Clinical Education Session

https://ashm.org.au/training/SSHC-sessions/

About These Slide

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Please contact may.wang@ashm.org.au for details.
• Survey of people who acquired HIV infection after PrEP became widely available to identify barriers to PrEP prior to HIV diagnosis.

• Aimed to identify factors associated with barriers to PrEP use

• 394 patients with recently acquired HIV infection (negative result year prior)

• 268 eligible members who were invited to complete the survey, 122 (46%) responded

• No statistically significant differences between those who did and did not respond with respect to age, gender identity, race/ethnicity, year of HIV diagnosis, or HIV-transmission risk factor (data not shown).
Median age of the 122 survey respondents was 36 (range 21–74)

Male 93%

Men who have sex with men 84%

64% were of minority racial/ethnic background

87% had at least some college education

48% reported being diagnosed with an STI in the year prior to HIV diagnosis

34% had ever been diagnosed with depression

3.3% reported ever sharing needles.

Barriers to PrEP use prior to HIV diagnosis

30% had discussed PrEP with a provider prior to HIV diagnosis

17% did not initiate PrEP because they were diagnosed with HIV infection at PrEP intake.

4.1% respondents reported having used PrEP: All discontinued PrEP prior to HIV diagnosis

Most common barrier to PrEP use was lack of PrEP awareness 51%

In the subset of respondents who were aware of PrEP prior to HIV diagnosis: common barriers

Cost/insurance concerns 36%

Perceived low risk for HIV acquisition 24%

Not wanting people to think poorly of them for taking PrEP 15%
12% not understanding what PrEP was
14% reported PrEP referral process being too lengthy or difficult
10% concerns about potential side effects

<table>
<thead>
<tr>
<th>Reason</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not know about PrEP</td>
<td>51%</td>
</tr>
<tr>
<td>Cost or did not have adequate insurance coverage</td>
<td>36%</td>
</tr>
<tr>
<td>Did not think I was at risk for HIV</td>
<td>24%</td>
</tr>
<tr>
<td>Was diagnosed with HIV at PrEP intake</td>
<td>17%</td>
</tr>
<tr>
<td>Did not want people to think poorly of me for taking PrEP</td>
<td>15%</td>
</tr>
<tr>
<td>Referral process was too lengthy/difficult</td>
<td>14%</td>
</tr>
<tr>
<td>Did not understand what PrEP was</td>
<td>12%</td>
</tr>
<tr>
<td>Worried about side effects</td>
<td>10%</td>
</tr>
<tr>
<td>Too busy to do the lab work required</td>
<td>6.8%</td>
</tr>
<tr>
<td>Provider did not know enough about PrEP or did not think I needed it</td>
<td>6.8%</td>
</tr>
<tr>
<td>Did not want to take a daily pill</td>
<td>6.8%</td>
</tr>
<tr>
<td>Had a prescription but never took it</td>
<td>1.7%</td>
</tr>
<tr>
<td>Did not know my provider offered PrEP</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

Percentage of respondents who reported various reasons for not using PrEP.

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Year of HIV diagnosis

- Lack of PrEP awareness
- Cost/insurance
- Perceived low HIV risk

- 2014: 61%
- 2015: 40%
- 2016: 25%

- 2014: 37%
- 2015: 27%
- 2016: 23%

Percentage of respondents by year of HIV diagnosis.
Small sample size (might not relate to populations outside the study)

Only 45% eligible who were invited to complete the survey

Accuracy of Recall

Possible selection bias if respondents and non-respondents differed in key ways that affected their reported barriers to PrEP use.

Selection bias could also have been introduced by the exclusion of patients whose primary care providers prefer they not be contacted for this study

Those who did not have a personal email address on file at KPNC; however, only nine (3.2%) of the 277 eligible patients were excluded for these reasons.

Cost may be an even greater barrier to PrEP use for people who are uninsured

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Barriers to PrEP use in a study population with recently acquired HIV infection

Considerations for SSHC


ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE (afao) The rate of HIV diagnosis is 1.6 times higher among the Aboriginal and Torres Strait Islander people than Australian born non-Indigenous people (4.6 v 2.8 per 100,000).

www.afao.org.au
Medicare illegible/ CALD/ Transgender/ Sex Work/ Homeless/ Mental Health & Substance Misuse

Overseas-born HIV diagnoses in Australia attributable to MSM, the proportion of Asian-born MSM has increased from 30% in 2006 to 57% in 2015.

