Asia-Oceania Federation of Sexology

AOFS NEWSLETTER

November 2016

Issue 20

Dear Colleagues and Members of AOFS,

2016 has been an exciting year as we held our biennial conference in Busan, Korea and elected a new committee. We now have the 2018 conference to look forward to. Put the date into your calendars and plan research and topics to present at the conference so we can all benefit and grow.

This is the last Newsletter for the year and I would like to wish everyone a successful end to 2016 and a happy healthy and productive 2017. For those who celebrate Christmas, I wish you a joyous time with your loved ones. For everyone else, I wish you a great end of year holiday.

Warm regards

Margaret Redelman

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Inside this issue

Servier Meeting attended by SAS members.

Dr Nenad Alempijevic

Dr Margaret Redelman OAM

Dr Anita Clayton

Dr Michael Lowy

Dr Snezana Alempijecic

Credit to Servier for including sexuality education in a psychiatry meeting.

"Treat the Mind, Respect the Body"

Dr Stephen M. Stahl and Dr Anita Clayton

22-23 October 2016

Sydney, Australia

Dr Anita Clayton presented to a capacity audience of over 500 psychiatrists from around Australia at the Hilton Hotel in Sydney. She was sponsored by Servier in their capacity as providers of mental health medication.

Dr Clayton's first presentation was titled, "Assessment and management of sexual dysfunction within psychiatric illnesses". She covered sexual response models and sexual function, illness and treatment induced sexual dysfunction, the neurobiology of antidepressant induced sexual dysfunction and recommended management strategies.

Dr Clayton described the biopsychosocial model of sexuality consisting of biology, psychology, interpersonal and sociocultural aspects. This was followed by a description of the classic Masters and Johnson linear model of sexual response and compared to the currently more accepted circular model of Rosemary Basson. Dr Clayton outlined the effects of neurochemicals on desire, subjective excitement and orgasm. A special mention was made of the inhibitory effects of serotonin which is central in many modern antidepressants. The peripheral effects of oestrogen, testosterone and progesterone on the sensation and vasocongestion of clitoral and penile tissue were described. Dr Clayton defined the differences between sexual complaint, sexual dysfunction and sexual disorder.

There is a 43% incidence of any form of sexual complaint in the USA in women aged 18 – 59 years and 31% for men in the same age bracket. This compares to an Australian survey where the incidence for women was 61% and men, 55%.

Many illnesses affect sexual function including mood disorders, other mental health issues, hypertension, urological and neurological disorders, cardiovascular disease, endocrine disorders, gynaecological problems and many chronic medical conditions. There is a direct connection between depression predicting sexual dysfunction and conversely sexual dysfunction predicting depression. SSRI medication paroxetine, has a higher incidence of sexual dysfunction compared to agomelatine. Antipsychotic medications also impact sexual function in varying and significant degrees.

Strategies for managing medication induced sexual dysfunction were described using substitution of other medications and off label use of medications, such as testosterone and sildenafil.

Dr Clayton's second presentation was titled "Tips for discussing sexual dysfunction with patients".

Correlations between sexual dysfunction and a reduced quality of life are associated with a multitude of medical conditions including CNS disorders, various cancers, autoimmune disorders and metabolic disorders. This results in poor health status and low quality of life in the presence of these medical conditions.

She presented data on how individuals respond to having a sexual difficulty eg 78.2% of women who experienced sexual problems related to their medical condition, initiated the conversation about their sexual dysfunction.

She further presented the barriers impeding the discussion of sexual problems from the patients' perspective (too embarrassed), the physicians' perspective (uncomfortable talking about the sexual problem) and cultural issues which are so pervasive in all practices now. It is thus important that the physician brings up sexual problems as part of the routine examination, to invite patients to discuss something that bothers them. A simple approach is to ask the patient if they have any concern over their sexual function. It is important to be direct in this questioning, as sexual concerns may be important to the patient thus it should also be important to the physician. It makes sense to include the sexual questioning as part of lifestyle questioning along-side exercise, diet, recreation and enjoyment of life.

There are a number of evidence based sexual health questionnaires available. These include for women, the Female Sexual Function Index, for men the Sexual Inventory for Men and for both sexes, the Arizona Sexual Experience Scale.

