gram stain of any obvious urethral discharge may provide a rapid diagnosis for gonorrhoea if intracellular Gram-negative diplococci are detected. If there is a suspicion for non-STI-related pathogens, it may be worth collecting a mid-stream urine sample for urinalysis and culture.

ANSWER 4
The Australian sexually transmissible infections management guidelines for use in primary care recommends either azithromycin 1 g stat or doxycycline 100 mg twice daily for seven days.⁴ Given the increasing concern about overuse of azithromycin in the community causing bacterial resistance to M. genitalium, certain centres (eg Melbourne Sexual Health Centre) prefer doxycycline 100 mg twice daily for seven days. It would be prudent to warn patients about potential side effects with the antibiotics:
- Azithromycin is often associated with gastrointestinal side effects (eg nausea, abdominal discomfort)
- Doxycycline is associated with photosensitivity and gastrointestinal side effects.

It will be important to advise Kieren not to have sex for the next seven days.

ANSWER 5
If an STI pathogen is detected (ie chlamydia, gonorrhoea), contact tracing for Kieren’s sexual partners is essential. This includes all partners in the preceding six months for chlamydia and in the preceding two months for gonorrhoea.

There is increasing evidence that female partners of men with pathogen-negative NGU should also be informed and examined for potential risk of pelvic inflammatory disease and signs of genital infection.⁵

ANSWER 6
Advise Kieren that his symptoms may take two to three weeks to resolve completely. If he continues to have persistent symptoms, consider:
- non-compliance with his medication
- re-infection from untreated sexual partner(s)
- untested pathogen (eg M. genitalium) resistant to doxycycline or azithromycin
- other causes of his urethritis: adenovirus, herpes, trichomonas.

REFERENCES
CASE 3

LARA IS NOT INTERESTED IN SEX

Lara, aged 33 years, has been married to Todd for four years, and is mother to Jamie, almost 3 years of age, and Tristan, 12 months of age. She has come to see you for contraceptive advice. Knowing she is a busy young mum, you ask how things are going more generally. Lara says ‘Actually, Todd has been nagging me for months to come for a check-up because I’m not that interested in sex’. Todd says he looked online and found that there is medication to fix it. He thinks Lara should get some of this medication. Lara thinks there are a lot of things Todd does not understand about what it’s like to be a mum with young children. She does not think she needs medication, but he’s been pretty persistent with that view.

QUESTION 1
What would you suggest as a next step?

FURTHER INFORMATION
Lara says there has never been any history of violence and she has never felt threatened by Todd. While she says it might be difficult to speak openly about her feelings in front of him, she also realises it might be helpful. Lara and Todd book a longer appointment and come to see you together.

QUESTION 2
What would you do to establish a diagnosis?

FURTHER INFORMATION
Lara and Todd are both in good health and neither is on medication. In particular, Lara has no relevant medical or sexual history, and no evidence of depression or anaemia.

Todd says he is particularly concerned because he had a girlfriend once who stopped wanting sex because it was painful. He really liked her but they started quarrelling about sex and broke up because he could not take it. Todd does not want that to happen again.

Todd says work is busy, but he thinks he has been quite understanding, and Lara should be back to normal with sex by now. Before the boys were born, they would have sex two or three times a week and he thought she was happy with that. Now, he’s lucky if it is once a week or once a fortnight, and even then, he feels she is often reluctant. He is worried that they will never have a normal sex life again. Todd read about testosterone and ‘pink Viagra’, and wanted her to just try them – maybe there was something with her hormones. Other than the ‘sex thing’, he thinks life is good. They do something as a family most Sundays. Both agree that is important, especially as Todd’s parents are divorced.

Lara said she thought it was normal not to be that interested in sex after having a baby – even less so with two active boys under the age of three years. She is exhausted by the time Todd gets home at night, which is often after she has put the boys to bed. Tristan had only recently started sleeping through the night. Lara does not think Todd really understands how tiring it all is.

Lara agrees she enjoyed sex more before they had children. There was no sex for a while after Jamie was born, but when she was ready for another baby, she probably initiated sex more than Todd. The second delivery was traumatic. She had a long, painful labour and lost a lot of blood. When they started having sex again, about six months after Tristan’s birth, she found it painful. That also contributed to her loss of interest in sex.

Lara says that she sometimes enjoys sex now, if it is not rushed. It is true that she does not want it as much as Todd, but she also feels he is fixated on it. She says, ‘You’d think there was no sex, the way he goes on about it!’ From her perspective, there is not much time for anything these days.

Lara says that while she enjoys Sunday family time, she also thinks: ‘What about us as a couple? What about time together – just the two of us – like we used to do before kids? I miss that.’ Todd looks surprised and notes that ‘once the kids are asleep we have time, but you’re the one still in the kitchen when we could be having sex – I’ve never said I’m too tired and you know I love you.’

Lara sighs audibly ‘I know you love me in the overall sense, but what I’m trying to get you to understand is that while you’re always ready for sex, and think I should be too, it doesn’t work like that for me. Part of it is about exhaustion with the kids, but part of it is also that I really don’t see that you’re that interested in me. I’m sick of just being mummy and daddy – what’s happened to our relationship as a couple?’
QUESTION 3 📚
What examinations and investigations, if any, will you do?