ACON/SSHHC Chinese MSM screening

Future: Other languages                                            Long Acting ARV’s (injectable as PrEP)

SHOE SMS/Email PrEP links


www.pan.org.au/buy-prep-online
Australian HIV health practitioners, practices and attitudes to: Addressing smoking among people living with HIV (PLHIV) Bell et al April 2019

People living with HIV have high rates of tobacco smoking, and smoking is a leading cause of premature mortality and morbidity.

179 health care workers working with PLHIV completed a survey (On-line 10-15 minute survey)

61.5% Medical Practitioners (of these 84% were ART prescribers)

49.7% see PLHIV regularly 50.3% see PLHIV irregularly

64.8% worked in metropolitan centres 58.1% worked solely in the public sector

Most respondents reported both identifying and recording the smoking status of their patients with HIV.

47.5% had received brief intervention smoking cessation training

Almost three-quarters of respondents regularly assessed patient readiness to quit.

96.1% of respondents non-smokers

17% reported providing self-help resources (always or most of the time)
Internationally best practice guidelines for addressing smoking follow the 5A framework.

5A framework for addressing smoking (Ask, Assess, Advise, Assist, Arrange)

Table 1. Respondent delivery of 5As of smoking cessation.

<table>
<thead>
<tr>
<th>SAs domain</th>
<th>Activity/theme</th>
<th>Activity performed (always or most of the time) N (%)</th>
<th>At least one activity performed (always or most of the time) N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask</td>
<td>Ask status</td>
<td>164 (91.6)</td>
<td>169 (94.6)</td>
</tr>
<tr>
<td></td>
<td>Record status</td>
<td>164 (91.6)</td>
<td></td>
</tr>
<tr>
<td>Assess</td>
<td>Readiness to quit</td>
<td>132 (73.7)</td>
<td>139 (77.7)</td>
</tr>
<tr>
<td></td>
<td>Nicotine dependence</td>
<td>89 (49.7)</td>
<td></td>
</tr>
<tr>
<td>Advise</td>
<td>Advise patient to quit</td>
<td>147 (82.1)</td>
<td>147 (82.1)</td>
</tr>
<tr>
<td>Assist</td>
<td>Health education</td>
<td>152 (84.9)</td>
<td>160 (89.4)</td>
</tr>
<tr>
<td></td>
<td>Self-help resources</td>
<td>31 (17.3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral</td>
<td>111 (62.0)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td>114 (63.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacotherapy</td>
<td>109 (60.9)</td>
<td></td>
</tr>
<tr>
<td>Arrange</td>
<td>Follow up progress</td>
<td>119 (66.5)</td>
<td>131 (73.2)</td>
</tr>
<tr>
<td></td>
<td>Discuss relapse prevention</td>
<td>92 (51.4)</td>
<td></td>
</tr>
</tbody>
</table>

All SAs 110 (61.5)
30% rate of PLHIV smoked in the previous year (Australia)

National Health Survey:

According to the Australian Bureau of Statistics’ National Health Survey, the prevalence of daily smoking for Australians aged 18 and over in 2017–18 was 13.8%, and 13.3% among people aged 15 years and over.

Things SSHC can do: Counselling Referral SSHC

GP for Nicotine Replacement Therapy

On-line Resources [quitnow - Welcome to the Quitnow Website](http://www.quitnow.gov.au)

Annual Health HIV Comorbidity Clinic SSHC (QI/ KPI audit referral numbers)
Knowledge and awareness of HIV self-testing among Australian gay and bisexual men: a comparison of never, sub-optimal and optimal testers willingness to use, HIV self test. Dean et al. 2019

An anonymous online cross-sectional survey involving a convenience sample of 241 Queensland GBM over 18 years of age was conducted in 2016 using Checkbox Survey Software. The survey included standard demographic data items and questions on past sexual and HIV testing practices (HIVST).

