GUIDELINES

For

GENERAL PRACTITIONERS

2024

Press record

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FOREWORD

It is a great honor for me to write a foreword to Guidelines for General Practitioners by General Practitioners' society, Myanmar Medical Association (Central).

General practitioners are the primary health providers in the community looking after the majority of the people of our country. They are being trusted and depend upon by every families in the surrounding area where they practice. The first and foremost care by the General Practitioners are the most important for all the people.

Guidelines based on a critical appraisal of scientific evidence (evidence-based guidelines) clarify which interventions are of proved benefit and document the quality of the supporting data. They alert clinicians to interventions unsupported by good science, reinforce the importance and methods of critical appraisal, and call attention to ineffective, dangerous, and wasteful practices.

Clinical guidelines can improve the quality of clinical decisions. They offer explicit recommendations for clinicians who are uncertain about how to proceed, overturn the beliefs of doctors accustomed to outdated practices, improve the consistency of care, and provide authoritative recommendations that reassure practitioners about the appropriateness of their treatment policies.

The Myanmar Medical Association together with the GP society has been helping out with the CME and CPD program for the Member doctors both inhouse sessions and online courses. This guideline is one of the essential parts of this CPD for the GPs.

I would like to congratulate the GP society for their effort for producing this guideline and also, I would like to encourage them to review and updated regularly.

Professor Aye Aung
President
Myanmar Medical Association

April, 2024

PREFACE

We are writing this letter to express our sincerest gratitude and appreciation for the successful completion of the **second edition** of the **General Practitioners' Guidelines**. This accomplishment is the result of an exceptional collaborative effort, and we would like to extend our thanks to all those involved.

The General Practitioners' Guidelines has been an invaluable resource since its inception with the launch of the first edition in November 2017. As per the initial plan, the guidelines were intended to be updated every three years to ensure the most up-to-date information reaches Myanmar General Practitioners, enhancing their knowledge in primary healthcare and family health.

However, the unforeseen outbreak of the Covid-19 pandemic disrupted our plans and posed numerous challenges for the team. In-person meetings became impossible due to safety concerns, making it necessary for us to find alternative means of communication and collaboration. Despite the adversity faced, the team members demonstrated remarkable resilience and adaptability by utilizing online platforms and technology to continue the update process.

We would like to extend our deepest gratitude to the dedicated team members who persevered and worked tirelessly during these trying times. Their commitment, professionalism, and unwavering dedication to the project enabled us to overcome the obstacles posed by the pandemic and successfully complete the second edition of the guideline.

Furthermore, we would like to express our sincere appreciation to the specialist societies that actively contributed to the development of the guidelines. Their expertise and invaluable insights have ensured that the content remains current, accurate, and relevant, enabling our General Practitioners to provide the highest quality of care to their patients.

We would also like to extend our heartfelt thanks to the esteemed President of the Myanmar Medical Association, for their continuous support and guidance throughout this endeavor. Their leadership and unwavering commitment to advancing medical knowledge in Myanmar have been instrumental in the success of this Guidelines.

Moreover, the decision to distribute the guideline as electronic copies reflects our commitment to ensuring easy access for all Myanmar General Practitioners. By making it available in this format, we aim to facilitate the dissemination of updated knowledge, thus empowering our healthcare professionals to deliver the best possible care to the community.

In conclusion, we would like to express our deepest gratitude to all those who contributed to the development and distribution of the General Practitioners' Guidelines Second Edition. The unwavering supports and collective efforts have made a significant impact on enhancing primary healthcare and family health care in Myanmar.

Once again, thank you for your outstanding dedication, resilience, and invaluable contributions. We look forward to our continued collaboration in advancing medical knowledge and improving healthcare outcomes for all.

Dr Khine Soe Win and Dr Win Zaw April, 2024
General Practitioners' Society (Central)
Myanmar Medical Association

EDITORIAL

It is my privilege to inform you that our updated and revised edition of "**Guidelines for General Practitioners**" will be published very soon and it is my great pleasure to be the editor-in-chief of this guideline book. There are various reasons for revising and updating the previous edition.

This is the fact that some important topics, for example, malaria and family violence are missing in the first edition and some clinical practice guidelines like Diabetes Management have been changed during the interim period. Of course, this opportunity arises due to the emergence of COVID-19 in the world. As all you know, Medicine is an ever-changing science; we need to consider updating our guidelines at least five- yearly. Hence the time is up now!

Education is achieved by assimilating information from many resources and readers of this book can enhance their learning experience in terms of reflecting in their daily Family/General Practice. We all take immerse pride in contributing good educational resource dedicated to Myanmar General Practitioners. The editors and authors anticipate that the readers will both enjoy and profit from their work in preparing this volume.

Happy studying and learning,

Dr Win Lwin Thein
Editor-in chief
Vice President (GP Society)
April, 2024

ACKNOWLEDGEMENT

We would like to thank all our talented and hard-working colleagues who have contributed to the ongoing development of the **Guidelines for General Practitioners**.

Especially, we would like to highlight the significance of the second edition which appears when the family medicine development process in Myanmar is being idle. Many factors are impeding the developing process lately, which has been accelerated previously by the commitment of the MOHS, the medical universities, and the General Practitioners' Society before the COVID-19 pandemic started.

