



# British Society for Sexual Medicine Newsletter

Issue 2 September 2005

## Leading sexual health expert receives OBE

Dr. Olwen Williams has been awarded the OBE in recognition of her work in placing sexual health on both the political and social agenda in Wales.

She has been involved in genito-urinary medicine for 17 years, and has been based in North Wales for the past 13 years. She divides her time between Wrexham Maelor Hospital and Ysbyty Glan Clwyd, Bodolwyddan, and has built up a high-quality sexual health service in the region.

Olwen's work in revolutionising sexual health in North Wales has been recognised before, when she was awarded Welsh Woman of the Year in 2000.

"It gets no easier to accept awards," she said. "But this is an award for my team, who have backed me 100%. Without their hard work, none of what we have done would have been possible."

"When I saw a white envelope with Her Majesty's Service printed on it, I thought I was being summoned for Jury Service! I was just taken aback to learn of this," Olwen told her local newspaper, the Chester Chronicle. "And I'm absolutely delighted. When I opened the envelope, I cried because it is a great honour for the team."

When Olwen decided to specialise in GUM in 1988, it raised a few eyebrows.

"A lot of my family and peers thought I was mad," said Olwen. "I was in my 20's and they all expected me to go into a conventional medical field. But it was at the beginning of the Aids epidemic and I wanted the challenge."

Olwen moved to North Wales and began building a GUM facility from scratch.

"When I got here, there was me and a filing cabinet and that was GUM," she said. "The unit treated around 1,000 people a year. Now we treat 5,000 and offer a standard of care that is not bettered by many."

Olwen's awards are a source of pleasure for her patients, "I like them to know I have an OBE because it is sort of a Royal Seal of Approval," she said. "I will use it like I use any award, to push the service forward. We've been able to give a voice to how the services should develop across Wales."

Olwen has sat on a number of committees debating the issue of sexual health, and is currently working with the Welsh Assembly government on how to integrate services across Wales.

"We have got a problem with teenage pregnancies and sexually-transmitted infections in Wales," she said. "We have got to find a way forward so that we can improve access to services. We must get to people early and also employ services in a better way."



Dr. Olwen Williams, OBE

## Sildenafil now indicated for pulmonary hypertension

Primary pulmonary hypertension affects approximately 1 in 200,000 people, is progressive and leads to right heart failure and death usually within 3 years of diagnosis.<sup>1</sup> In the pulmonary circulation, PDE5 is one of the isoforms that regulates pulmonary resistance.<sup>2</sup> PDE5 inhibition with sildenafil and other PDE5 inhibitors has been shown to reduce pulmonary artery pressure in experimental animal models and healthy volunteers, but most importantly patients with pulmonary hypertension.

In 2002, John Chambers and I reported 2 cases of primary pulmonary hypertension benefiting from oral sildenafil (50 mg and 100 mg thrice daily) in the short and long-term regarding improved quality of life, exercise ability and sustained lowering of pulmonary pressure.<sup>3</sup> Subsequent larger studies have confirmed the benefit using both intravenous and oral sildenafil. In one study a patient no longer needed to be on the transplant list.<sup>4</sup> Currently treatment is often delayed until significant symptoms develop (invariably breathlessness), when benefit occurs, but the obvious next question is whether the disease progression can be modified to a greater degree by earlier initiation of sildenafil. Our traditional ED use of sildenafil is on demand, so we need long-term efficacy and safety data with a regular dosing regimen. The early data are encouraging, and when the poor prognosis is considered, it is unlikely that problems will be encountered.

Current treatments include anticoagulation, vasodilator therapy with calcium antagonists, long-term treatment with prostacyclin and in the severely symptomatic, the endothelin receptor antagonist bosentan. Sildenafil is compatible with all these therapies, and combination therapy may improve the overall clinical condition.

PDE5 inhibition has important cardiovascular effects. Sildenafil began as a drug for angina, became a

## From the Editor



Welcome to the first in a new style of BSSM Newsletter. It is a great privilege for me to be able to bring to you such a diverse and interesting selection of articles.