Respondents were classified into low and high-risk HIV categories using the 2014 Australian Sexually Transmitted Infection and HIV Testing Guidelines for Asymptomatic Men Who Have Sex with Men: STIGMA guidelines.

The respondents were further divided into three testing groups based on their reported testing patterns and risk classification:

(1) Optimal Testers (meeting the STIGMA guidelines for their risk status)

(2) Suboptimal Testers (testing but less often than STIGMA recommendations)

(3) Never-testers
Knowledge and awareness of HIV self-testing among Australian gay and bisexual men: a comparison of never, sub-optimal and optimal testers willingness to use, HIV self test. Dean et al. February 2019

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HIV Self-testing was seen as empowering, convenient and an acceptable option by users.

Not having to discuss sexual practices & not having to see a health care professional and not waiting for results

13% had never had a HIV test

41.9% testing sub-optimally (STIGMA)

58.4% had never heard of HIV Self-testing

56.2% reported willingness to Self-test (“Likely” to use HIV Self-test)
Preferred location for accessing HIVST kits

61.1% Online availability and sexual health clinics were the two most preferred locations for accessing HIVST

58.2% over-the-counter from a pharmacist

47.75% supermarket

52.6% GP

51.3% peer-based community organisation

28.9% Sex-on-premises venues

31.9% vending machines

23.6% Only were willing to pay for a test kit ($15 being the estimated preferred price)

Common concerns against HIVST use were:

57.4% concerns about kit accuracy

57% not knowing where to access HIVST

56.1% fear of a positive results without professional support

53.9% absence of post-test support

45.7% not knowing what to do if the result was positive
Where can I get tested?
Most people in NSW get HIV/STI testing with a general practitioner (GP). GPs also provide Cyt Test (previously known as pap smear), contraception, PrEP & other services related to sexual health.

If you’re gay, exclusively heterosexual and have no genital symptoms, the [online testing](#) site has all the tests you need. A referral isn’t required for testing with a GP, but bringing it with you can be an easy way to start the conversation. If you’re gender and/or sexuality is more diverse, STI testing recommendations may need to be personalised depending on your experience. Talk to your doctor about which tests are right for you.

[b]Free testing[/b] is available with a Medicare card through any GP who bulk-bills and through some specialist services even if you don’t have Medicare or Insurance.

Specialist services that may provide HIV/STI testing include:
- [Sexual Health Centers](#)
- [Health Clinics](#)
- [NSW Public](#), sexual health for trans and gender diverse people.
- [Check4Free](#), cervical screening and STI testing for Uly people
- [HGST](#), STI testing service for gay, bisexual, and other men who have sex with men.
- [Aboriginal Medical Services](#)
- [Women’s Health Centers](#)
- [Reproductive Health Clinics](#)

[b]Online testing[/b]
- [DST and Syphilis](#) – free HIV & Hepatitis C testing, available in NSW only
- [Syphilis testing](#) for a fee, available across Australia
- [Rapid HIV home testing kit](#) for a fee, available across Australia

For information about which service is right for you:
DO YOU NEED A HIV TEST?

DO YOU NEED A HEPATITIS C TEST?

The answer is yes. HIV and Hep C are treatable health conditions. The first step to living a healthy life is to get tested. A dried blood spot (DBS) test is a new, free, easy, private and accurate way to test for HIV and hepatitis C. It involves a few drops of blood that you collect from your finger. You return the DBS test to us in a reply paid envelope and receive the result by phone, text or email.

You don't need to go to a clinic or see a doctor to do this test.

Australia’s only approved HIV Self Test

Safe, convenient and accurate

BUY NOW
Accurate Blood Collection
The easy-to-use blood collection unit is designed to collect exactly the right sample volume, ensuring optimal test performance.

Built-in Safety Lancet
The auto-retracting safety lancet eliminates the risk of hazardous sharps injuries by locking the needle inside the device after use for safe disposal.