Submitted by Dr Michael Lowy

Dr Anita Clayton

Dr. Anita Clayton's clinical practice and research interests focus on women's mental health and sexual dysfunctions. She is the David C. Wilson Professor and Chair of the Department of Psychiatry and Neurobehavioral Sciences, with a secondary appointment as professor of clinical obstetrics and gynaecology at the University of Virginia, USA. She is board certified in psychiatry and neurology. Additionally, she is a member of the Board of Directors of the American Society of Clinical Psychopharmacology.

She has authored articles and abstracts that have been published in scientific journals, including, among others, the American Journal of Psychiatry, the Journal of Clinical Psychiatry, the Journal of Sex and Marital Therapy and the Journal of Sexual Medicine. She developed and validated the Changes in Sexual Functioning Questionnaire to measure sexual desire and function, which has been utilized in over 90 clinical studies. She also authored a book on women's sexuality for the general public, titled "Satisfaction: Women, Sex, and the Quest for Intimacy." Her current re-search includes mood and anxiety disorders associated with reproductive-life events in women, sexual dysfunction related to illness and medications, treatment of sexual disorders and potential new treatments for hypoactive sexual desire disorder, sexual arousal disorder, orgasmic disorder, antidepressant-induced sexual dysfunction, and major depressive disorder.

Besins Meeting attended by SAS members

Dr Graham Neilsen

Dr Margaret Redelman OAM

Dr Michael Lowy

Dr Marie Tudor

With some of the keynote speakers

Dr Eric Chung

Dr Sonia Davison

Dr Jean Paul Deslypere

Drs Lowy and Redelman presented the sexuality content.

Testosterone Deficiency - National and International Guidelines

1.International Consensus

International Consensus Conference on Testosterone Deficiency and its Treatment

Professor Mario Maggi
Chief, Sexual Medicine and Andrology Unit,
Department of Experimental and Clinical Biomedical Sciences
University of Florence, Florence, Italy

Professor Maggi summarised the nine, unanimous resolutions on the management of testosterone deficiency (TD) from the Consensus Conference held in Prague in 2015. These are shown below:

1 TD is a well-established, clinically significant medical condition that negatively affects male sexuality, reproduction, general health, and quality of life;

2 Symptoms and signs of TD occur as a result of low levels of testosterone and may benefit from treatment regardless of whether there is an identified underlying etiology;

3 TD is a global public health concern;

4 Testosterone therapy for men with TD is effective, rational, and evidence based;

5 There is no testosterone concentration threshold that reliably distinguishes those who will respond to treatment from those who will not;

6 There is no scientific basis for any age-specific recommendations against the use of testosterone therapy in men;

7 The evidence does not support increased risks of cardiovascular events with testosterone therapy;

8 The evidence does not support increased risk of prostate cancer with testosterone therapy; and

9 The evidence supports a major research initiative to explore possible benefits of testosterone therapy for cardiometabolic disease, including diabetes.

References
1. Morgentaler A et al. Fundamental Concepts Regarding Testosterone Deficiency and Treatment: International Expert Consensus Resolutions. Mayo Clin Proc 2016;91:881-6.

2. Corona G et al. Perspective: Regulatory agencies' changes to testosterone product labelling. J Sex Med 2015;12;1690-3.

3. Wu FCW et al. Identification of late-onset hypogonadism in middle-aged and elderly men. N Engl J Med 2010;363:123. doi: 10.1056/NEJMoa0911101

2. Australian Position

Endocrine Society of Australia Position Statement

Professor Bu Yeap

School of Medicine and Pharmacology

University of Western Australia

Consultant Endocrinologist

Department of Endocrinology and Diabetes

Fiona Stanley Hospital

Perth, Western Australia

Professor Yeap summarised the ESA position statement as published recently in two parts in the Medical Journal of Australia. He highlighted the critical importance of making a pathological diagnosis of TD before offering testosterone treatment.

The key recommendations regarding **patient assessment** are shown below:

1 Pathological hypogonadism arises due to diseases of the hypothalamus or pituitary gland (hypogonadotropic hypogonadism) or testes (hypergonadotropic hypogonadism). It is a clinical diagnosis with a pathological basis, confirmed by hormone assays.