One of the main news features looks at the work of Dr. Olwen Williams, who was awarded the OBE in this year's Queen's Birthday Honours List. Sexual medicine is finally getting the establishment recognition it deserves.

Prof. Wallace Dinsmore shares his thoughts with us about the early days of our society. Many of the 'original cast' are still very active members today, although even this eminent group can't claim to have been practising sexual medicine in the times of the Hittite civilisation, which is also covered in this issue. We get a fascinating insight into early sexual medicine from Dr. David Edwards, who is currently studying for his M.Sc. in Medical Anthropology.

One of the recent pieces of research to hit the headlines, both at home and abroad, has been Dr. Irwin Goldstein's research on the oral contraceptive pill and long-term loss of libido. In this newsletter, we get a top expert in contraception and sexual health to discuss the relevant implications of these findings and the impact this type of study has on the general public.

In our conference round-up, some of our members bring to you the latest news from as far afield as San Antonio and Torquay. What a well travelled lot we are in our quest to seek out the latest and the best in sexual medicine. It seems that there was a whole conference on the menopause, and somehow the subject of sex was neatly avoided!

And finally sildenafil literally breathes new life into people. We have a report from Dr. Graham Jackson on the exciting new application for sildenafil citrate.

We hope that this newsletter goes from strength to strength. Already it has double the number of pages compared with the previous edition. Moreover, this is the voice of the BSSM and the way it communicates to its members. Let's maintain the good work and keep the articles, conference round-ups and journal watch items coming in, as well as any snippets of information, either small local issues or personal triumphs that you would like to share. We intend to keep it in the spirit of a newsletter. Even if you have never written articles before, please send your thoughts to me at: eastburyward@yahoo.com

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revolutionary drug for ED and is now re-entering the cardiac arena. Pulmonary hypertension is a disabling progressive condition and though uncommon, deserves to be treated aggressively, even if quality of life is the only improvement, though obviously prognostic benefit would be extremely important.

All credit to Pfizer for developing a programme which has been seen to help both children ("Viagra saved my baby's life") and adults. The next step is to look at other conditions with increased vascular resistance – Raynaud's phenomenon, hypertension, heart failure and altitude sickness. If PDE5 inhibitors improve endothelial function in the long-term, their use will extend to prevention in high-risk individuals such as diabetics. From saving sex lives to saving life in its widest sense – are these the drugs of this decade?

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# Conference Round-Up

American Urological Association Meeting, San Antonio, 21-26 May 2005

The meeting was held in the delightful Texan city, San Antonio. The city is perhaps better known for being the home of Alamo, Tex-Mex food, and a championship-winning basketball team, but it also houses one of the premier conference facilities available in the U.S. From Britain, though, it is not the easiest place to get to because it requires routing through either Chicago or Dallas, both airports which, in my experience, are best avoided at all costs!

From a sexual medicine perspective, the highlight of the conference was the seven presentations regarding Dapoxetine, which will be the first licensed therapy for premature ejaculation.

These presentations highlighted the safety and efficacy of Dapoxetine from its earliest research trials, and engendered much active discussion. The associated symposium also highlighted the importance of patient-related outcomes in the management of premature ejaculation. Speakers stressed the fact that it is not just about the time, but about the feeling of the patient and his partner's satisfaction with the sexual event and the concept of control over ejaculation. We well appreciate this, but some urologists don't.

The majority of the presentations and symposia regarding the PDE5s focused on the importance of the partner and on a variety of preference studies. I was particularly struck by the fact that all of the companies seemed to have latched onto the partner concept at approximately the same time and that each of them claims that their drug is the best one for managing the sexually malfunctioning relationship.

The American Sexual Medicine Society held its annual scientific meeting during the AUA meeting. This is a fascinating meeting, and I would urge anybody who has the opportunity to attend future events to do so. The highlights for me were a series of debates on current topics, such as testosterone rescue of PDE5 failures, progress in the treatment of Peyronie's disease and ED prevention with chronic dosing.