Easy Blood Delivery
Blood is delivered directly to the test strip by simply rotating the blood collection unit. The test result is displayed clearly in just 15 minutes.
Outcomes of Resistance-guided Sequential Treatment of *Mycoplasma genitalium* Infections: A Prospective Evaluation

Tim R. H. Read,1,2 Christopher K. Fairley,1,2 Gerald L. Murray,3,4,5,6 Jorgen S. Jensen,7 Jennifer Danielewski,3,4 Karen Worthington,2 Michelle Doyle,2 Elisa Mokany,8 Litty Tan,8 Eric P. F. Chow,1,2 Suzanne M. Garland,3,4,6,9 and Catriona S. Bradshaw1,2
Background

- Rising macrolide and quinolone resistance in *Mycoplasma genitalium (MG)* necessitate new treatment approaches
  
  - cause of nongonococcal urethritis (NGU) and is associated with cervicitis, pelvic inflammatory disease (PID) and poor obstetric outcomes

Outcomes of Resistance-guided Sequential Treatment of Mycoplasma genitalium Infections

- Macrolide-resistant mutations (MRMs) are now reported in >50% of diagnosed infections in many countries
- unknown to what extent this represents emerging resistance during treatment vs populations with preexisting MRM
- Pristinamycin has recently been shown to cure only 75% of macrolide-resistant infections
- Meta-analysis has shown decline in cure for moxifloxacin from 100% in studies prior to 2010, to 89% in studies from 2010 onward
Background

• European, British, and Australian treatment guidelines recently recommended replacing azithromycin as treatment for NGU with doxycycline 100 mg twice daily for 7 days
• only cures about a third of MG however, does not appear to select further identifiable resistance in treatment failures
• Studies of extended azithromycin treatment of MG show better outcomes in those previously treated with doxycycline
• Is lower microbial load in play?

Background

• In 2016, Melbourne Sexual Health Centre (MSHC) introduced a 3-step approach to treatment of MG
  1. doxycycline (100 mg twice daily for 7 days) for the treatment of NGU, proctitis, and cervicitis
  2. combined diagnostic/resistance assay that detected MG and the 5 main MRMs
  3. treatment guided by the macrolide-resistance result
Method

- Prospective evaluation from 20 June 2016 to 15 May 2017 of patients treated by resistance-guided therapy for MG at MSHC
- All received doxycycline 100 mg twice daily for 7 days then
  - no detectable MRMs = azithromycin 2.5 g (1 g followed by 500 mg daily for a total of 4 days)
  - detectable MRMs = sitafloxacin 100 mg twice daily for 7 days.

Method

- Test of cure using the same assay 21–28 days after starting sitafloxacin or azithromycin
- sub study to measure the impact of doxycycline on organism load was performed in 56 patients with MG urethritis
  - 2nd urine sample tested simultaneously by quantitative PCR for MG load alongside original sample
Method

• Inclusion Criteria:

(1) treatment followed protocol
(2) returned for TOC at 14–90 days after starting their second antibiotic
(3) did not report ongoing condomless sex with a pre-treatment partner who had not completed treatment

Method

• Test-of-cure results stratified by posttreatment reinfection risk:

  • no sex since treatment
    • sex with 100% condom use
      • any condomless sex with a fully treated partner
      • any condomless sex with a new partner
      • any condomless sex with a partner who had not completed treatment
Results

Treatment Outcomes

- 73/77 (94.8%) cure in macrolide susceptible cases receiving doxy then 2.5 gm azithro

- 154/167 (92.2%) cure in macrolide-resistant cases receiving doxy then sitafloxacin

- No difference in sexual risk group, sites of infection, symptom status between groups in those cured
Self reported adherence

<table>
<thead>
<tr>
<th>Adherence</th>
<th>Doxycycline</th>
<th>Azithromycin</th>
<th>Sitafloxacin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took all doses</td>
<td>195 (89.9%)</td>
<td>63 (100%)</td>
<td>138 (90.8%)</td>
</tr>
<tr>
<td>Missed 1-4 doses</td>
<td>18 (8.3%)</td>
<td>0</td>
<td>10 (6.6%)</td>
</tr>
<tr>
<td>Missed &gt;4 doses</td>
<td>4 (1.8%)</td>
<td>0</td>
<td>4 (2.6%)</td>
</tr>
</tbody>
</table>

Results

- *MG* bacterial load after/during doxycycline in 56 men with urethritis:
  - Undetectable 22 (39%)
  - Reduced but detectable 28 (50%)
  - Increased 6 (11%)
Discussion