FURTHER INFORMATION
On examination, there was some initial mild spasm, which quickly settled when the examining finger was left still for a moment. Lara was then ready to continue with the examination and had no further discomfort. The blood test results were within normal limits.

QUESTION 4 📚
From the history, examination and tests, what is the problem?

QUESTION 5 📚
Is a lack of interest in sex a ‘medical’ problem? Is this something doctors can treat, and if so, how?

QUESTION 6 📚
How would you discuss the problem with Lara and Todd?

FURTHER INFORMATION
Todd still wants to know if medication could help, even though he now understands that there’s nothing medically wrong with Lara. You tell him that there is no medication approved by the Therapeutic Goods Administration (TGA) in Australia, and that the medication he saw advertised on the Internet, while available in the US, has not been shown to be effective – understandably because it cannot deal with the underlying problems – and may have significant side effects. You suggest they make a follow-up appointment to see if, having talked about some important issues, they can make the changes they need themselves, or if they will benefit from further appointments, either from you or a sexual and relationship counsellor.

QUESTION 7 📚
What can doctors do to help identify and treat this condition?
A lack of sexual interest, or lack of libido (LOL), in women is now called female sexual interest/arousal disorder (FSAD) in the Diagnostic and statistical manual of mental disorders, fifth edition,1 (DSM-5), differentiating it for the first time from male hypoactive sexual desire disorder (MHSDD);11 that is, female interest in sex is no longer expected to be the same as male interest.12

DSM-5 states that to call the low desire FSAD, the symptom must not be better accounted for by another disorder, such as depression, or by a general medical problem or a drug (legal or illegal), and must cause significant distress. Of note is that the distress is usually to the partner, not the identified patient.

The DSM-5 nomenclature (FSAD) is both confusing and widely debated.13 Although officially a ‘disorder’, it is really only a description of a symptom, not a medical diagnosis. However, the DSM-5 ‘diagnosis’ is widely accepted as the consensus view in terms of naming mental disorders. FSAD is the most common female sexual difficulty, affecting one in 10 women.1 While sexual interest can be affected by illness, medication and hormonal change, it is most commonly affected by fatigue2 and relationship issues, when it can reflect unconscious anger or resentment, especially when a partner wants sex but is not interested in non-sexual intimacy.3,8 A lowered level of sexual interest is common at predictable life stages, including after the birth of a baby or with young children, around menopause6 and with increasing age.5,6 While older people in general are less sexually interested and active, if they have a new partner, interest in sex increases. In addition, if sexual difficulties such as vaginismus (or erectile difficulties and premature ejaculation in men) are treated symptomatically (eg with dilators for vaginismus or medication for men with erectile dysfunction or premature ejaculation), they may later present with LOL if underlying personal or relationship issues have not been resolved.

Currently, there is no medication approved by the TGA for treatment of LOL in Australia.7,9,10

There is not enough time for a full discussion during this short consultation, so you should offer Lara a longer appointment to explore the issue in more depth. Your preference would be for both Lara and Todd to attend this appointment, especially as Todd is more concerned about what is or is not happening in the bedroom.

To ascertain whether this would be safe for Lara, you should first ask whether she has ever felt afraid of Todd; in particular, has there been any history of violence or has she has ever felt threatened by him?

You also ask whether she would feel comfortable enough to speak openly about her feelings in front of him.

At the follow-up consultation, ask each of them about the problem and their understanding of it. Ask them about their general, medical and psychosexual histories — although Lara is the ‘identified patient’, there may be issues for each of them. The detailed psychosexual history helps determine what life circumstances, including health issues, have contributed to the symptom (Table 1).
happens outside the bedroom”) are important to keep the relationship alive and both partners feeling happy and connected.

**ANSWER 7**

Doctors can initiate a conversation about sex and sexual difficulties by taking a brief psychosexual history as a routine part of a medical history. If any sexual concerns are identified, a longer appointment is arranged for a detailed psychosexual history (Table 1) and examination as the start of treatment.

Debate continues on whether the search for medication is appropriate, given that FSAD, though called a disorder and implying it is a medical condition, is really a description of a symptom. Currently in Australia, there is no symptomatic treatment (medication) available. This is fortunate because the ethics of prescribing medication that is not very effective, has potential side effects, and does not address the causes of the symptom in people whose problems are not organically based needs more attention. Underlying anger and resentment, resulting in tension between partners, needs to be addressed. It is also important to think about the value placed on ‘normality’ (Table 2).