There was relatively little about female sexual dysfunction at this meeting, but what there was stressed heavily testosterone therapy for women. This emphasis may have been due to the influence of the supporting pharmaceutical companies.

Socially, the evenings were spent alongside the river, which runs through the middle of San Antonio. Of course, the highlight was the evening that our esteemed founder member Dr. John Dean arrived for dinner in the full Texan cattle rancher outfit, complete with Stetson and snakeskin boots! Many of us have urged him to attend the next British Scientific Meeting dressed in this outfit, but we will have to wait and see if he does so.

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The sexual medicine content of the AUA is less than at other meetings, but a number of interesting papers were presented. Below is a summary of them.

Paper 731 from Park et al looked at vascular perfusion in the microvascular circulation in 20 coronary artery disease patients in a double-blind crossover study of sildenafil 50mg v placebo, 1 hour after dosing, and found a 45% increase in perfusion. They concluded that PDE5 inhibitors improved the endothelial function of the human vasculature in general. A large number of recent papers have shown this potentially important clinical benefit of these drugs.

Paper 733 from Levinson et al evaluated data from 9 open-label extension studies that showed 69% of all patients and 63% of mild ED patients opted for a 100mg dose. Adverse events were not significantly different between the two doses. They suggested that 100mg might be the optimum dose for initiating therapy.

Paper 734 from Faich et al looked at data from 29,358 patients, including 1,239 who had taken alpha-blockers and vardenafil concurrently between March and December 2003. There were no significant cardiovascular issues, providing further reassurance for combined use of these drugs.

Four papers were presented on the use of Dapoxetine in premature ejaculation, the most important being from Althof et al, reviewing 2,614 PE patients in a double-blind placebo-controlled crossover study of 30 and 60mg. IELT increased from baseline 0.9 minutes to 1.75 min (placebo), 2.78 (30mg) and 3.32 (60mg), with similar improvements in control and satisfaction. Adverse events were less than 5%, apart from nausea, which was experienced by 8.7% (30mg) and 20.1% (60mg) of patients.

Paper 741 from Sommer et al conducted an open label crossover study of vardenafil 10mg versus sertraline 50mg on demand in 34 men with PE. IELT increased from 0.54 minutes to 5.23 minutes with vardenafil and 2.87 with sertraline. They suggested a potential application for vardenafil in PE. It was not clear whether patients with mild ED were definitely excluded.

At the World Congress of Sexology in Montreal (July 10-14), three papers from Dean et al, Kell et al, and Hackett et al presented data from the first open-label crossover study of sildenafil and tadalafil in naïve patients. 70.8% preferred tadalafil, and IIEF data showed no significant difference between the drugs. SEP 3 data was significant for tadalafil, but the most important results were from the PAIRS analysis, which showed greater self confidence, spontaneity and lack of time concerns for tadalafil over sildenafil.

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"The ED Kid", Dr. John Dean

# Document on sexual health services merits attention

Medfash are to be congratulated on the production of the Recommended Standards for Sexual Health Services ahead of schedule on 16 March 2005.

This document, which was endorsed by the Department of Health, is intended for those involved in planning, commissioning and providing sexual health services. It contains a comprehensive set of recommended service standards, with supporting evidence, and complements the existing recommended standards for NHS HIV services (2003). It is intended to meet varying local circumstances and situations in England.

Reference to sexual dysfunction can be found throughout the document, integrated within the 10 standards where relevant. On page 40, the authors acknowledge that "the lack of priority accorded to sexual problems along with variable access and insufficient provision for specialist services for sexual dysfunction, have meant that high rates of sexual dysfunction remain undetected or are not being managed." This acknowledgement comes as no surprise to us working within a field that has clear examples of patchy service provision within England.

On page 53, the document

encourages the need for an increase in access to services. "PCTs should ensure that people with identified sexual dysfunction have access to services which can address their needs. Increased local coordination of available resources and clear information on referral criteria will support this, as well as ongoing needs assessment to establish local demand."

Sexual Health Services' local implementation groups are already meeting to decide how this document will be reflected in their locality. The Department of Health is very clear that the funding will be given to the locality and not held centrally.