• >92% *MG* infections can be cured in population where 2/3 macrolide resistant & 20% also likely quinolone resistant

• Hypothesis: reduction in bacterial load before 2\textsuperscript{nd} antimicrobial contributed to high cure rate

• Replacing azithromycin with doxycycline for the initial treatment of STI syndromes, and increasing the dose of azithromycin, appears to increase proportions cured and to reduce selection of macrolide-resistant mutants

Limitations

• Multiple components not implemented separately therefore difficult to determine what brought about improvement in cure rate

• No control group

• Effect of doxycycline on bacterial load only measured in NGU group
A Fungal Immunotherapeutic Vaccine (NDV-3A) for Treatment of Recurrent Vulvovaginal Candidiasis—A Phase 2 Randomized, Double-Blind, Placebo-Controlled Trial

John E. Edwards Jr,1,2 Michael M. Schwartz,3 Clint S. Schmidt,3 Jack D. Sobel,4 Paul Nyirjesy,5 Florian Schodel,6 Erica Marchus,3 Mary Lizakowski,3 Elizabeth A. DeMontigny,3 Jesse Hoeg,3 Tuomas Holmberg,3 M. Timothy Cooke,3 Keila Hoover,7 Lance Edwards,8 Mark Jacobs,9 Steven Sussman,10 Michael Augenbraun,11 Michael Drusano,12 Michael R. Yeaman,1,2 Ashraf S. Ibrahim,1,2 Scott G. Filler,1,2 and John P. Hennessey Jr3

Background

• Globally, a substantial number of women are afflicted with vulvovaginal infections due to Candida spp

• Candida infections have substantially increased in prevalence in recent years, as has antifungal resistance

• Self-reported recurrent vulvovaginal candidiasis (RVVC) estimated by to impact 6%—9% of women in the United States
Background

• Recurrent vulvovaginal candidiasis (VVC) has a substantially negative impact on quality of life
• Current treatments variable efficacy and potential safety concerns
• Safe and effective vaccine would represent a substantial improvement in management of RVVC
• NDV-3A vaccine contains protein (Als3) that allows candida spp to adhere to vaginal wall (purified recombinant fungal protein vaccine)

Method

• Exploratory randomized, double-blind, placebo-controlled trial

• Explored the safety, immunogenicity, impact on (VVC) recurrence and time to first recurrence
Method

• 188 women aged 18-55 years, using approved method of birth control and presenting with clinically diagnosed active VVC enrolled from July 2013 to May 2016 in 20 study sites within the continental United States

Method

• Participants were scheduled for 7 office visits and allowed unlimited unscheduled visits to address questions or symptoms

• complete history, including review of adverse events and medications, physical examination, symptom scores, sign scores, mycological culture of vaginal swabs, cervicovaginal wash & bloods taken
Method

• All patients pretreated with 3 doses of oral fluconazole (150 mg each) taken on days −14, −11, and −8
• At day 0, those with sign/symptom scores ≥3 were exited from the study
• Remaining participants were randomized to a single intramuscular dose of either vaccine NDV3-A or placebo
• All were given 3 more doses of fluconazole (150 mg each) taken on days 0, 7, and 14

Method

• If presented at office visits after day 17 with symptom scores ≥3 were considered recurrent cases of VVC
• An episode of VVC in vaccinated patients within 17 days of a previous episode was considered a failure of fluconazole therapy and not counted as a new recurrence of VVC.
Results

• Adverse events mild to moderate not considered related to study treatment
  • 58% Placebo & 55% vaccine at least 1 adverse event

• Both NDV-3A and NDV-3 elicited robust immunologic responses, with serum anti-Als3 IgG and IgA1 titres significantly higher in the vaccine groups than the placebo group at all time points beyond baseline
Results

- vaccine efficacy appeared to decrease with increasing age
- subset of patients aged <40 years was analysed alongside the dataset of all patients
Discussion

• Vaccine shown to be generally safe with comparable AE to placebo
• Rapid immune response in virtually all vaccine recipients
• As vaccine was not expected to eradicate the organism chose recurrence as a return of symptoms
• Host response to vaccine often age-dependant noted impact of NDV-3A was higher in patients <40 years old
Discussion