---

**Table 1. Psychosexual history, examination, tests**

<table>
<thead>
<tr>
<th><strong>Psychosexual history:</strong> To understand the symptom in the context of the patient’s life</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Describe the symptom in detail: sudden or gradual onset; every time or specific situations</td>
</tr>
<tr>
<td>• Has this been a problem in any previous relationship?</td>
</tr>
<tr>
<td>• Any previous treatment and outcome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal history:</strong> Including family’s attitudes and beliefs about sex and a brief outline of life history, including school, friendships, work. Questions to ask include:</td>
</tr>
<tr>
<td>• What was it like growing up in your family?</td>
</tr>
<tr>
<td>• Was sex talked about, or was it unmentionable?</td>
</tr>
<tr>
<td>• How did you find out about sex? What were your ideas about it before you started? How have they changed?</td>
</tr>
<tr>
<td>• How did you find out about periods? Any pain with periods? Tampon use?</td>
</tr>
<tr>
<td>• Response to wet dreams?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Relationship history:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relationship with current partner</td>
</tr>
<tr>
<td>• Past relationships</td>
</tr>
<tr>
<td>• Feelings of self-worth and desirability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sexual history</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contraception</td>
</tr>
<tr>
<td>• Past sexual difficulties, the context in which they occurred, and if there were times that were symptom-free</td>
</tr>
</tbody>
</table>

| **Medical and surgical history:** Pelvic or breast surgery, infections (eg recurrent thrush), episiotomies, painful birth, miscarriage, thyroid disease, anaemia, chronic illness |

| **Past traumatic experiences:** History of physical abuse, childhood sexual abuse, adult sexual trauma including painful vaginal examinations |

| **Drugs:** Prescribed and recreational eg antidepressants, antipsychotics, marijuana, alcohol |

| **Current life:** Home, relationship, work — any problems they perceive |
| • Why have they come now? They may have had the symptom for years |
| • Partner involvement and co-operation |

<table>
<thead>
<tr>
<th><strong>Specific questions for same-sex couples:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• The coming out history, including any negative messages</td>
</tr>
<tr>
<td>• Medical concerns, including human immunodeficiency virus (HIV) status</td>
</tr>
<tr>
<td>• Family and community support</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Psychosexual examination:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• General medical examination, gynaecological check and vaginal examination if relevant</td>
</tr>
<tr>
<td>• Tests if indicated: full blood evaluation, thyroid-stimulating hormone</td>
</tr>
</tbody>
</table>
# Table 2. Factors affecting sexual interest

## Medical or surgical

- Severe illness: Diabetes, cancer, anaemia, thyroid dysfunction, chronic illness, depression, anxiety
- Surgery that affects body image (e.g., mastectomy, hysterectomy, colostomy)
- Is intercourse physically painful?

## Medication

Prescribed (e.g., antidepressants, antipsychotics, statins, 5a-reductase inhibitors) or recreational (e.g., marijuana) drugs

## Psychological (personal)

- Background: Culture, religion, family attitudes to sex
- Feelings about own femininity (e.g., response to menarche, menstruation, menopause)
- Sexual beliefs (e.g., is it all right for females to initiate or to say no to unwanted sex)
- Past history of trauma, especially sexual or physical abuse. Post-traumatic stress disorder (PTSD)
- Painful birth, episiotomy, infertility and its treatment, termination, miscarriage, stillbirth
- Life stage (e.g., exhaustion with young children, menopause, older age)
- Suitable contraception

## Relational

- Emotional relationship with partner
- Relationship issues that need to be addressed

## Contextual or situational

- Is there privacy?
CASE 4

JANE PRESENTS FOR A PAP SMEAR
Jane comes to see you for her first Papanicolaou (Pap) smear. She is 22 years of age, asymptomatic and was vaccinated against the human papillomavirus (HPV) as part of the National Immunisation Program Schedule when she was in high school. Jane has a certificate of completion for all three doses. She currently has a boyfriend and has been sexually active since 17 years of age.
Jane is particularly anxious because her mother had ‘serious Pap smear changes’ that needed treatment when she was young.

QUESTION 1
What can you tell Jane about Pap tests and cervical screening? What should you offer Jane in the way of preventive healthcare?

FURTHER INFORMATION
Jane returns to you when she is 25 years of age. She has been having her annual chlamydia tests as you suggested. So far, her tests have been negative. She is now due to have a cervical screening test (CST).

QUESTION 2
How do you take a CST? What do you request on the form?

FURTHER INFORMATION
Jane’s result is negative. As the years go by, you see her less frequently, but you become aware that at 28 years of age, she was sexually assaulted. This was an extremely traumatic event for her and, consequently, she missed her episode of screening at 30 years of age. More recently, as life has settled a bit, she has been seeing you again. Jane is 36 years of age and now has a baby aged six months. She still refuses a CST as she does not want a speculum examination. You now discuss a self-sampled human papillomavirus (HPV) test with her.

QUESTION 3
How would you explain this new test to patients?

FURTHER INFORMATION
Jane’s self-sampled result is ‘other high-risk HPV (not 16/18) positive’. You discuss the results with Jane. She understands the need for speculum examination and further testing but asks why this has happened as she had all three HPV vaccinations and thought she was protected.
CASE 4

QUESTION 5
What do you tell Jane? What is your management?

FURTHER INFORMATION
After your explanation, Jane is happy for you to take the cervical sample as she recalls you were very good when she had her first one and she knows you understand her anxieties concerning a genital examination.

QUESTION 6
How do you take the sample? What test do you order?

FURTHER INFORMATION
Jane’s result shows cellular changes consistent with a low-grade intraepithelial squamous lesion (LSIL).

QUESTION 7
What is the recommendation now?