The document emphasises the value in service collaboration, and the concept of network development is presented as a priority. Medfash held a one-day conference in April. Presentations were made by services where networks have already been established within England. Some shared learning around strengths and weaknesses was made available, and recommendations and guidelines on creating networks will soon be available. Integrated care pathways for sexual health care will necessitate coordinated information pathways within and between local services.

Standards 3 are aimed to increase the empowerment and involvement of people who use the services. This is not only about personal control and choice as a service user, but also about being involved in planning and development. Giving a voice to an under-represented group feels timely and important. The practicalities about how to do this were debated in the small workshop I attended. The need to maintain confidentiality and anonymity was raised. It was noted that those who speak out may not be representative of all service users and may also not represent the diversity within sexuality and sexual expression that we know exists. It was felt that energy had to go into creating multiple approaches, to access the inclusivity that was needed.

The document can be downloaded in PDF format from the Medfash website [www.medfash.org.uk](http://www.medfash.org.uk) or can be obtained in published form by contacting Medfash at BMA House, Tavistock Square, London WC1 9JP, tel number 020 7383 6345.

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## Government puts added emphasis on training excellence

The first National Strategy for HIV and Sexual Health was published in 2001. This was followed by an action plan for both national and local implementation. Part of that implementation plan involved a training mapping exercise, with recommendations made to implement a training action plan.

In addition, in 2004 the Public Health White Paper, 'Choosing Health', identified training and workforce capacity issues as

being integral to the sexual health agenda. Quality standards for sexual health training have been developed by a national sexual health training group convened by the Department of Health. The purpose of the quality standards is to allow organisations to incorporate these within their existing standards, and hopefully to enhance sexual health training thereafter. In essence, a consistently high quality experience will be offered to clinical staff, educators and volunteers who work with sexual health advice, education, information, services and support.

The quality of standards document lists some training values and principles,

standards for preparation of sexual health training and standards for the delivery of sexual health training. Guidance on content, style and evaluation are provided and are endorsed by the Working Group, Department of Health and other interested parties. The document is available at: <http://www.dh.gov.uk/asset-Root/04/11/00/57/04110057.pdf>

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# Historical and cultural aspects of erectile dysfunction

**Get excited, get excited, erect, erect,  
Get enthusiastic like a deer, erect like a bull,  
Erect a lion with yourself,  
Erect a snake with yourself,  
Make the emotionless feel!**

When was the last time you suggested chanting this verse for the treatment of ED?!

Both primary and secondary care have seen a fundamental change in how we understand the aetiology and treatments of ED. Treatments for ED have been around in one form or other for many thousands of years. For example, between 1650 and 1200 BC the Hittite civilisation in Central Anatolia, Turkey, produced texts on

subjects as diverse as fine arts and war techniques. Medical science (including a treatise on ED) was represented on the cuneiform tablets of the Boğazköy Hittite archives (left). Unfortunately not all of the 30,000 texts created could be deciphered, arguably showing that medical practitioners' writing has perennially been an issue!

One inscription that could be translated, described the treatment of ED as:

'If a man's potency comes to an end in the month of Nisannu, you catch a male partridge, you put its blood into water, and you swallow its heart and that liquid,

you set it overnight; when the sun comes up you give it to him to drink and then he will get potency'.

Is it a coincidence that the serum testosterone levels would also be elevated then and the presence of early morning erections might be an adjunct to the magical powers?!

Medical treatments in these early Indo-European societies could be divided into three. Firstly, the knife (i.e., surgery) was important in warrior population groups. Another group involved using medicinal plants, particularly among the agricultural peoples. Finally, in societies where religion was important, magical treatment pervaded.<sup>1</sup> The Hittites used mainly the latter two forms of health-care, in spite of them having a warrior culture. An example of how the Hittites incorporated magical rituals is as follows:

Diseases were 'transferred' to animals such as goats, bulls or sheep termed the 'scapegoats' or sometimes a person who are then expelled into enemy territory.

