

Top 3 Contemporary FSD Articles in JSM in the Past Year

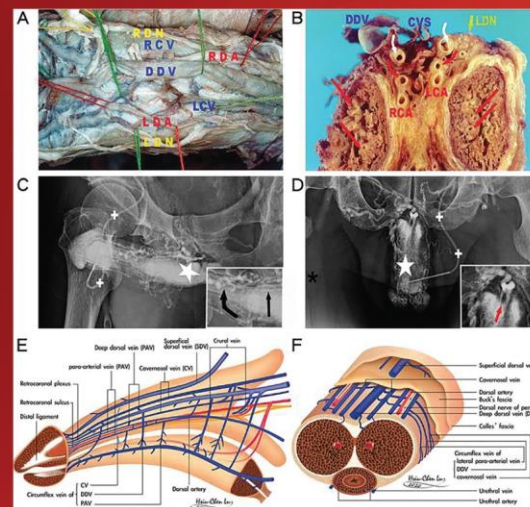




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Original Research



Efficacy of in-office lysis of clitoral adhesions with excision of keratin pearls on clitoral pain and sexual function: a pre-post interventional study

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Table 2. Main outcome measures of LCA-KPE.

	Before LCA-KPE	After LCA-KPE	<i>P</i> value ^a
FSFI total	12.12 ± 9.36	17.68 ± 9.70	.017
Desire	2.31 ± 1.10	2.79 ± 0.91	.018
Arousal	1.98 ± 2.10	2.81 ± 1.91	.091
Lubrication	2.04 ± 2.18	3.39 ± 2.35	.015
Orgasm	1.98 ± 2.23	3.09 ± 2.24	.039
Satisfaction	2.46 ± 1.64	3.16 ± 1.64	.062
Pain	1.37 ± 1.92	2.43 ± 2.36	.049
FSDS	29.91 ± 13.35	27.50 ± 13.10	.27
Self-reported clitoral pain	6.91 ± 2.81	2.50 ± 2.48	<.001
Difficulty with orgasm	5.45 ± 3.42	3.13 ± 3.24	<.001

Values are mean ± SD. Abbreviations: FSDS, Female Sexual Distress Scale; FSFI, Female Sexual Function Index; LCA-KPE, lysis of clitoral adhesions with keratin pearl excision. ^aPaired *t* test.

Table 4. Qualitative responses on patient experience with keratin pearls and in-office LCA-KPE.

Themes	Quotes
Improvement and minimally painful	<p>"I was sore for a couple days afterwards, but the procedure itself was low-pain and I'm glad it's available. I wish more gynecologists knew about this! It's no fun feeling like you have sand around your clit."</p> <p>"Easy, didn't know one was going to be there."</p>

"The excision was extremely painful, but it gave me my life back."

"I did not know anything about them. I went to Dr. A with concerns of pain and he explained to me what they were. Since then I've been pain-free."

"Excellent. Was less than a week ago and already I feel largely healed."

"My clit feels MUCH better after that! It was gritty and hurt my clit."

"It was painful and had to have it done again."

"Was very uncomfortable procedure but 100% worth it."

"The excision itself was painful but removed the aching sensation I felt in my pelvic region soon after it was out! Stabbing pain has subsided."

"Immediately following excision, I had severe burning for about 48 hours (ice helped to keep this under control and reducing any contact from underwear/clothing). After that, the burning slowly stopped and I felt sharp, stabbing pain."

"Was very uncomfortable, but 100% worth it."

Pain and distress

dysfunction, but I feel my clitoris has greatly improved and is extremely less irritated."

"Painful during and after."

"The excision was painful as well as the recovery. I also had endometriosis which contributed to the pain."

"It was really distressing for me- the procedure was intense and even though I was numbed it felt quite painful. I had hope for a bit after, but honestly it didn't seem like my pain with sex has been lessened."

"I also have a much better understanding of my anatomy since."

Recurrence

"Unfortunately, the keratin pearl adhesions continue to reform, so I do worry about them coming back, and having to receive constant treatment."

"It was painful & had to have it done again."