FURTHER INFORMATION
Jane returns a year later. This time, she agrees to a speculum examination and a CST, as last year she found it difficult to have two tests. She hopes the screening test will give her the answer all at once. Jane’s results are positive for other high-risk HPV (not 16 or 18); cytology changes are consistent with high-grade squamous intraepithelial lesion (HSIL).

QUESTION 8
How do you manage Jane now?

FURTHER INFORMATION
Jane sees the gynaecologist and you receive a letter outlining the successful treatment of her severe dysplasia with a large loop excision of the transformation zone (LLETZ procedure). Subsequent colposcopy and cytology are normal at six months post-treatment. The gynaecologist has now discharged Jane back into your care. She comes in 12 months after her treatment.

QUESTION 9
What tests, if any, would you order?
QUESTION 10
At what age can screening cease?

ANSWER 1
You can explain to Jane that Pap tests will soon be replaced by CSTs. In the new National Cervical Screening Program (NCSP), screening will commence at 25 years of age and can be repeated every five years if the results are negative. This major change is based on evidence that testing women for HPV every five years can save more lives than Pap tests every two years. In fact, it is estimated that the introduction of HPV testing as a primary screening test will reduce the incidence of cervical cancer by an additional 15–20%. Jane is not eligible for screening under this program as she is not yet 25 years of age. However, she should be offered a chlamydia test. The Royal Australian College of General Practitioners (RACGP) recommends annual testing for chlamydia in all sexually active people under 30 years of age.

Background to changes in cervical screening guidelines

More than 99% of cervical cancers are caused by oncogenic or ‘high-risk’ HPV types. There are 14 high-risk types of HPV, of which types 16 and 18 are the most important as they are responsible for approximately 70% of cervical cancer worldwide. Women born after 1 July 1980, have been, or are currently being, offered the quadrivalent HPV vaccine, which protects against HPV types 6, 11, 16 and 18 as part of a school-based program. Types 6 and 11 are non-oncogenic types responsible for around 95% of genital warts. Uptake of the vaccination in Australia has been very good, with 73% of girls aged 12–13 years completing the three-dose schedule. Studies have already shown a decline in high-grade lesions in young Australian women who have been HPV-vaccinated. It is anticipated that this will ultimately translate into a decline in cervical cancer, squamous and adenocarcinoma, both of which are most frequently caused by HPV types 16 and 18.

Using polymerase chain reaction technology, we can now easily test for oncogenic HPV genotypes and thus determine a woman’s risk of developing cervical cancer. Figure 1 illustrates the superior negative predictive value of an HPV test, compared with cytology. The data shown in Figure 1 are taken from a European cohort study of many thousands of women from countries with a similar demographic background to Australia. The green line shows that doing both tests (cytology and an HPV test) makes little difference to this outcome. This means that the balance of benefits and potential harms associated with screening is optimal when the primary screening strategy is an HPV test on its own. Cytology is then reserved as a reflex test to be performed when the HPV test is positive.

The most significant message that needs to be conveyed to women is that having an HPV test at five-yearly intervals is safer than having a Pap test at two-yearly intervals.

Genital HPV infection is extremely common in the first 10 years of sexual activity. It is overwhelmingly subclinical and transient (even the high-risk types), although, it may take 12–24 months to clear. Occasionally, HPV becomes integrated within the DNA of the host epithelial cell leading to persistent infection. If this occurs, cellular changes may ultimately be identified as high-grade abnormalities on a Pap smear. This process usually takes 7–10 years.

Sexual activity most commonly begins between the ages of 15 and 25 years in Australia. The majority of women in this age group have now been vaccinated against the most important oncogenic HPV types: 16 and 18. This fact contributes to the decision to begin screening at 25 years of age.

Cervical cancer in women aged <25 years is rare. Australian figures suggest approximately two new cases of invasive cervical cancer per 100,000 women aged <25 years. Despite screening since the introduction of the NCSP in 1991, the incidence has remained the same. Note that all women with abnormal vaginal bleeding (regardless of age) warrant further assessment and are no longer considered part of the routine cervical screening program.
CASE 4

ANSWER 2
A CST is taken from the cervix in the same way that Pap tests have been taken. However, glass slides should not be prepared, as the sample collected is placed directly in liquid medium (such as Thin Prep) by placing the instruments into the vial and agitating them about 10 times. Discard the sampling instruments and ensure the lid is properly screwed on. Refer to ‘Resources for doctors’ for a video demonstration of sample collection.
The request on the form is ‘Cervical screening test’ or ‘CST’.

ANSWER 3
The following is an example of an explanation you might give to your patients regarding the new program.

Jane, we now have a very good understanding of the cause of virtually all cervical cancer. There is no evidence that cervical cancer is inherited. In fact, it is caused by long-term, persistent infection with certain strains of a virus called the human papillomavirus or HPV. This virus is exceptionally common in all men and women who have ever had sex. Most people clear this infection with no further problems. Persistent infection over many years (usually at least 10 years) with particular strains or types of HPV may result in changes to the cells of the cervix. If these changes are left untreated over many years they may become cancerous.
The good news is that we can now test for the types of HPV that we know can cause these cell changes.