According to Brewer,<sup>2</sup> scapegoats were part of the ancient ritual for the Day of Atonement by the Hebrews:

Two goats were brought to the altar... and the high priest cast lots, one for the Lord and the other for Azazel (angel of death). The Lord's goat was sacrificed and the other the scapegoat having had the sins of the people transferred upon it was released into the wilderness and suffered to escape.

Chronologically speaking, our own phosphodiesterase-5 inhibitors (PDE5i) seem mere 'babes in arms' when compared to treatments from the past. For example, one preparation, 'the paste of Mesir', has been utilised for some 5000 years and apparently is still available from the Covered Bazaar in Istanbul. Its name derives from a former king of Pontus, called Mithridates VI, who lived in Trabzon, a city on the Black Sea in NE Turkey.<sup>3</sup> Originally it contained 54

ingredients, but this number has gradually reduced as it became more difficult to source the spices. Many of the pastes contain substances such as pepper or ginger that presumably act as a rubefacient and increase local blood flow. Similar substances are licensed today for joint pain and post herpetic neuralgia, namely Axsain, which is derived from a pepper-capsicum.<sup>4</sup>

I found it interesting to note that my herbal text did not have anything to advise me on impotence, but mentions 36 preparations for menstrual problems. Nevertheless, it did allude to the use of lettuce or hops for the treatment of hypersexuality or priapism, the hops taken as an infusion not in the form of beer!<sup>5</sup>

Low et al looked at cultural differences in 'knowledge, attitudes and practices related to erectile dysfunction' among Malay, Chinese and Indian ethnic groups.<sup>6</sup> There were some interesting variations. The Chinese felt that ED was due to insufficient stimulation or situational rather than physical causes. They used live sex shows or pornographic films with their partner and used food supplements, exercise and holidays as treatment. Interestingly, one of my English patients paid £10 per tablet for a Chinese herbal male tonic from a stall on the Banbury market. Nevertheless, it worked for his ED but gave him a fearful headache enough to put him off the job in hand.

Some of the more exotic treatments described by the Malay participants suggest using squirrel or tiger semen, again confirming how desperate patients can get. On the other hand, until his retirement in 1989, a GP colleague proffered the use of ex Post Office rubber bands. No doubt he had his own SHIM scoring system and 'prescribed' these items when a high score was obtained for the question: do you have difficulty maintaining your erection to completion of intercourse?

In reality, in spite of their youth, the PDE5Is are considered to be a first-line approach in the treatment of ED, not only by the World Health Organisation but also by several national guidelines.<sup>7,8</sup> Moreover, a holistic approach to treating the problem is essential; for example, cultural, religious, psychological and lifestyle factors need to be addressed. We have a wonderful opportunity to offer advice on smoking, alcohol, exercise, weight, diet and stress rather than just reaching for the prescription pad.

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# Why we need to take action over Schedule 2 regulations.

Government guidance for ED was introduced in 1999 amid concerns that demand for therapy could produce an unacceptable burden on the NHS. A range of qualifying conditions (HSC 1999/148), avoiding the common cardiovascular diseases, was approved and a category of "severe distress" was introduced (HSC 1999/177) a few months later. This guidance has not been modified in the light of subsequent advances, and NICE guidance has never been sought as ministers felt that this was "unnecessary".

Close examination of the government guidance reveal several vague terms that have caused confusion and sometimes confrontation between clinical health-care providers. At a time when most other NHS initiatives have involved directing resources from secondary to primary care, it may seem incongruous that these regulations involve the transfer of patients with mainly primary care conditions in the opposite direction.

It might be worthwhile clarifying a few of the confusing issues:

1. One dose per week is "anticipated to be appropriate for the majority of patients but a greater quantity may be prescribed by the doctor according to clinical need", which is not defined further. Clinical trials for licence purposes involved well motivated specialists and patients with unlimited 'free' medica-

tion, taken on average 2.5 occasions per week, produced response rates of 55% in diabetes and 70% overall. Many studies have shown that more frequent exposure leads to greater response, suggesting that 'clinical need' should be interpreted as 'sufficient dose required for efficacy', but government advisers leave this open to interpretation by clinicians. GPs with acute pressure on prescribing costs frequently interpret the term 'clinical need' differently and seek to transfer these 'higher cost' patients back to secondary care. As a group, we should pressurise the relevant DOH department (address below) to provide clear up to date guidance.