• women aged >40 years may require separate studies and perhaps a different course of treatment
• Therapeutic vaccine to mitigate disease from pathogen present before vaccination

Limitations

• efficacy endpoints on a post hoc basis, which will need to be confirmed in further studies
• lack of standardization of clinician’s sign-scoring technique
• did not include a quality-of-life assessment
GENITO PELVIC PAIN / PENETRATION DISORDER: GPPPD

OVERVIEW

- GPPPD Diagnosis & Prevalence
- Pain or Sexual Disorder?
- Multiple Aetiology
- GPPPD Assessment
- Multi-Team Treatment Approach
- Psychological Treatment
GPPPD

• Previously Dx Vaginismus or Dyspareunia: DSM-5 fused into GPPPD due overlap Sx and clinically indistinguishable.
• ICD-10 still separate Dx

  ✓ Intercourse specific
  ✓ Difficulty with penetration: persistent or reoccurring
  ✓ Genito-pelvic pain with penetration attempts
  ✓ Fear or anticipation of pain with penetration
  ✓ Tight pelvic muscles
  ✓ At least 6 months duration: Life Long or Acquired
  ✓ Severity = Distress: Mild - Severe

  ➡ Not sexual pain, rather PAINFUL SEX

GPPPD PREVALENCE

• Hard to say as new DSM criteria, vaginismus 1-6%, dyspareunia 5-25%. Different ranges due study design definition.

• Australian Longitudinal Study of Women’s Health 2012.
  • N= 4366, 1 month duration painful sex 5%
  • 12 month follow up N= 955 persistent 35%
  • Non cohabiting increased incidence x2
IS IT A PAIN DISORDER OR SEXUAL DISORDER?

- Both! Most genital pain syndromes will impact sexual function
- Well established fact that pelvic floor reacts to emotional states

- Anticipation of pain/pain turns on the protective system F/F/F and turns off the sexual system.
- Women w aversion experience pain once they attempt I/C.

DIAGNOSTIC CONFUSION

- No uniform assessment protocol
- Different methods assessment depending on discipline

- Multifactorial
- Involves multiple high value systems:
  - reproductive, digestive,
  - excretory, sexual, musculoskeletal systems

- Interconnected and turning on and off automatically

- Problem in one system can generalise to other system interconnecting muscle and nerve systems (VD =IC)
MULTIPLE PHYSICAL AETIOLOGY

• Musculoskeletal
• Dermatological: Vestibule/vulvodynia, lichen sclerosis/planus
• Vaginal infections (HSV/Candida) / PID
• Bladder infections/Interstitial Cystitis
• Ovarian cancer and treatments
• Pudendal neuralgia/ Pudendal entrapment (trauma)
• Endometriosis/ Adenomyosis/Fibroids
• Constipation, IBS, diverticulitis
• Ulcerative colitis/Crones

PHYSICAL AETIOLOGY CONT.

• Anal fissures, pilonidal sinus
• Ovarian cysts/PCO
• Ectopic pregnancy/miscarriage
• Kidney stones
• Child birth trauma/surgery
• Hernia
• Fibromyalgia
• Hormonal changes/ contraception
• Allergic reactions
PSYCHOLOGICAL CONTRIBUTIONS

- GAD: increase IBS, pelvic tension
- Somatic symptom disorder: negative appraisal, reduce pain resilience, preoccupation, Google Dr, low pain self-efficacy
- Specific phobia: birth fear, penetration fear.
- PTSD: sexual assault
- Unpredictable family of origin (ETOH, DV family, emotional abuse)

- Sexual desire discrepancy (pressure to please) leading to inadequate stimulation (mercy sex), persistence with I/C despite pain
- Sexual Interest/ Arousal Disorder (secondary to GPPP)
- Co-morbid depression, perfectionism, neuroticism, disgust
- Less knowledge of sexual response, body
- Reduced masturbation practices
GPPPD: ASSESSMENT

• Normal sexual health/medical assessment with specific focus on:

• Hx of penetration: tampons, PAP, digital penetration, intercourse, generalised or context specific (partner specific vs masturbation)

• Viewing of own genitals or avoidance (looking for disgust reaction)?

