





# Hysterectomy and Sexuality

(Article courtesy of Women's Health Queensland)

Each year, approximately 30,000 Australian women undergo a hysterectomy, with most procedures performed to treat conditions such as fibroids, heavy bleeding and pelvic pain. Information provided to women prior to a hysterectomy has often been inadequate in the past, limited to basic details about the actual operation and recovery. Even today, there appears to be little information available on certain aspects of having a hysterectomy. One particularly neglected area is the effect of hysterectomy on a woman's sexuality. A 1994 study investigating pelvic surgery found that there was a lack of available information about the potential effects of surgery on sexual function, which concerned many of the women participating in the study.

A brochure produced by the Royal Australian College of Obstetricians in 1987, "Hysterectomy: An Important Decision", reflects a general belief that a woman's uterus only has two purposes - menstruation and reproduction. What is not recognised is that the uterus, in fact, has another important function - a sexual one. In research conducted by Masters and Johnson in 1966, the uterus was shown to be a contractory organ that elevated during sexual excitement and contracted with orgasm. For some women these uterine sensations are particularly evident and play an important part in their orgasm. The removal of the uterus may leave these women with different or changed sensations at orgasm. They may feel as though there is a missing element or that their orgasms are incomplete.

The removal of the cervix, (this takes place in all hysterectomies except sub-total), can also adversely affect a woman's sexual response. One study suggests that internal (vaginal) orgasms are actually cervical orgasms, caused by nerve endings surrounding the cervix and attached to the upper vagina. The study explains that the removal of the cervix and, therefore, the loss of some of these sensory nerve fibres "is bound to have an adverse effect on sexual arousal and orgasm in women who previously experienced internal orgasm"

Similarly, some women also find that having the cervix repeatedly touched is pleasurable and contributes to orgasm. Masters and Johnson explain how "many women will certainly describe cervical sexual pressure as a trigger mechanism for coital responsivity". The loss of cervical stimulation following a hysterectomy may leave a woman with inferior orgasms or no orgasmic ability at all. The cervix also plays a part in lubrication so its removal can result in vaginal dryness, making sexual intercourse uncomfortable and even painful.

A significant percentage of women also experience a loss of libido after a hysterectomy, particularly if they have had both ovaries removed (oophorectomy). One study suggests that between 33% and 46% of women report a decreased sexual response following a hysterectomy with oophorectomy. In women who have had an oophorectomy, this can be attributed to a decrease in the male hormone, testosterone. Previously it was thought that only the adrenal glands produced testosterone, but it is now evident that the ovaries probably produce the most significant amount. Testosterone is the hormone responsible for sexual desire through "increasing susceptibility to psychosexual stimulation, heightening sensitivity of the external genitals, and creating greater intensity in sexual gratification"

A lack of testosterone can leave women with a decline in "sexual interest, sensation and frequency of orgasm". The menopausal symptoms of vaginal dryness and thinness that occur after a oophorectomy can also interfere with a woman's sexual response. It is also important to note that some women who retain their ovaries in a hysterectomy may still experience either temporary or permanent ovarian failure, most probably caused by damage to the local blood supply during surgery. These women may, therefore, also experience menopausal symptoms that affect their sexuality.

Other physiological changes that may negatively impact on sexual response includes the formation of scar tissue at the top of the vagina. The scarring can cause discomfort and pain when it is touched. The closing of the top of the vagina in a hysterectomy can also sometimes result in a shortening of the vagina. While physiological changes play an important part in women's sexual response after a hysterectomy, psychological aspects can be equally influential.



# Ovarian Cancer - The Silent Killer

Cancer of the ovary is a disease that affects the cells of the ovary.

The causes of ovarian cancer are not known, but what is known is that it is more common in white women living in westernised countries with a high standard of living.

Those at risk include women who have had no or few full term pregnancies; who have never been on the contraceptive pill; have a family history of cancers of the ovary, bowel, breast and lining of the uterus; have a medical history of multiple exposures to fertility drugs; are of Ashkenazi Jewish descent; or have a high fat diet and are overweight.

There are no tests available to detect this disease, which is why it is known as the silent killer.