The new cervical screening program tests for these particular types of HPV. From extensive research, we know that this test is better than a Pap test. A negative HPV test is a more accurate test than a negative Pap test because a Pap test looks for cell changes once they have occurred (and this might take many years), whereas now we can look for the virus directly. So we’re looking to see if you have any potential for changes occurring in your cervical cells. If you don’t have HPV (ie if your test is negative) then your risk of developing changes is extremely low. Having an HPV test every five years is safer than having a Pap test every two years.

I still need to take the test from the cervix in the same way as a Pap test that you are used to. If the test is negative for HPV, you should have another test in five years. If the test is positive for HPV, then further testing or monitoring will be required to see if you need treatment.
Of course, if at any time you have any symptoms, such as unusual vaginal bleeding or discharge, please come back to see me even if your last test was negative.

ANSWER 4
Clinicians can suggest a self-sampled HPV test for patients >30 years of age who are two or more years overdue for cervical screening and who decline a speculum examination.

Advantages:
• No need for a speculum examination for the primary test (HPV)
• Less invasive

Disadvantages:
• Quick and timely
• Increased acceptance for under-screened patients

ANSWER 5
As discussed in Answer 1, Jane would have received the quadrivalent vaccine, which protects against HPV types 6, 11, 16, and 18. Jane now has evidence of infection with one of the other 12 oncogenic HPV types (not 16/18).

Under the new guidelines, all women who are positive for any of the oncogenic HPV types will automatically have cytology performed on their specimen (known as ‘reflex cytology’). The practitioner does not need to order the reflex test. The pathology laboratory follows the testing algorithm for positive HPV results and performs a cytology test automatically. Those who are positive for types 16 and/or 18 should be referred for colposcopy regardless of the cytology result. Those who are ‘other high-risk HPV (not 16/18) positive’ should have colposcopy if cytology suggests high-grade cellular changes. If the cytology is negative or shows low-grade changes, these patients should have a repeat CST in 12 months.

So, what about women who are positive for one of the high-risk types? If positive for HPV type 16, a woman’s risk of having a histologically confirmed, HSIL in the next 10 years is around 17% (Box 1). For HPV type 18, the risk is 13%. For the other 12 high-risk types, the risk is 3%. This last group is often referred to as ‘other’ high-risk HPV (not 16/18).

Box 1. HPV strain and risk of progression to high-grade abnormality

<table>
<thead>
<tr>
<th>HPV strain</th>
<th>Progression to high-grade abnormality in 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>17%</td>
</tr>
<tr>
<td>18</td>
<td>13%</td>
</tr>
<tr>
<td>HR POS (not 16/18)</td>
<td>3%</td>
</tr>
</tbody>
</table>

ANSWER 6
To obtain a sample, you insert a speculum, visualise the cervix, and take the sample in the same way you have taken Pap smears in the past. But the sampling instruments are rinsed in a liquid-based medium (eg Thin Prep). A glass slide should NOT be taken.

As Jane has had a self-collected HPV test you should order a cytology test only.
**CASE 4**

**ANSWER 7**

Given Jane’s results showing changes consistent with LSIL, she should have a repeat CST in 12 months. When the test is repeated in 12 months, you should write in the clinical notes section ‘last screening 12 months ago. Positive HPV other (not 16 or 18), cytology LSIL’.

**ANSWER 8**

Jane should be referred to a specialist gynaecologist who will perform a colposcopic evaluation.

**ANSWER 9**

Jane should now have a ‘Co-test: HPV and cytology’. She requires a successful test of cure (TOC) before she can return to routine screening every five years. The TOC consists of a ‘co-test: HPV and cytology’ taken from the cervix annually until two sets of the tests are all negative (Table 1). That is, cytology is ordered and is not a reflex test depending on the HPV result. It is required in the TOC. This is the same as the recommendation in the previous NCSP guidelines published in 2005.\(^{10}\) If at any point the HPV test is positive for types 16 and/or 18, or the cytology is reported as an HSIL, the patient will need to return for colposcopy.

**ANSWER 10**

Patients will be advised to have an exit test between 70 and 74 years of age. If this is negative, they have fulfilled their screening requirement and do not require further screening. However, if they have a positive test for any type of oncogenic HPV they should be referred for colposcopy.

**RESOURCES FOR DOCTORS**

- VCS Pathology provides resources, including video demonstrations of sample collection,  [www.vcspathology.org.au/practitioners/resources](http://www.vcspathology.org.au/practitioners/resources) resources for health professionals

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**Table 1. Co-test: HPV and cytology test of cure**

<table>
<thead>
<tr>
<th>Time since treatment</th>
<th>Cytology test result</th>
<th>Colposcopy result</th>
<th>HPV test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>4–6 months</td>
<td>Negative</td>
<td>Negative</td>
<td>Not done at this stage</td>
</tr>
<tr>
<td>12 months</td>
<td>Negative</td>
<td>Not done at this stage</td>
<td>Negative</td>
</tr>
<tr>
<td>24 months</td>
<td>Negative</td>
<td>Not done at this stage</td>
<td>Negative</td>
</tr>
</tbody>
</table>

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**Figure 2. Testing algorithm for positive HPV results**