2 Hormonal assessment is based on measurement of circulating testosterone, luteinising hormone (LH) and follicle-stimulating hormone (FSH) concentrations. Measurement of sex hormone-binding globulin levels can be informative, but use of calculated free testosterone is not recommended for clinical decision-making.

3 Testosterone replacement therapy is warranted in men with pathological hypogonadism, regardless of age.

4 Currently, there are limited data from high-quality randomised controlled trials with clinically meaningful outcomes to justify testosterone treatment in older men, usually with chronic disease, who have low circulating testosterone levels but without hypothalamic, pituitary or testicular disease.

5 Obesity, metabolic syndrome and type-2 diabetes are associated with lowering of circulating testosterone level, but without elevation of LH and FSH levels. Whether these are non-specific consequences of non-reproductive disorders or a correctable deficiency state is unknown, but clear evidence for efficacy and safety of testosterone therapy in this setting is lacking.

6 Glucocorticoid and opioid use is associated with possibly reversible reductions in circulating testosterone level, without elevation of LH and FSH levels. Where continuation of glucocorticoid or opioid therapy is necessary, review by an endocrinologist may be warranted.

The key recommendations regarding **patient management** are shown below:

1 Excess cardiovascular events have been reported in some but not all studies of older men without pathological hypogonadism who were given testosterone treatment. Additional studies are needed to clarify whether testosterone therapy influences cardiovascular risk.

2 Testosterone is the native hormone that should be replaced in men being treated for pathological hypogonadism. Convenient and cost-effective treatment modalities include depot intramuscular injection and transdermal administration (gel, cream or liquid formulations).

3 Monitoring of testosterone therapy is recommended for efficacy and safety, focusing on ameliorating symptoms, restoring virilisation, avoiding polycythaemia and maintaining or improving bone mineral density.

4 Treatment aims to relieve an individual's symptoms and signs of androgen deficiency by administering standard doses and maintaining circulating testosterone levels within the reference interval for eugonadal men.

5 Evaluation for cardiovascular disease and prostate cancer risks should be undertaken as appropriate for eugonadal men of similar age. Nevertheless, when there is a reasonable possibility of substantive pre-existing prostate disease, digital rectal examination and prostate -specific antigen testing should be performed before commencing testosterone treatment.

References

1. Yeap BB et al. Endocrine Society of Australia position statement on male hypogonadism (part 1): assessment and indications for testosterone therapy. Med J Aust 2016;205:173-8. doi: 10.5694/mja16.00393.

2. Yeap BB et al. Endocrine Society of Australia position statement on male hypogonadism (part 2): treatment and therapeutic considerations. Med J Aust 2016;205:228-31. doi: 10.5694/mja16.00448.

3. USANZ Position

Urological Society of Australia and New Zealand Position Statement

Associate Professor Eric Chung

Urological Surgeon

AndroUrology Centre for Sexual, Urinary and Reproductive Excellence

Brisbane, Australia

Chairperson, Andrology Special Advisory Group

Urological Society of Australia and New Zealand

Professor Chung summarised the USANZ position statement on the management of TD. He stated that the statement was consistent with similar statements from the American and European Urological Associations and that of the International Society for Sexual Medicine. The core issues from the statement are summarised below.

1 Management of hypogonadism should start with careful evaluation of clinical symptoms and signs and biochemical confirmation of low total testosterone.

2 Many testosterone deficiency symptoms are non-specific and may be multifactorial in nature.

3 Testosterone therapy should not be offered in men with normal testosterone level.

4 The use of alternative testosterone products (Selective Estrogen Receptor Modulators – SERMs and Aromatise Inhibitors – AIs) remains off-label and prescription is case-based only.

5 Testosterone therapy is contraindicated in men who wish to start a family and/or remain fertile.

6 Concern about misuse and abuse of testosterone for non-medical indications.

7 Conflicting data on impact of testosterone therapy on cardiovascular risks; individualised assessment.

8 Men with low libido, poor morning erections and/or erectile dysfunction documented TD are candidates for testosterone replacement therapy (TRT).

9 Check testosterone level in PDE5 inhibitor non-responders (especially in those with type-2 diabetes mellitus).

10 No evidence that testosterone replacement therapy increases risk of benign prostatic hypertrophy (BPH) or contributes to worsening of lower urinary tract symptoms in hypogonadal men with BPH.