• Can they orgasm: how...rubbing with sheet, pants on: idiopathic sexual arousal, different nerve systems for different orgasms

GPPPD: ASSESSMENT CONT.

• Non-provoked pain: identify where exactly on the genitals (abdomen, vestibule, anus, vagina)

• Pain on urination: bladder infections, difficulty urinating or defecating: musculoskeletal problems.

• Provoked pain on penetration: when (at beginning I/C, during, after) where? introitus or deep
PAIN @ INTROITUS

• Vaginal and vulvar skin issues – dryness and splitting, dermatological conditions, recurrent fungal, bacterial or viral infections HSV

• Vaginal thinning (atrophy) – dryness, burning, and itchiness (Hormone changes seen w polycystic ovaries/anorexia/CA Treatments/ menopause/high athletic training/low body weight)

• Unperfornated hymen

• Congenital abnormalities

DEEP PAIN ON PENETRATION

Deeper pain in pelvis, low back or abdomen

• Endometriosis – significant pain with periods, bowel movements, pain between periods, very heavy bleeding and clots.

• Trauma after having a baby, from a fall or injury.

• Pelvic scarring or adhesions – after an infection, surgery or radiation treatment

• Bowel issues such as IBS, constipation and straining, loose stool.
DEEP PAIN ON PENETRATION

- Musculoskeletal, ssacroiliac or hip joint pain, aching in the low back, hips, pelvis or low abdomen, limping (gait and posture)
- PID – other indicators of infection such as fever, diarrhoea, cramping, coloured or smelly discharge, stinging urination or a history of unprotected sex
- Sexual positions related to sensitive cervix; penis size

PERSISTENT PAIN CAN BE SUPERFICIAL OR DEEP OR BOTH

- Nerve injury/trauma after surgery and post baby
- Bladder issues such as recurrent infection or Painful Bladder Syndrome, IC
- Pain getting worse at end of day or with prolonged sitting:
  - Pelvic floor hypertonicity/Pudendal neuralgia
PUDENDA: SHAMEFUL PARTS

GPPPD: TREATMENT

- Majority of women are ashamed and don’t disclose until unbearable
- Women usually seen more than 2 different clinicians prior to diagnosis
- Previously 2 distinct treatment approaches:
  - psychological or medical
- Pain is biopsychosocial: physical/environmental/relationship and psychological factors, exacerbate and maintain pelvic pain.
MULTIDISCIPLINARY TEAM APPROACH

- **Physiotherapist** to identify musculoskeletal conditions, pelvic floor relaxation, myofascial release, behavioural exposure/motivation to vaginal trainers.

- **Sydney Pelvic Floor Clinic Bondi Junction**

  Loads of resources: on line education video’s
  - Pelvic stretches online
  - Run 2 hour group education session: Pelvic Pain and Your Brain
WHRI: WOMEN’S HEALTH RESEARCH INSTITUTE:

• Inhouse multidisciplinary team
  • Gynecologists, Pain specialists, osteo/physio and counsellor

• Pain specialist for chronic pain conditions:
  • somatic pain disorder
  • pelvic nerve conditions
  • Interstitial Cystitis
  • Endometriosis
  • Persistent vulvar/vestibulodynia

WHRIA
GPPPD: PSYCHOLOGICAL INTERVENTIONS

- Realistic goal setting around pain management and penetration
  - Pain resilience and self-efficacy vs pain free
  - Outercourse vs intercourse
  - Improved sexual communication/relationship satisfaction
  - Subjective sexual satisfaction rather than goal oriented I/C focus...reduce the push through and shame/disgust

- Motivation and importance of homework:
  - Diary with mood graph and pain scale
  - Procrastination
  - Avoidance

GPPPD: PSYCHOEDUCATION ON PAIN

- Pain is worse when you don’t understand it!