- **Other high-risk HPV**
  - Reflex cytology
    - Reflex cytology negative or LSIL
      - Repeat in 12 months
    - Reflex cytology HSIL
      - Colposcopy
  - HPV 16/18 positive
    - Reflex cytology
      - Colposcopy (regardless of cytology results)
REFERENCES


CASE 5

ERIC HAS ALWAYS EJACULATED TOO FAST
Eric, a computer programmer aged 36 years, is in a new relationship with Tiffany. He sees you today because he is concerned about ejaculating too fast. He tells you that he has always ejaculated within 20–30 seconds of penetration on almost every intercourse attempt with every sexual partner since his first sexual experience. He has little or no control over ejaculation, but can delay ejaculation slightly after two or three glasses of wine. Eric is embarrassed, visibly upset and tells you that Tiffany is confused and both are starting to avoid sex. He asks, ‘Is it me or is it Tiffany?’.

QUESTION 1 🤔
How would you respond to Eric’s question?

QUESTION 2 🤔
What is the ‘normal’ intravaginal ejaculation latency time (IELT)?

QUESTION 3 🤔
Why do you think Eric has developed a pattern of sexual avoidance?

QUESTION 4 🤔
What could be the possible causes of Eric’s premature ejaculation (PE)?

QUESTION 5 🤔
How common is PE?
CASE 5

QUESTION 6
How would you evaluate Eric?

Erik reports normal erectile function and his sexual history fulfils the three criteria for a diagnosis of lifelong PE, which have been present since his first sexual experience on virtually every intercourse attempt and with every sexual partner:

• short ejaculatory latency of less than about one minute
• reduced or absent ejaculatory control
• presence of negative personal consequences from PE.

Physical examination of Eric was entirely normal and no additional investigations were indicated.

QUESTION 7
How would you treat Eric?

ANSWER 1
Eric has lifelong PE, which is defined as a male sexual dysfunction characterised by:1

• ejaculation that always or nearly always occurs prior to or within about one minute of vaginal penetration
• the inability to delay ejaculation on all or nearly all vaginal penetrations
• negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy.

This definition intentionally includes a degree of diagnostic conservatism and flexibility. The one-minute IELT cut-off point for lifelong PE should not be applied in the most absolute sense, as about 10% of men seeking treatment for lifelong PE have IELTs of one to two minutes. The phrase, ‘within about one minute’ must be interpreted as giving the clinician sufficient flexibility to also diagnose PE in men who report an IELT as long as 90 seconds. Men who report these ejaculatory latencies but describe adequate control and no personal negative consequences related to their rapid ejaculation do not merit the diagnosis of PE.2

Some men who self-diagnose PE and present for treatment fail to fulfil all three criteria for PE. These men are suffering from either subjective or variable PE. Subjective PE is characterised by a normal range IELT but a preoccupation with an imagined short ejaculatory latency or lack of control over the timing of ejaculation. Variable PE is characterised by short IELT that occurs irregularly and inconsistently, and is considered a normal variation in sexual performance.

ANSWER 2
IELT represents a continuum of time that shows variation across men, within men, and across situations. Community-based stopwatch studies of the IELT demonstrate a median IELT of 5.4 minutes (range: 0.55–44.1 minutes), which decreases with age and varies between countries.3 There is evidence to suggest that individual genetic polymorphisms may predispose some men to the development of lifelong PE, but data remain scant and controversial.4 Patient education about ‘normal’ sexual function assists men and their partners in the establishment of reasonable treatment outcome expectations.

ANSWER 3
It is increasingly recognised that a diagnosis of PE can have a profound impact on the patient’s and partner’s quality of life. PE can lead to withdrawal from intimacy, avoidance of all physical contact with a partner, and an increase in emotional stress, which itself can perpetuate any psychogenic component to the PE. The condition can affect a man’s self-esteem and self-image, and lead to anxiety and hence depression. Treatment of PE has been shown to lead to resolution of depression and restoration of self-esteem, and thus improvement in quality of life.
**ANSWER 4**
Several studies have suggested that in some men, neurobiological and genetic variations could contribute to the pathophysiology of lifelong PE, and that the condition may be maintained and heightened by psychological or environmental factors. However, the current body of evidence suggests that individual genetic polymorphisms exert a minor, if any, effect on ejaculation latency.

**ANSWER 5**
Premature ejaculation is often characterised as the ‘most common male sexual dysfunction’, on the basis of several community-based observational studies that describe a self-reported prevalence rate of 20–30%. However, it is unlikely that the prevalence of PE is as high as 20–30% given the relatively low number of men who present for treatment of PE. However, more recent studies suggest that most men who self-report PE fail to understand what constitutes normal ejaculatory latency. Consequently, these men have unrealistic expectations, or are confused by the variable nature of ejaculatory function and overly concerned by occasional rapid ejaculation. These men are described as suffering from subjective or variable PE. These studies suggest an approximate prevalence of 5% for lifelong and acquired PE in the general population.

Acquired PE differs from lifelong PE in that these men develop early ejaculation at some point in their life, which is often situational, having previously had normal ejaculation experiences. Acquired PE is commonly due to sexual performance anxiety, psychological or relationship problems, or erectile dysfunction. Occasionally, it can be caused by prostatitis, hyperthyroidism, or during withdrawal/detoxification from prescribed or recreational drugs.