Symptoms can include:

Pelvic or abdominal pain or discomfort and or feeling of fullness;	
Swelling in the abdomen	Unexplained weight gain
Weight or appetite loss	Bloating
Feeling tired	Persistent gastrointestinal upsets
Backache	Cramps
Bladder or other urinary problems	Unexplained changes in bowel habits
Unusual vaginal bleeding	Pain during intercourse.

The only way to determine for sure if these symptoms are a sign of ovarian cancer is to make contact with your doctor and have a physical examination including an internal pelvic examination, blood tests, x-rays and an ultrasound.

Ovarian cancer is often mistakenly diagnosed as Irritable Bowel Syndrome, indigestion and menopausal conditions and unfortunately a pap smear does not detect ovarian cancer.

While little is known about the cause of the cancer or how to detect it, ovarian cancer is prevalent among Australian women with one in 70 developing it during their lifetime. Every year 800 Australian women lose their battle and die from ovarian cancer with one woman dying every 10 hours. If the disease is detected and treated at an early stage there is a 90 per cent chance of surviving past five years. However, some 80 per cent will be advanced stages and a staggering 74 per cent will not survive past five years.

It is also important that women who are post menopausal and have an ovarian cyst have it checked as they can become malignant and turn into cancer if left untreated.

## Cancer Helpline

For support and information on cancer and cancer-related issues, call the Cancer Helpline. This is a free and confidential service.

Cancer Helpline ..... 13 11 20 or 1800 422 760  
(toll-free)

TTY ..... (02) 9334 1865 for deaf  
and hearing-impaired

Cantonese and

Mandarin ..... 1300 300 935

Greek ..... 1300 301 449

Italian ..... 1300 301 431

Arabic ..... 1300 301 625

For further information and details please visit our website [www.cancer.com.au](http://www.cancer.com.au)

## OVARIAN HEALTH STUDY

You are invited to take part in an Ovarian Health Study that is currently being conducted at Monash University to develop screening programs for assessing the ovarian health of the post-menopausal woman. This is a new initiative as little is known about what constitutes Ovarian Health in post-menopausal women.

If you are healthy and it is at least five years since your final menstrual period, you are invited to participate in this study. It will involve having a blood test and an ultrasound. For more information about this important initiative call 9544 0599 or email the Ovarian Cancer Research Foundation on [info@odrf.com.au](mailto:info@odrf.com.au) or go to [www.wholewoman.org.au/community-then-consultations/research-projects](http://www.wholewoman.org.au/community-then-consultations/research-projects).







## Emotional factors:

The months following childbirth can be a vulnerable time for many women, men and families, bringing conflicting emotions. Some reasons for this may include:

### *Body image*

While a changed body shape is natural during pregnancy, many women expect to return to their pre-pregnancy weight and shape as soon as possible after childbirth. Self-esteem and confidence may be challenged if this doesn't happen quickly. Feelings of lovability and sexual attractiveness may need to be discussed and addressed.

Generally, within twelve months after birth, body weight returns to what it was before the pregnancy. Breastfeeding, healthy eating habits and regular exercise can all help this process.

### *Depression*

While having a baby can be one of the most joyful times, it is also true that it can greatly affect parents' emotional well-being. Stress and depression can result in a lack of sex drive.

Coping with a new baby at home may be stressful, particularly if there are other children to attend to. Mild depression is common. As many as 85 % of women report having 'maternity blues'. This may start shortly after childbirth and continue for a few weeks.

Lack of sleep, poor diet and loss of confidence may account for symptoms of tearfulness, mood changes, irritability and anxiety. This is an expected reaction requiring support and reassurance. There are usually no long-term consequences. Talking to family and friends who can offer support, reassurance and advice may help.

Another condition called post natal depression (PND) is more serious, sometimes starting two to four weeks after birth. Should you feel concerned about depression, it is important you seek professional help from doctors, midwives or counsellors.

## Other factors:

Likelihood of interruption during sex. Sexual activity may be inhibited through fear of disturbing the new baby or being interrupted by another child. Placing the baby in another room to sleep, if only for a few hours, may be helpful.

### Relationship issues

The increased responsibilities that a new baby brings may be a source of stress on relationships. The intimacy between mother and baby could pose a threat to a partner who may previously have enjoyed the new mother's full attention.

It is important that couples openly communicate their feelings, expectations and concerns about their relationship.