- WHAT is going on: Identify initial injury and what is maintaining or exacerbating it

- Increases pain self-efficacy and control

- Partner facilitated active coping
GPPPD: PAIN EDUCATION: MIND BODY CONNECTION

• Explain Pain handbook: Protectometer. Moseley & Butler

• Lorimer Moseley Mind and Pain education TED talk
  • [https://www.youtube.com/watch?v=bj9CUqzw6f8](https://www.youtube.com/watch?v=bj9CUqzw6f8) (24.10 minutes)
  • [https://www.youtube.com/watch?v=ICF1_Fs00nM](https://www.youtube.com/watch?v=ICF1_Fs00nM) (1.23 hours)

GPPPD: FEAR AVOIDANCE MODEL
VLAEYEN & LINTON(2000)

• Identified the what....move to the maintaining cycle
• What/medical/physical become less focused
• Change to why it is still happening
  • Time to diagnosis, unclear diagnosis? Unsuccessful Rx.
  • Threatening information gained through clinicians:
    Chronic, Endo invading my body/organs, coming back.....
COGNITIVE RESTRUCTURING: PAIN CATASTROPHISING

• Pain Catastrophising:
  • Getting worse, I cant stand it, My day is ruined
  • I’ll never have a baby/relationship/ll be alone

• Explain CBT: Catastrophic thoughts = threatening thoughts= increase emotional reaction = hypervigilance= increase tension in the pelvis physical sensations = freeze, tucking under, avoidance (behavioural or thinking about it)

• Change language: I cant stand it, I cant do it, it hurts, I’m dry, its rubbing, wrong position, not in the mood, not arouse, distracted

COGNITIVE RESTRUCTURING: SHAME & DISGUST.

• Shut down sexual system turn on threat

• CBT: Shameful thoughts “I'm a freak, no one will want me” = avoiding, secretes, silence, turning away, relationship conflict.

• CBT: Disgusting thoughts “Yuck, gross” = moral distancing, expelling, rejecting.
  • Can’t let anyone in (literally) if disgusted by self/genitals/body fluid

• Change to self loving talk, kindness, personal encouragement, more neutral, curious, feminist thoughts
SHAME AND DISGUST: FEMININE PRIDE
CONT.


KNOWLEDGE OF FEMALE GENITALS & MENSTRUAL CYCLE

• Flow app https://flo.health/
• Betty Dodson: https://www.dodsonandross.com
• Sex Smart Films: http://www.sexsmartfilms.com/
• Stop self treatment of thrush/douching
COGNITIVE RESTRUCTURING: HYPERVIGILANCE

- Address hypervigilance (attention focus) on pain:
  - High value area, prioritized over other body parts.
  - Brain is keen to keep safe and responds in sensitised/dramatic way to perceived threat
    - E.g. leg cramp vs pelvic pain response
    - Brain wired to focus threat over sexual stimuli

- Teaching mindfulness skill: Change perception to non-judgmental awareness of body: brain controlling pain perception

MINDFULNESS

- Connect body and breath and pelvic floor;

- Calming the pelvis, down regulating the system

- General relaxation exercises, look at lifestyle: “BUSY” is a problem.

- Make time essential to treatment: Life Skill

- Sleep, food (carbs/sugar/stimulants spike FF system) exercise

- Can’t relax pelvic floor if unable to slow down, take time for self and reduce general anxiety and stress.
GPPPD: **GRADUAL EXPOSURE**

- Avoidance: never have opportunity to learn and change.
- Avoidance spreads: avoid sex, avoid affection, avoid intimacy
- Disuse: poor condition: Sexual dysfunction
- Cheer Leader: Motivator, get excited with them

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GPPPD: **GRADUAL EXPOSURE**

- Body exposure genitals/ self exploration (Rx disgust)
  - Look mirror, identify anatomy, feel fingers.

- Betty Dodson: [https://www.dodsonandross.com](https://www.dodsonandross.com)

- OMG YES. Sexual arousal/ orgasm [https://www.omgyes.com/](https://www.omgyes.com/)
GPPPD: **GRADUAL EXPOSURE**

- Graded exposure sensate focus, fingers outside, fingers inside.
- Fingers with mirror
- Trainers, get sexually excited to reduce the clinical experience
- Preparation for intercourse.
- Improvement not linear: always lapse, plateau

GPPPD: **INFORMATION PROCESSING MODEL (JANSSEN 2000)**

- (fear of) pain increased attention to pain and, therefore, less attention to sexual stimuli, more negative appraisal of sexual stimuli, decreased motivational tendencies, and lower subjective and genital sexual arousal/ also describes why is some women low subjective arousal and genital arousal