"I've had a pearl removed then a year later had adhesions that were separated. I occasionally have sensitivity and it gives me anxiety a lot. It's upsetting. And feels like there is nothing that can be done that I just have to deal with."

"...was a traumatic experience...painful and unnecessary!"

Education

anything with a zipper or a seam; it rubs on the left side. So, I use a dab of lidocaine when it is intense. I also wear the baggiest pants I can find when I'm around the house. I've had 7 more in the past 3 years. I rub them vigorously with a q-tip every day, apply a bit of lidocaine and (believe it or not) they finally fall off."

"Positive. I didn't know that repeated infections caused phimosis of the clitoral hood, so now I have a better understanding of the importance of retracting the clitoral hood as a component of my daily hygiene regimen."

"I also have a much better understanding of my anatomy since."

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Original Research



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Testosterone therapy in females is not associated with increased cardiovascular or breast cancer risk: a claims database analysis

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Table 1. Odds of adverse effects between adult females (≥ 18 years) receiving testosterone and propensity score-matched controls.

	Female participants, No. (%)		
	Testosterone ($n = 10\,300$)		Controls ($n = 10\,300$)
Major adverse cardiac event	118 (1.15)		184 (1.79)
Odds ratio (95% CI)	0.64 (0.51–0.81)	↓	
Upper or lower emboli and deep vein thrombosis	41 (0.40)		67 (0.65)
Odds ratio (95% CI)	0.61 (0.42–0.90)	↓	
Pulmonary embolism	19 (0.18)		40 (0.39)
Odds ratio (95% CI)	0.48 (0.28–0.82)	↓	
Breast neoplasm	83 (0.81)		174 (1.69)
Odds ratio (95% CI)	0.48 (0.37–0.62)	↓	
Hirsutism	63 (0.61)		25 (0.24)
Odds ratio (95% CI)	2.52 (1.59–4.00)	↑	

Table 2. Odds of adverse effects between adult females (18-55 years) receiving testosterone and propensity score-matched controls.

	Female participants, No. (%)	
	Testosterone (<i>n</i> = 6128)	Controls (<i>n</i> = 6128)
Major adverse cardiac event	18 (0.29)	37 (0.60)
Odds ratio (95% CI)	0.49 (0.28–0.85)	
Upper or lower emboli and deep vein thrombosis	13 (0.21)	27 (0.44)
Odds ratio (95% CI)	0.48 (0.25–0.93)	
Pulmonary embolism	<10	21 (0.34)
Odds ratio (95% CI)	—	
Breast neoplasm	18 (0.29)	29 (0.47)
Odds ratio (95% CI)	0.62 (0.34–1.12)	
Hirsutism	36 (0.59)	20 (0.33)
Odds ratio (95% CI)	1.80 (1.04–3.11)	

Table 3. Odds of adverse effects between adult females (≥56 years) receiving testosterone and propensity score-matched controls.

	Female participants, No. (%)	
	Testosterone (<i>n</i> = 4172)	Controls (<i>n</i> = 4172)
Major adverse cardiac event	100 (2.40)	119 (2.85)
Odds ratio (95% CI)	0.84 (0.64–1.10)	
Upper or lower emboli and deep vein thrombosis	28 (0.67)	34 (0.82)
Odds ratio (95% CI)	0.82 (0.50–1.36)	
Pulmonary embolism	12 (0.29)	23 (0.55)
Odds ratio (95% CI)	0.52 (0.26–1.05)	
Breast neoplasm	65 (1.56)	128 (3.07)
Odds ratio (95% CI)	0.51 (0.38–0.68)	
Hirsutism	27 (0.65)	<10
Odds ratio (95% CI)	—	



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Original Research

What are future doctors learning about sex? An assessment of sexual health curricula across medical schools in the Northeastern United States

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Table 1. Percentage of ideal curriculum material included in each school's curricula by category.