### Fear of unplanned pregnancy

Fear of an unplanned pregnancy may have an effect on a woman's sexual desire, response and enjoyment of sex. Reliable contraception will help relieve this anxiety.

So, when is it okay to start having sex?

Unless a doctor or midwife has advised against it, each woman can decide when she feels ready and comfortable to resume sexual intercourse. It is best to wait until the vagina and cervix have healed. It may surprise and/or distress some women and men to find that breasts may leak during sex. Keeping a towel handy may be helpful.

## Sexuality and Labelling

A person's sexual behaviour does not always represent his or her sexual orientation. Often people jump to conclusions and try and 'box' people into certain categories because of their behaviour, appearance, beliefs and so on. People may choose to be sexually active with a person from the opposite sex but actually wish they were with the same sex. Other people can behave in ways that are more or less traditionally 'masculine' or 'feminine' eg women may play football or men enjoy needlework. This does not mean that they identify as gay/lesbian or bisexual. For some people, sexual orientation does not stay the same. Instead they fluctuate during their life, depending on circumstances, other people in their life and their environment.

# Sexually Transmitted Infections (STI'S)

## WHAT IS CHLAMYDIA?

Chlamydia is a curable sexually transmitted infection (STI); you can get genital chlamydial infection during oral, vaginal, or anal sexual contact with an infected partner. It can cause serious problems in men and women, such as penile discharge and infertility respectively, as well as in newborn babies of infected mothers.

## WHAT ARE THE SYMPTOMS OF CHLAMYDIA?

Chlamydia bacteria live in vaginal fluid and in semen. Chlamydia is sometimes called the "silent" disease because you can have it and not know it. Symptoms usually appear within 1 to 3 weeks after being infected. Those who do have symptoms may have an abnormal discharge (mucus or pus) from the vagina or penis or experience pain while urinating. These early symptoms may be very mild.

The infection may move inside your body if it is not treated. Bacteria can infect the cervix, fallopian tubes, and urine canal in women, where they can cause pelvic inflammatory disease (PID). In men the bacteria can cause epididymitis (inflammation of the reproductive area near the testicles). PID and epididymitis are two very serious illnesses.

You can reduce your chances of getting chlamydia or giving it to your partner by using condoms correctly every time you have sexual intercourse.

## WHAT IS GENITAL HERPES?

Genital herpes is an infection caused by the herpes simplex virus or HSV. There are two types of HSV, and both can cause genital herpes. HSV type 1 most commonly infects the lips, causing sores known as fever blisters or cold sores, but it also can infect the genital area and produce sores. HSV type 2 is the usual cause of genital herpes, but it also can infect the mouth. A person who has genital herpes infection can easily pass or transmit the virus to an uninfected person during sex. Both HSV 1 and 2 can produce sores (also called lesions) in and around the vaginal area, on the penis, around the anal opening, and on the buttocks or thighs. Occasionally, sores also appear on other parts of the body where the virus has entered through broken skin. HSV remains in certain nerve cells of the body for life, and can produce symptoms off and on in some infected people.

## HOW DOES SOMEONE GET GENITAL HERPES?

Most people get genital herpes by having sex with someone who is having herpes "outbreak." This outbreak means that HSV is active. When active, the virus usually causes visible lesions in the genital area. The lesions shed (cast off) viruses that can infect another person.

Sometimes, however, a person can have an outbreak and have no visible sores at all. People often get genital herpes by having sexual contact with others who don't know they are infected or who are having outbreaks of herpes without any sores.

A person with genital herpes also can infect a sexual partner during oral sex. The virus is spread only rarely, if at all, by touching objects such as a toilet seat or hot tub.

## WHAT ARE THE SYMPTOMS?

Unfortunately, most people who have genital herpes don't know it because they never have any symptoms, or they do not recognize any symptoms they might have. When there are symptoms, they can be different in each person. Most often, when a person becomes infected with herpes for the first time, the symptoms will appear within 2 to 10 days. These first episodes of symptoms usually last 2 to 3 weeks.

Early symptoms of a genital herpes outbreak include

- Itching or burning feeling in the genital or anal area
- Pain in the legs, buttocks, or genital area
- Discharge of fluid from the vagina
- Feeling of pressure in the abdomen

Within a few days, sores appear near where the virus has entered the body, such as on the mouth, penis, or vagina. They also can occur inside the vagina and on the cervix in women, or in the urinary passage of women and men. Small red bumps appear first, develop into blisters, and then become painful open sores. Over several days, the sores become crusty and then heal without leaving a scar.