2. 'Severe Distress' is defined (HSC 199/177) as a "significant disruption on interpersonal relationships" and is totally unrelated to the timing of this event. For those of us treating ED regularly, this involves most couples. Telling a man that he is only "moderately distressed" today and to return when his relationship is "significantly disrupted" would seem, at best, unhelpful.

3. Prescribing for premature ejaculation or female sexual dysfunction is 'off licence', and Schedule 2 does not apply as this is purely for patients suffering from impotence. This is a significant 'loophole' that causes conflict between primary and secondary care. The official guidance from the DOH is that prescribing depends on the "clinical judgement"

of the specialist. The imminent licensing of drugs for these conditions must lead to a fundamental review of prescribing regulations for sexual conditions.

In summary, the current regulations lead to inequalities for patients and divisions between primary and secondary care, wasting precious resources to interpret guidance that is not evidence-based. NICE is yet to rule on this therapy area as "ministers do not consider it necessary". The best way to effect change would be a bombardment of the department for interpretation of specific clinical issues to highlight the absurdity of the regulations. Thankfully, the licensing of drugs in other areas of sexual therapy should initiate greater clarity of thought by government departments.

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## Conference Round-Up

British Menopause Society meeting, Torquay, 7 and 8 July 2005

Meeting the challenges posed by menopause

The main focus of this conference was the challenge of conveying risk and appropriateness of hormone replacement therapy (HRT) use to our clinical colleagues and patients. Topics under discussion included ultra-low dose oestrogen replacement, endometrial protection with progestogens, the risk of stroke, the place of oestrogen in preventing osteoporosis, colon cancer and incontinence.

The audience of gynaecologists, specialist nurses, pharmacists and interested general practitioners were already familiar with the Women's Health Initiative research and the Million Women's Study. Emphasis was put on the importance of discussing absolute risk and individual relative risk of side effects (and benefits) in context. The effect of media scares has resulted in a 25% reduction in the use of HRT in the U.K., and in some areas GPs will not prescribe HRT at all. Unfortunately for some women, their HRT was stopped abruptly, resulting in vasomotor symptoms, causing them additional problems.

Sexual function did not figure greatly at this particular meeting, although the identification and treatment of vaginal atrophy was covered by a lunchtime seminar. Even when a woman is taking standard HRT, she can still complain of vaginal atrophy symptoms. It was reiterated that topical vaginal oestrogen therapy can be used alongside HRT and long-term use is necessary, as these low-dose preparations used at recommended regimens do not raise systemic oestrogen levels.

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## What do we know about the combined oral contraceptive pill and libido?

Claudia Panzer et al from the Boston University School of Medicine have reported a study on raised levels of sex hormone binding globulin (SHBG) following cessation of the combined oral contraceptive pill (COC). An abstract was presented at the American Association of Clinical Endocrinologists' 14th Annual meeting in May 2005.<sup>1</sup>

Combined oral contraception is the most commonly used contraceptive method by women aged 16-49 years in the U.K.<sup>2</sup> It is extremely effective but highly user dependant, so to ensure good continuation rates, a full explanation of risks and benefits should be given by the prescriber.

In October 2003, the Faculty of Family Planning and Reproductive Health Care issued guidance on the First Prescription of Oral Combined Contraception.<sup>3</sup> Side effects thought of as 'minor' or temporary by clinicians may have a great deal of influence on whether or not a woman continues with the pill. The effect on libido is not specifically mentioned in either the FFPRHC guidance or in the Family Planning Association client leaflet,<sup>4</sup> although the leaflet does refer to possible mood changes. The complaint of reduced libido or loss of interest in sex is something nurses and doctors in contraception and sexual health hear quite often (personal communication), but reliable estimates of prevalence are not available.