Categories	School										total % category inclusion
	A	B	C	D	E	F	G	H	I	J	
Embryology	100	100	100	100	100	100	100	100	100	100	100
DSD	100	100	100	20	100	100	100	100	100	40	86
Birth Control	100	92	92	92	100	83	75	100	58	92	88
STI's	100	100	100	40	40	40	40	100	100	100	76
Infertility	95	95	70	15	100	15	95	95	90	40	75
Genital Anatomy	95	79	79	53	84	79	47	58	79	79	73
Abortion	97	91	85	50	81	54	64	88	82	78	65
Puberty	100	100	100	0	100	25	0	100	100	0	63
Sexuality in non-normative groups	100	82	55	36	55	55	64	64	55	64	58
Physiology of sex/pleasure	86	86	86	43	43	43	0	57	71	14	53
Sexual Violence	100	0	100	29	29	0	0	86	86	43	47
Sexual dysfunction	92	46	54	3	49	3	51	49	56	0	40
Psychosocial influences on sexuality	50	25	75	0	0	0	50	100	100	0	40
Sexuality Postpartum	100	0	0	0	0	0	0	0	1	0	20
Vulvar Conditions	100	0	0	0	0	0	0	20	0	0	12
overall ideal curriculum met	94	66	73	32	59	40	46	74	72	43	

Figure 4. Percentage of schools including information on listed genital anatomy terms.

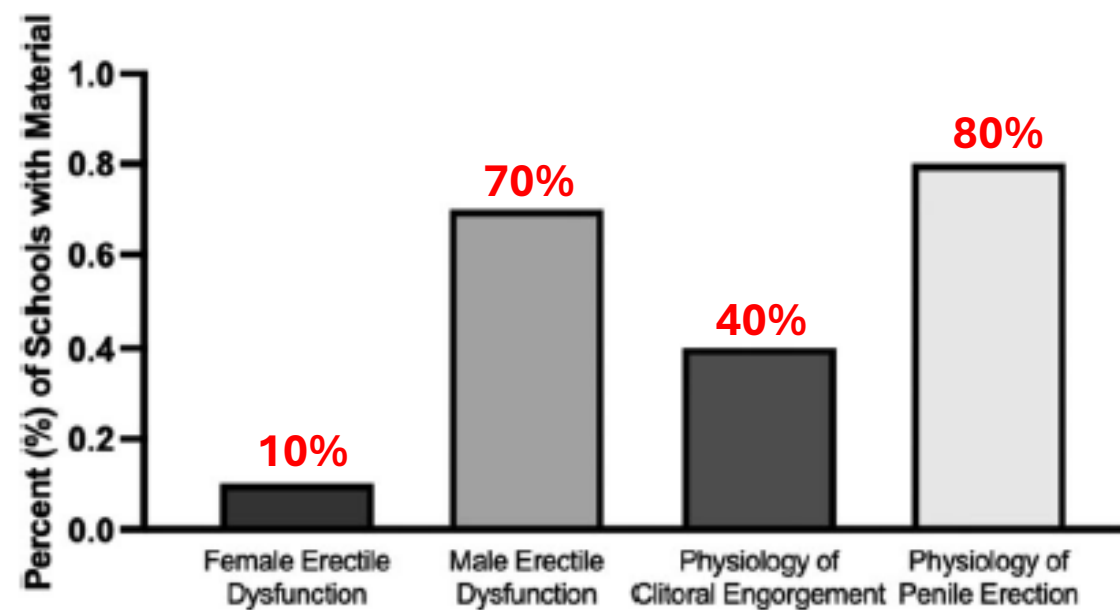


Figure 5. Comparison of inclusion of male specific vs female specific information on erection and erectile dysfunction.



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Original Research



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Comparisons and correlations of 1-month recall vs 24-hour recall in patient-reported outcomes of an exploratory, phase 2b, randomized, double-blind, placebo-controlled clinical trial of sildenafil cream, 3.6% for the treatment of female sexual arousal disorder

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Original Research



OXFORD

The Vaginal Penetration Skills Scale (VPSS): a paradigm shift in genito-pelvic pain/penetration disorder screening, assessment, and stratification

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Original Research



OXFORD

An examination of sexual function & distress among sexual minority & heterosexual women seeking care at menopause and sexual health specialty clinics

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Original Research




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A healthy lifestyle can support future sexual satisfaction: results from a 9-year longitudinal survey

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