**ANSWER 6**
Patients want clinicians to enquire about their sexual health. Often, patients are too embarrassed, shy and/or uncertain to initiate a discussion of their sexual complaints in the doctor’s office. Enquiry by the GP into sexual health gives patients permission to discuss sexual concerns and also screens for associated health risks (e.g., cardiovascular risk and erectile dysfunction).

Clinicians should take a medical and psychosocial history. Box 1 lists recommended and optional questions that patients who complain of PE should be asked. The recommended questions establish the diagnosis and direct treatment considerations, and the optional questions gather detail for implementing treatment.

**Box 1. Recommended and optional questions to establish the diagnosis of PE and direct treatment**

<table>
<thead>
<tr>
<th><strong>Recommended questions for diagnosis</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the time between penetration and ejaculation?</td>
</tr>
<tr>
<td>• Can you delay ejaculation?</td>
</tr>
<tr>
<td>• Do you feel bothered, annoyed and/or frustrated by your premature ejaculation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Optional questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To differentiate between lifelong and acquired PE:</strong></td>
</tr>
<tr>
<td>• When did you first experience premature ejaculation?</td>
</tr>
<tr>
<td>• Have you experienced premature ejaculation since your first sexual experience on every or almost every attempt and with every partner?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>To assess erectile function:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is your erection hard enough to penetrate?</td>
</tr>
<tr>
<td>• Do you have difficulty in maintaining your erection until you ejaculate during intercourse?</td>
</tr>
<tr>
<td>• Do you ever rush intercourse to prevent loss of your erection?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>To assess relationship impact:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• How upset is your partner with your premature ejaculation?</td>
</tr>
<tr>
<td>• Does your partner avoid sexual intercourse?</td>
</tr>
<tr>
<td>• Is your premature ejaculation affecting your overall relationship?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>To assess impact on quality of life:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do you avoid sexual intercourse because of embarrassment?</td>
</tr>
<tr>
<td>• Do you feel anxious, depressed or embarrassed because of your premature ejaculation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Previous treatment:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have you received any treatment for your premature ejaculation previously?</td>
</tr>
</tbody>
</table>
For lifelong PE, a physical examination is advisable but not mandatory. However, some patients find it reassuring for the physician to perform a hands-on physical examination. For acquired PE, a targeted physical examination is mandatory. The purpose of a targeted physical examination for the patient with acquired PE is to assess for comorbidities, risk factors and aetologies. Additional investigations are usually not required in men with lifelong PE unless indicated by the patient history and/or examination findings.

**ANSWER 7**

There are multiple psychosexual and pharmacological treatments for PE. Men with lifelong PE are best managed with PE pharmacotherapy in combination with basic psychosexual education or coaching, and, if indicated by the presence of high distress or relationship problems, graded levels of patient or couple psychosexual therapy. Men with acquired PE should receive aetiology-specific treatment, such as psychosexual counselling or pharmacotherapy for erectile dysfunction, alone or in combination with PE pharmacotherapy. Men with subjective or variable PE should primarily be treated with psychosexual education, and graded patient and couple psychotherapy.

All men seeking treatment for PE should receive basic psychosexual education or coaching. This may include providing information on the prevalence of PE, ejaculatory latency of the general population to dispel myths about PE, information on enjoyable sexual activities to extend the man and his partner’s sexual repertoire, and strategies to address avoidance of sexual activity or unwillingness to discuss sex with his partner. These educational strategies are designed to give the man the confidence to try the medical intervention, reduce performance anxiety and modify his maladaptive sexual scripts.

Several forms of pharmacotherapy have been used in the treatment of lifelong PE. These include the use of topical local anaesthetics or selective serotonin reuptake inhibitors (SSRIs), such as on-demand dapoxetine, or the tricyclic antidepressant clomipramine, or daily dosing of paroxetine or sertraline.

Dapoxetine (30 mg or 60 mg) is a rapid-acting SSRI with a short half-life. It is taken one to two hours before intercourse, is more effective from the first dose, and results in 2.5–3.0-fold increases in ejaculatory latency, increased ejaculatory control, decreased distress, and increased sexual satisfaction. Treatment-related side effects are uncommon, dose-dependent, and include nausea, diarrhoea, headache, and dizziness. No drug–drug interactions associated with dapoxetine, including phosphodiesterase inhibitor drugs, have been reported. There is no indication of an increased risk of suicidal ideation or suicide attempts and little indication of withdrawal symptoms with abrupt dapoxetine cessation.

**FURTHER INFORMATION**

You explain to Eric that the anxiety, annoyance and frustration he is currently experiencing are almost invariable in men with lifelong PE and usually settle within a few weeks once effective treatment is commenced. You prescribe dapoxetine 30 mg, to be used at least twice a week, and advise Eric of possible side effects. Eric also agrees to have basic psychosexual education and to see you for a follow-up appointment four weeks after starting treatment.

At his follow-up visit, Eric reports that he can now defer ejaculation for three to four minutes, and that both he and Tiffany are happy about his response. Tiffany no longer avoids intercourse and their relationship has strengthened considerably. Eric did experience minor transient nausea for two to three hours after the first two doses of dapoxetine, but no longer experiences this. A variety of ejaculatory control techniques were discussed with Eric and a further follow-up appointment in three months was made.