The COC is known to decrease serum testosterone levels by decreasing ovarian production of testosterone and by increasing the production of SHBG from the liver. It has been assumed that these metabolic changes are reversible after discontinuation of COC use. However, this group of researchers have found that levels of SHBG can remain elevated for prolonged periods.

Ethical approval was given for a retrospective study of 102 women with sexual dysfunction, 62 of whom were currently taking COCs and 40 of whom had stopped taking COCs during their treatment. There was a control group of 23 women who had never taken COCs. The level of SHBG was measured and compared in all three groups at baseline and at 3 month intervals after discontinuing the use of COCs. SHBG values in the COC user group were 7 times higher than those in the "never use" group. Although the SHBG level dropped by 55% when women first stopped taking COCs, the level remained elevated six months to one year later.

The abstract did not indicate what sexual dysfunction the women were receiving treatment for, nor how the women were recruited. The three groups were similar in terms of age (37, 33 and 36 years), but no other characteristics were reported. This study was reported in newspapers and other scientific journals with sensational headlines.<sup>5,6,7</sup> The authors were said to be surprised at the findings, and emphasised the need to inform women of this effect when they contemplate starting the COC. Yet others commented on the small size of the study and its limited usefulness.

Loss of interest in sex in women can have many interrelated psychosocial causes, and changing or stopping a woman's contraceptive pill may simply produce a placebo response. This study suggests that the hormonal changes induced by COC are not immediately reversible and the free androgen index may remain low for a prolonged time. Further work is needed to define the precise role of androgen levels in women with low libido.

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## BMJ paper assesses impact on contraceptive practice of making emergency hormonal contraception available over-the-counter

Allowing emergency hormonal contraception to be sold over the counter in the U.K. has not increased its use or changed patterns of use, finds a study published online by the BMJ during June. These results appear to suggest that the predicted rise in unsafe sex has been overstated and support the case for lifting the ban on over-the-counter sales in the United States and other countries.

Since January 2001, emergency hormonal contraception (EHC), commonly known as the 'morning-after pill', has been available without prescription across Britain to women aged 16 or over at a cost of £20-25. Opponents claimed this would lead to 'abuse' and encourage unsafe sex, particularly among teenagers, while supporters argued that easier access would help to reduce unwanted pregnancies.

Using national survey data, researchers examined use of EHC among British women aged 16 to 49 years to assess the impact of making it available over-the-counter. The level of use of different contraceptives remained very similar before and after EHC was made available over-the-counter. No significant change occurred in the proportion of women using EHC (8.4% in 2000, 7.9% in 2001, and 7.2% in 2002) or having unprotected sex. A change did, however, occur in where women obtained EHC. A smaller proportion obtained it from general practitioners and NHS clinics, and a greater proportion bought it over the counter, but overall use remained the same.

No significant change occurred in the proportion of women using more regular methods of contraception, such as the oral contraceptive pill, or in the proportion of women using EHC more than once during a year.

Making emergency hormonal contraception available over-the-counter does not seem to have led to an increase in its use, to an increase in unprotected sex, or to a decrease in the use of more reliable methods of contraception, say the authors of the study. Despite some weaknesses, this study may have important policy implications. Study contacts:

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To view the full paper, go to: <http://press.psprings.co.uk/bmj/july/contraception.pdf>

# Founding member gives a brief history of the BSSM

Prof. Dinsmore arranged the first meeting of interested parties at the Medical Society of London, 11 Chandos Street, London W1M 0EB, on 1 December 1997. The persons present at the first meeting were Bill Alexander, Wallace Dinsmore, Clive Gengell, John Green, Geoff Hackett, Willy Harris, Chris Mathias, John Pryor, Alan Riley and Judie Turner. This meeting cost £55 for the use of the library and £20 for tea and sandwiches.

Previously there had been multiple groups formed with the aims of encouraging meetings and research in the fields of sexual dysfunction. Some of these efforts had been short-lived, while others had prospered, but in general there was a feeling that there was a need for a single national body that encompassed all the present groups with the aim of eventual affiliation with the European Society of Sexual and Impotence Research and the International Society for Sexual and Impotence Research. This would give the new body national and international standing and a framework on which to prosper that was not reliant on any one individual.