11 Saturation model of testosterone; low-risk of TRT on prostate cancer biology; exercise care in prostate cancer.

12 Annual digital rectal examination and prostate-specific antigen test important in TRT.

13 Testosterone therapy should be initiated only after full discussion and proper informed consent.

14 Patients should understand that treatment requires follow-up and monitoring.

15 There is a need for further research to better understand indications, long-term benefits and risks of current treatments of hypogonadism, as well as to develop new and improved treatment options.

Reference

1. Dean JD et al. The International Society for Sexual Medicine's Process of Care for the Assessment and Management of Testosterone Deficiency in Adult Men. J Sex Med 2015;12:1660-86.

Submitted by Dr Graham Neilsen

President of the Australasian Chapter of Sexual Health Medicine, Royal Australian College of Physicians

Sexual Health Physician and SAS-accredited Clinical Psychosexual Therapist

Stonewall Medical Centre, Brisbane, Australia

Risk Reducing Salpingo-Oophorectomy (RRSO): case report and literature review regarding aftercare for women over 50years of age at time of surgery

Chantelle Otten Master Of Science, Ingrid M Pinas Gynecologist ZBC FeM-poli Zwolle, Matthé PM Burger Gynecologist Oncologist. AMC Amsterdam The Netherlands

Introduction: A 54 year old woman underwent RRSO after her mother and aunt died of ovarian and breast and ovarian cancer respectively. Despite postoperative progressively debilitating vasomotor and mood symptoms and complete loss of energy and sexual interest, menopausal hormone treatment (MHT) was considered contra-indicated. Follow up surveillance was discontinued. Assessment at age 57 showed high cholesterol, chronic migraine and development of osteopenia, alongside psychosexual dysfunctions. Her younger sister of one year declined the surgery and remained under specialist care with regular ultrasounds and laboratory evaluations and to date is disease free. Her natural menopausal transition was uneventful, and also contrary to her older sister, the episodic migraines that occurred throughout her fertile life subsided.

RRSO is increasingly accepted by women at high risk of ovarian cancer. This is due to ultrasound and laboratory surveillance proving less effective in detecting early disease and reducing associated mortality. RRSO is preferred when these women reach age 40 years or after the conclusion of childbirth. In BRCA mutation carriers the surgical procedure results in risk reduction of 75%-96% for ovarian cancer and 50% for breast cancer. However, RRSO causes sudden menopause with bothersome symptoms, health risks and psychosexual setback as in the case report. Despite complaints and increased risks of cardiovascular disease, lung cancer, osteoporosis, cognitive decline and death from any cause, use of oral estrogen/progestogen combinations after RRSO is limited presumably for fear of increased breast cancer risk. Older and postmenopausal women benefit less from RRSO than the younger at-risk population but may experience similar consequences. Structured screening to detect treatable negative consequences is not fully established. Instead, postoperative management of severe menopausal complaints in women over the age of 50 challenges caregiver's resources to individualize treatment because RRSO was only recently introduced. Differential age-related benefits and risks have not been studied to the fullest degree.

Methods: We reviewed literature and published guidelines regarding RRSO aftercare for women over age 50 until July 2016 from PUBMED, Cochrane Library databases and websites from menopause and gynecologic oncology societies.

Results: There were no randomized controlled trials from which recommendations for optimal care after RRSO could be extracted. The updated 2016 Global Consensus Statement argues in favor of a wider use of MHT in women between ages 50-59 years, or 10 years post menopause with persistent vasomotor symptoms.

RRSO affects all domains of psychosexual functioning. Low dose local estriol treatment is effective for vaginal atrophy, dryness and dyspareunia and does not pose additional breast cancer risk. Androgen replacement therapy e.g. use of continuous transdermal testosterone, and professional counseling are shown to improve sexual function and decrease personal distress.

Risk of breast cancer with transdermal testosterone does not seem to be increased. Protective effects of MHT on bone health and cognitive functioning have been demonstrated in surgically menopausal women. Observational studies also suggest benefits on heart disease and survival compared to women who are not using MHT.

Discussion: RRSO is more effective in preventing breast and gynecologic cancers than current screening methods for women at high risk. There is growing acceptance of the procedure but postoperative and long-term health risks need to be taken into consideration. Adequate information and structured management strategies are essential in order to control early development of cardiovascular, bone and mental disease and address psychosexual concerns. Use of MHT after natural age of menopause is controversial although safety has been shown of oral estrogen/ progestogen combinations in women between ages 50-59 years or 10 years postmenopause.