No one can deny that the Myanmar health care system is lacking a strong and effective primary care task force. The best solution to mend this defect is retraining the thousands of general practitioners who are working individually across the country. Here comes the role of family medicine to train these GPs and primary care doctors to be able to use its principles effectively and, in turn, strengthen primary care.

Many GPs are using some family medicine principles consciously or unconsciously in varying degree of competency. Person-centered care, continuity of care, and family-oriented care became the culture of most practices for a long time. But only a few GPs can enjoy the most effective coordinated care and seamless continuity of care with secondary and tertiary care providers. The reasons behind this would be the absence of standardization in general practitioners' service quality and unawareness of the value of family medicine practitioners by other specialties and the public.

To resolve this ambiguity, primary care doctors should be involved in the retraining programs and thereafter CME/CPD and other life-long-learning programs which prescribe family medicine curricula.

We also acknowledge the effort of the contributors to make this new edition more family medicine-oriented, in addition to the Family Medicine chapter at the beginning of the book. We genuinely believe that the new edition will be a better reference for the GP/FP who wants to practice quality primary care and for future family medicine programs in Myanmar.

Finally, we would like to thank all academic writers who contributed to the General Practice Guidelines-first edition. Without their kind support, this second edition could never have happened.

Regards,

Dr. Tin Aye and Dr. Kyaw Thu

General Practitioners' Society (Central), MMA **April, 2024**

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SYMBOLS AND ABBREVIATIONS

AAA abdominal aortic aneurysm
ABC airway, breathing, circulation
ABCD airway, breathing, circulation, dextrose
ABO A, B and O blood groups
ACE angiotensin-converting enzyme
ACEI angiotensin-converting enzyme inhibitor
ACTH adrenocorticotrophic hormone
ADHD attention deficit hyperactivity disorder
ADT adult diphtheria vaccine
AFP alpha-fetoprotein
AI aortic incompetence
AIDS acquired immunodeficiency syndrome
AIIRA angiotensin II (2) reuptake antagonist
AKF acute kidney failure
ALE average life expectancy
ALL acute lymphocytic leukaemia
ALP alkaline phosphatase
ALT alanine aminotransferase
AMI acute myocardial infarction
AML acute myeloid leukaemia
ANA antinuclear antibody
ANF antinuclear factor
AP anterior–posterior
APH ante-partum haemorrhage
ASD atrial septal defect
ASIS anterior superior iliac spine
ASOT antistreptolysin O titre
AST aspartate aminotransferase
AV atrioventricular
AZT azidothymidine
BCC basal cell carcinoma
BCG bacille Calmette-Guérin
BMD bone mass density
BMI body mass index
BP blood pressure
BPH benign prostatic hyperplasia
Ca carcinoma
CABG coronary artery bypass grafting
CAD coronary artery disease
CAP community acquired pneumonia
CBT cognitive behaviour therapy
CCF congestive cardiac failure
CCU coronary care unit
CD4 T helper cell
CD8 T suppressor cell
CDT combined diphtheria/tetanus vaccine
CEA carcinoembryonic antigen
CFS chronic fatigue syndrome
CHD coronary heart disease
CHF chronic heart failure
CIN cervical intraepithelial neoplasia
CK creatinine kinase
CKD chronic kidney disease
CKF chronic kidney failure
CML chronic myeloid leukaemia
CMV cytomegalovirus
CNS central nervous system
COAD chronic obstructive airways disease
COC combined oral contraceptive
COCP combined oral contraceptive pill
COPD chronic obstructive pulmonary disease
COX cyclooxygenase
CPA cardiopulmonary arrest
CPAP continuous positive airways pressure
CPK creatine phosphokinase
CPR cardiopulmonary resuscitation
CR controlled release
CREST calcinosis cutis; Raynaud's phenomenon; oesophageal involvement; sclerodactyly; telangiectasia
CRF chronic renal failure
CR(K)F chronic renal (kidney) failure
CRP C-reactive protein
CSF cerebrospinal fluid
CT computerised tomography
CTS carpal tunnel syndrome
CVA cerebrovascular accident
CVS cardiovascular system
CXR chest X-ray
DBP diastolic blood pressure
DC direct current
DHA docosahexaenoic acid
DI diabetes insipidus
DIC disseminated intravascular coagulation
dL decilitre
DMARDs disease modifying antirheumatic drugs
DNA deoxyribose-nucleic acid
DRABC defibrillation, resuscitation, airway, breathing, circulation
drug dosage bd—twice daily, tid/tds -three times daily, qid/qds -four times daily
ds double strand
DS double strength
DSM diagnostic and statistical manual (of mental disorders)
DU duodenal ulcer
DUB dysfunctional uterine bleeding
DVT deep venous thrombosis
EBM Epstein-Barr mononucleosis (glandular fever)
EBV Epstein-Barr virus
ECG electrocardiogram
ECT electroconvulsive therapy
EDD expected due date
EEG electroencephalogram
ELISA enzyme linked immunosorbent assay
ESRF end-stage renal failure
ESR(K)F end stage renal (kidney) failure
ERCP endoscopic retrograde cholangiopancreatography
esp. especially
ESR erythrocyte sedimentation rate
FB foreign body
FBE full blood count