According to the constitution, later approved: "The British Society for Sexual and Impotence Research was founded in 1997 for the purpose of promoting research and exchange of knowledge of impotence and other aspects of sexual function and dysfunction in both men and women throughout the UK scientific community. The principal orientation of BSSIR is toward basic science of sexual function - dysfunction and clinical aspects of diagnosis and treatment of sexual problems in both men and women. The society recognises the importance of a holistic approach to understanding human sexuality and its problems and encourages research into all of its many aspects".

At the first meeting, it was agreed that Clive Gengell would be the first Interim President of the society, Alan Riley would be Interim Vice President, Geoff Hackett Interim Treasurer, and Wallace Dinsmore Interim Secretary. The Interim Committee comprised of others attending from a broad-based group representing most fields involved in the treatment of sexual dysfunction. Early links were established with the Erectile Dysfunction Alliance, the British Erectile Dysfunction Society, BEDS, BASRT and the Impotence Association, among others.

The first official conference of this new society was held on 11 November 1998 in the MDS Room at the Royal Society of Medicine, where the U.K. guidelines for the management of erectile dysfunction were presented, having recently been agreed by the Erectile Dysfunction Alliance.

Finances were an initial early problem and were dealt with extremely well by Dr. Hackett. In the first accounts, the society was given an educational grant from Pfizer and Fournier Pharmaceuticals, and the first meeting was sponsored again by Pfizer. In addition a very substantial transfer of funds was made from BEDS in the financial year 1998-1999. The second Committee meeting was held on 13 March 1998 at the Royal Society of Medicine. The logo of the new society was agreed by the interim office bearers in September 1998 and is the same as at present. There was an early call for membership

for the new society. In November 1998 there were 45 members. Legal advice was taken from Monroe Pennefather & Co Solicitors, 8 Great James St., London. At the committee meeting on 9 March 2000, a membership fee of £25 was agreed, and at that stage there were 125 members.

Dr. John Dean (Assistant Secretary) drafted a provisional constitution which was discussed at a number of committee meetings and initially was agreed by an Annual General Meeting of the society. At this meeting, it was agreed that all initial members of the new committee would be elected at the forthcoming Annual General Meeting, and re-election of these members would take place on a rolling basis. It was also decided that ex officio members of the committee would be initially from the Impotence Association, MSSVD, RCN and BASRT. Dr. John Dean, with the assistance of Nigel Westwood, established a website for the society in 1999.

It was intended to have Spring and Autumn meetings of the society, and the majority of these were held at the Royal Society of Medicine, with some meetings being held with the Impotence Association and BASRT, among others. The start-up funds were also provided by Fournier Pharmaceuticals.

In 2001 the Interim Presidency of the society passed to J.R.W. Harris. The constitution was adopted at an Annual General Meeting on 21 November 2001 at the Royal Society of Medicine. The Interim Office Bearers and Committee were officially ratified.

Since 1997 there have been a number of changes made by the society. It has now changed its name to the present title British Society for Sexual Medicine. All of the initial committee and others who joined later have played an important role in bringing this society to the present position, where it is regarded as the principal society in the United Kingdom for the organisation of scientific and educational meetings.

After eight years, the society has stood the test of time. The society now has its fourth President, previous ones in order being Clive Gengell, Willy Harris and Alan Riley. All of these Presidents have served the society exceptionally well through some difficult periods, with David Ralph (President) most recently successfully integrating the society with the European and international bodies. He is ably supported by Dr. John Dean (Secretary) and Mr Tim Terry (Treasurer).

It is difficult in this short article to document everything. The society seems guaranteed to last as the initial goodwill that surrounded its foundation has persisted and strengthened over the years, particularly when difficult decisions have been made. We should now be planning something significant to commemorate the 10th anniversary on 1 December 2007!

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Editor's note

Further information on the history of Sexual Medicine in the UK:  
Bancroft J. Journal of Sexual Medicine Vol.2 No.4 2005 p569-574