Other symptoms that may go with the first episode of genital herpes are fever, headache, muscle aches, painful or difficult urination, vaginal discharge, and swollen glands in the groin area.

[www.niaid.nih.gov/factsheets/stdherp.htm](http://www.niaid.nih.gov/factsheets/stdherp.htm)

## Where to get help

- Your doctor
- Regional Women's Health Clinics
  - Geelong District 5260 3778
  - Bellarine Peninsula District 52561311
  - Colac District 5232 5180
  - Apollo Bay District 5237 8500
  - Camperdown District 5593 1892
  - Timboon District 5558 6000
  - Warrnambool District 5562 7434
  - Hamilton District 55518450
  - Portland District 5522 1180
- Family Planning Association Vic  
Tel (03) 9257 0100 or (03) 9654 4766
- Kids Help Line Tel. 1800 551 800
- Adolescent Health Service Tel (03) 9526 4400



## *Local Projects from Greater Geelong, SurfCoast & Queenscliffe*

The Women's Health Resource Service is very much focussed on work place skill development at present with **Gender and Diversity training being conducted at Bellarine Community Health Service**. A collaborative project, partnering with Linda Mckinnon, Health Promotion Co-ordinator at Bellarine, this training is being undertaken by a range of health workers and managers across various sites of the Service. The program has been specifically designed to provide health professionals with opportunities to critically reflect on how they work with a broad range of people. The aim of the training is to ensure that services are both accessible and appropriate for women and men, sensitive to the needs of those of culturally & linguistically diverse backgrounds, diverse sexualities, those with disabilities and those who experience disadvantage associated with age & geographical isolation. The program provides opportunities for workers to examine the structural issues that influence and shape our own personal values and challenges us to think creatively about ways to broaden our approaches to ensure a welcoming culture exists for all those wanting support and assistance in maintaining and improving their health and wellbeing. It has been a pleasure to partner with workers who have undertaken the training so far as they enthusiastically grapple with the challenges to ensure they are providing the most appropriate and accessible services possible for the Peninsula.

**The 5<sup>th</sup> Australian Women's Health Conference** was held in late April, and provided a brilliant opportunity to hear about the latest innovations in women's health from around the globe. The conference explored the state of Australian women's health in the world-wide context examining where we are leading and where we are falling behind of world best practice in Women's Health. It was particularly sobering to hear from some of our Canadian counterparts, who had previously looked to us as leaders in Women's Rights, now speaking about how those various rights have been eroded. The conference gave much food for thought about exploring ways to more effectively address issues such as the various and insidious forms of violence, discrimination and social and economic disadvantage experienced by women and was both awe inspiring and challenging, with many ideas for future work.

After presenting on gendered planning and analysis, the **Geelong Primary Care Forum** will soon embark upon a gendered analysis review of their programs. I look forward to updating you as this process progresses.

A new phase of planning has commenced for the **Barwon South Western Regional Women's Health Plan**. With the help of Rob Kennedy of the Geelong PCF we are currently compiling a comprehensive set of data relating to women's health across the Barwon South Western Region. This forms the first stage of creating a profile of the state of Women's health in our region. From this data, along with the gathering of more localised qualitative and quantitative data, our aim is to formulate a set of priorities that will help inform not only the work of the Regional Women's Health Resource Workers and Reference Group but also be an essential resource to inform the priority setting of a wide range of services and Organisations that assist the Women of our communities.

*Liz Murphy*



## *Local Projects from Warrnambool & Moyne*

As the winter months approach we need to be more vigilant than ever about taking care of our health and wellbeing. It is not just the colds and flus of the season that I'm referring to here, but also looking after the other aspects of our health- mental, emotional and spiritual.

Although winter is a time for rest and renewal, it is vital that we make an effort to maintain our social connections, and to get outside into the cool fresh air whenever we can. So I encourage you to treat yourself to a nurturing, mood lifting activity in addition to an extra boost of vitamin C this month!