Efficacy of vaginal estriol for urogenital complaints and transdermal testosterone for sexual disorders has been well established. Studies comparing the course of events and quality of life in women after RRSO with those who declined the procedure are lacking. Awaiting further studies, clinicians need to individualize aftercare strategies while controlling for unfavourable long-term consequences of RRSO and optimizing quality of all aspects of life.

Conclusion: Care for women over 50 years of age after RRSO is not consistent. Postoperative use of MHT is based on individual informed choices, but may be safely extended to women younger than 60 years old with persistent bothersome vasomotor symptoms. Scheduled specialized follow up visits and screening for cardiovascular disease, bone and cognitive decline are required for all women after RRSO. Besides wider use of MHT, local estriol, transdermal testosterone and psychosexual therapy need to be offered. Development of international guidelines and adequate education for caregivers to standardize post RRSO management is encouraged.

Submitted by Chantelle Otten

One of the aims of this Newsletter is to promote and showcase work and research being done by our members and especially the young upcoming sexologists in our region.

Chantelle is a SAS member.

If you have written, researched or taught and would like other AOFS members to know, please send to the editor.

Chantelle Otten's education includes BA/Psychological Science from Australian Catholic University and Masters of Science in Medicine, Sexual Health/Psychosexual Therapy from the University of Sydney. She has also trained at FemPoli clinic in Zwolle, The Netherlands alongside her mentor Dr Ingrid Pinas. She currently travels between Melbourne and Amsterdam to work with Dr Pinas on clinical research on the impact of migraines and hormones on sexual functioning, which is proposed for the 2017 ESSM conference in Nice, France.

Chantelle is opening her private clinic in Camberwell, Melbourne at the end of this year and she hopes to gain exposure as a sexologist who can identify with Gen Y and Gen X complexities.
Her specialisation is sexuality for female migraine sufferers and women who have experienced surgical and early menopause. E: info@chantelleotten.com

HOSTED BY THE SCHOOL OF SOCIAL SCIENCES AND PSYCHOLOGY, WESTERN SYDNEY UNIVERSITY

Sexual Science in the 21st Century: The Australasian Experience

The Society for the Scientific Study of Sexuality (SSSS) is pleased to announce its first Symposium in Australia. The Society, celebrating its 60th anniversary in 2017, has been a haven for sexual science and is excited to extend its reach to Australasia as we look to the future. We cordially invite you to join us in February at the beautiful Parramatta campus of Western Sydney University for 2 days of extraordinary speakers and concurrent sessions on the current state and future direction of sexual science in the Australasian region.

At the 2017 SSSS Australasian Symposium, we are seeking to be challenged by emerging and innovative research and practice from researchers, educators, and clinicians from a diversity of fields pushing the boundaries of sexual science. Concurrent session submissions will be considered from all areas of sexuality including anthropology, communication, education, natural sciences, medicine, media/film, psychology, public policy, public health, religion, sociology, and other related disciplines. Of particular interest are submissions focused on multidisciplinary perspectives on innovative regional sex research and considered perspectives on the future of sex research down under.

See Attached for Abstract Submission Guidelines!

Visit www.sexscience.org or e-mail SSSSAustralia@sexscience.org for details

Join us in 2017 for the SSSS Australasian Symposium in Sydney, NSW, Australia

Invitation to participate

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

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

Three editions fare planned for 2017— March, July and November.

Please send contributions to the Newsletter to Margaret Redelman at:

drmredelman@gmail.com

Warm regards

Dr Margaret Redelman OAM, Australia

Editor

Regional conferences 2017

18-20 January

19th Bangkok International Symposium on HIV Medicines

Queen Sirikit National Convention Center, Bangkok, THAILAND

www.hivnat.org/bangkoksymposium/contact

1-2 February

The Society for the Study of Sexuality (SSSS)

Host : School of Social Sciences & Psychology, Western Sydney University, NSW, Australia

www. Sexscience.org

SSSSAustralia@sexscience.org

Please send information if you know about sexual health/sexuality

conferences/meetings in your country