**RESOURCES FOR PATIENTS**


**RESOURCES FOR DOCTORS**


**REFERENCES**


CASE 1 – ESTHER
Esther, 52 years of age, is one of your regular patients. She has been generally well and has no significant medical history. She has been using a non-oestrogen containing hormonal contraceptive for the past 10 years, but does not take any other medication. She presents today for advice about the need for ongoing contraception and is unsure if she has reached menopause. She does not want to stop using contraception if there is a chance that she could become pregnant, but she is also concerned about the safety of ongoing hormonal contraception. She asks if there is a test to determine if she is postmenopausal.

QUESTION 1
What can you tell Esther about ongoing contraception and testing for menopausal status?
A. The risk of pregnancy at Esther’s age is very low and she can safely stop using contraception.
B. If Esther’s blood level of follicle-stimulating hormone (FSH) is ≥30 IU/L she can stop using contraception.
C. Esther can stop using contraception if two FSH tests, six or more weeks apart, show levels of ≥30 IU/L.
D. If two FSH tests, six or more weeks apart, show levels of ≥30 IU/L, Esther should continue using contraception for a further 12 months.

QUESTION 2
Which of the following statements regarding hormonal contraception in women over the age of 50 years is correct?
A. The etonogestrel (ENG) implant is not recommended as it increases cardiovascular risk in women over the age of 50 years.
B. The progestogen-only pill (POP) does not have a significant effect on lipid profile or cardiovascular risk.
C. Depomedroxyprogesterone acetate (DMPA) increases fracture incidence in women over the age of 50 years.
D. Progesterone-only contraceptives increase the risk of breast cancer.

CASE 2 – GEORGE
George, 32 years of age, presents with a three-day history of a mild dysuria and a clear urethral discharge.

QUESTION 3
What is the most likely cause of George’s symptoms?
A. Gonococcal urethritis
B. Non-gonococcal urethritis
C. Advenoviral urethritis
D. Herpes infection

FURTHER INFORMATION
A first-pass urine test is positive for Chlamydia trachomatis. You advise George that, in addition to treatment for his infection, contact tracing of his sexual partners is essential.

QUESTION 4
In George’s case, contact tracing is necessary for sexual partners he has had in the preceding
A. two months
B. three months
C. six months
D. twelve months

CASE 3 – GINA
Gina, 28 years of age, comes to see you for a Pap smear. You tell her that Pap smears will soon be replaced by a new cervical screening test (CST), which tests for human papillomavirus (HPV).

QUESTION 5
What information can you give Gina about the benefits of HPV testing, compared with the Pap smear?
A. HPV testing detects the potential for changes occurring in cervical cells.
MULTIPLE CHOICE QUESTIONS

B. HPV testing every five years is safer than having a Pap smear every two years.
C. A negative HPV test is more accurate than a negative Pap smear.
D. All of the above.

FURTHER INFORMATION
Gina’s initial HPV test is negative, but five years later she tests positive for ‘other HR HPV (not 16/18).

QUESTION 6
The next step in managing Gina would be?
A. reflex cytology, which the pathology lab would perform automatically
B. reflex cytology, which you as the general practitioner (GP) would order
C. colposcopy
D. repeat HPV testing in 12 months

CASE 4 – BRENDAN
Brendan is 34 years of age and comes to see you because he has been depressed after his girlfriend left him. One of the reasons she gave for breaking up was that sex with him was not enjoyable because he ejaculated too fast. This is not the first time he has heard this from a sexual partner. He says it’s true that he is unable to delay his ejaculations, which always occur within less than a minute of penetration.

QUESTION 7
Which of the following questions is recommended for evaluating Brendan’s premature ejaculation?
A. What is the time between penetration and ejaculation?
B. When did you first experience premature ejaculation?
C. Do you avoid sexual intercourse because of embarrassment?
D. Have you received any treatment for your premature ejaculation previously?

QUESTION 8
Lifelong premature ejaculation is characterised by:
A. Short ejaculatory latency of less than 30 seconds
B. Abnormal erectile function
C. Preoccupation with a perception of short ejaculatory latency
D. Negative personal consequences, such as distress or avoidance of sexual intimacy.

CASE 5 – CELINE
Celine, 38 years of age, presents complaining of fatigue. As you take a history, she reveals that there has been tension in her marriage. She has three young children, aged between three and 10 years, and she works full-time. She finds that work and family life can be quite demanding and it doesn’t help that her husband constantly complains about her lack of interest in sex. ‘What does he expect me to do?’ she asks. ‘The only bit of free time I have is at night after the children have gone to bed, and by then I’m exhausted.’ He convinced her to see you for treatment for her lack of interest in sex, which he says is not normal in a woman of her age.

QUESTION 9
Your assessment of Celine should include:
A. Blood tests
B. Psychosexual history
C. Physical examination
D. All of the above

QUESTION 10
Female sexual interest/arousal disorder (FSAD):
A. describes a symptom
B. is a medical diagnosis
C. describes a mental disorder
D. is usually indicative of underlying depression.

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