Jane and I are keeping warm and busy in Warrnambool with an assortment of activities. Jane has taken over the facilitation of the Sudanese women's group and they continue to be engaged in a colourful array of activities this term with a focus on culture, food and nutrition, with some singing and story telling thrown in for variety. A number of (non-Sudanese) Warrnambool women have also been attending this group and the cross-cultural relationships being developed are fantastic.

We have been successful in attracting funding to initiate an Indigenous spiritual and emotional wellbeing visual arts project with Kirrae Health Services. We will shortly engage an artist to work with the community to develop a piece of art that depicts the participants' meanings of wellbeing. This piece when complete will be able to be displayed at various community health services, and we hope may assist in building positive relations between Indigenous people and health services.

Another exciting yet challenging initiative coming up is the presentation of education

sessions to local football clubs regarding sexual behaviour. We are communicating with the AFL, VFL and Vichealth in an attempt to bring an education package currently being developed, to our local clubs. We'll keep you posted on this one...

Jane has been working on bringing a performance of the 'Condom Dialogues' to Warrnambool secondary schools, which we hear are very informative and entertaining. Rochelle has been to Mortlake to deliver information about the development of healthy body image to year 9 students, as part of Rural Health Week.

In Koroit a new walking group has been established, and pram walks are on the way...

Lynda and Rochelle have also recently returned from a women's health services tour which left us both inspired by the wealth of knowledge and expertise that exists around women's health, and envious that we don't have autonomous women's health centres in our region. The take home message I think was plan, plan, plan, document, document, document. Then we will be able to advocate for gender health issues in a more informed way.

The best part of this job for me is the conversations I am privileged to have with women in the community who work tirelessly for their families and the community. It is in predominantly unpaid roles that women are making huge change and carrying on the values of humanity, justice and equity whether the issue is animal welfare, the environment, children or asylum seekers. As we soak in the Federal budget is it timely to remember that it is the things that can't be measured in economic terms that are the most valuable.

*Rochelle Campbell & Jane Meiklejohn*

# *Sexual Health Update - Portland*

Primary Care's Youth Health Worker Sam Sharp and Women's Health Resource Worker Lynda Smith's Principal Health Promotion initiative has been focused around Sexual Health and youth, you may have seen the new Safer Sex packs floating around town. This initiative was bought about by collaboration between the Country Aids Network, the Emergency Department and Primary Care.

This is one of the many initiatives that are being worked on across both the Glenelg and Southern Grampians Shires, through the KISSE Health Promotion plan that the two women are working on with the help of Shelly Nevins the Glenelg Shire Councils Youth Service Officer.

With the increased requests for information and education regarding sexual health for young people, the two have set out to develop and deliver education and training for teachers, parents, health and welfare professionals and young people.

One of the first initiatives was to persuade Family Planning Victoria (FPV) to providing training in "Rural Remote" areas.

The following article was printed in the first Family Planning Newsletter May 2005.

FPV's Training and Education unit continues to target a range of rural and regional service providers from various settings, including schools, disability sectors, nursing and medical fields, indigenous health and allied health areas.

FPV recently approached and worked with a collaborative in the Glenelg & Southern Grampians region, including Portland District Health and Glenelg Shire Council, to develop and run S&RH education sessions in Portland.

A one-day Sexual Health Update was held on Wednesday 27 April. Twenty-seven teachers and community workers who work with young people attended. A range of topics were covered, including updates on contraception, sexually transmitted infections and adolescent sexual behaviour, sexual decision-making and relationships, gender and power issues and safe partying. In the evening, 45 Family Day Care and after-school/school holiday program workers attended a session on "**Tackling the Birds and Bees.**"

Participants came from Warrnambool College, South West Institute of TAFE, DHS, Youthbiz - Western District Health Service, Brophy Family & Youth Services, Casterton Memorial Hospital - Community Health, Brauer College, Balmoral High School, Portland District Health and other local schools and organisations.

The whole day format is a suitable option for regional areas in Victoria.

Please contact FPV on 9257 0133 if your organisation is interested in holding a similar event. If you would like more information on sexual health training and education initiatives in the Glenelg and Southern Grampians Shires, please contact Lynda Smith or Sam Sharp at Portland District Health on 55221180.

If you would like confidential Safer Sex information contact: Your local GP, Portland District Health Emergency Department 55210333, Otway Street Women's Health Clinic or the Youth Health Worker 55221180.

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