FEV1 forced expiratory volume in 1 second
fL femtolitre = (1e–15) litre
FSH follicle stimulating hormone
FUO fever of undetermined origin
FVC forced vital capacity
g gram
GA general anaesthetic
GABHS group A beta-haemolytic streptococcus
GBS Guillain-Barré syndrome
GFR glomerular filtration rate
GI glycaemic index
GIT gastrointestinal tract
GLP glucagon-like peptide
GnRH gonadotrophin-releasing hormone
GO gastro-oesophageal
GORD gastro-oesophageal refl ux
GP general practitioner
G-6-PD glucose-6-phosphate
GU gastric ulcer
HAV hepatitis A virus
anti-HAV hepatitis A antibody
Hb haemoglobin
HbA haemoglobin A
anti-HBc hepatitis B core antibody
HBeAg hepatitis B e antigen
anti-HBs hepatitis B surface antibody
HBsAg hepatitis B surface antigen
HBV hepatitis B virus
HCG human chorionic gonadotropin
HCV hepatitis C virus
anti-HCV hepatitis C virus antibody
HDL high-density lipoprotein
HEV hepatitis E virus
HFM hand, foot and mouth
HFV hepatitis F virus
HGV hepatitis G virus
HIV human immunodeficiency virus
HNPCC hereditary nonpolyposis colorectal cancer
HPV human papilloma virus
HRT hormone replacement therapy
HSV herpes simplex viral infection
IBS irritable bowel syndrome
ICE ice, compression, elevation
ICS inhaled corticosteroid
ICS intercondylar separation
ICT immunochromatographic test
IDDM insulin dependent diabetes mellitus
IDU injecting drug user
IgE immunoglobulin E
IgG immunoglobulin G
IgM immunoglobulin M
IHD ischaemic heart disease
IM, IMI intramuscular injection
inc. including
IPPV intermittent positive pressure variation
IR internal rotation
ITP idiopathic (or immune) thrombocytopenia purpura
IUCD intrauterine contraceptive device
IUGR intrauterine growth retardation
IV intravenous
IVI intravenous injection
IVP intravenous pyelogram
IVU intravenous urogram
JCA juvenile chronic arthritis
JVP jugular venous pulse
KA keratoacanthoma
kg kilogram
KOH potassium hydroxide
LA local anaesthetic
LABA long acting beta agonist
LBBB left branch bundle block
LBO large bowel obstruction
LBP low back pain
LDH/LH lactic dehydrogenase
LDL low-density lipoprotein
LFTs liver function tests
LH luteinising hormone
LHRH luteinising hormone releasing hormone
LIF left iliac fossa
LMN lower motor neurone
LNG levonorgestrel
LRTI lower respiratory tract infection
LSD lysergic acid
LUQ left upper quadrant
LUTS lower urinary tract symptoms
LV left ventricular
LVH left ventricular hypertrophy
mane in morning
MAOI monoamine oxidase inhibitor
mcg microgram (also µg)
MCV mean corpuscular volume
MDI metered dose inhaler
MDR multi-drug resistant TB
MI myocardial infarction
MRCP magnetic resonance cholangiography
MRI magnetic resonance imaging
MS multiple sclerosis
MSM men who have sex with men
MSU midstream urine
N normal
NAD no abnormality detected
NGU non-gonococcal urethritis
NHL non-Hodgkin's lymphoma
NIDDM non-insulin dependent diabetes mellitus
nocte at night
NSAIDs non-steroidal anti-inflammatory drugs
NSU non-specific urethritis
(o) taken orally
OA osteoarthritis
OCP oral contraceptive pill
OGTT oral glucose tolerance test
OSA obstructive sleep apnoea
OTC over the counter
PA posterior–anterior
PAN polyarteritis nodosa
Pap Papanicolaou
pc after meals
PCA percutaneous continuous analgesia
PCB post coital bleeding

PCL posterior cruciate ligament
PCOS polycystic ovarian syndrome
PCP pneumocystis carinii pneumonia
PCR polymerase chain reaction
PCV packed cell volume
PDA patent ductus arteriosus
PEF peak expiratory flow
PEFR peak expiratory flow rate
PET pre-eclamptic toxaemia
PFT pulmonary function test
PH past history
PID pelvic inflammatory disease
PLISSIT permission: limited information: specific suggestion: intensive therapy
PMS premenstrual syndrome
PMT premenstrual tension
POP plaster of Paris
POP progestogen-only pill
PPI proton-pump inhibitor
PPROM preterm premature rupture of membranes
PR per rectum
prn as and when needed
PROM premature rupture of membranes
PSA prostate specific antigen
PSIS posterior superior iliac spine
PSVT paroxysmal supraventricular tachycardia
PT prothrombin time
PTC percutaneous transhepatic cholangiography
PU peptic ulcer
PUO pyrexia of undetermined origin
pv per vagina
qds, qid four times daily
RA rheumatoid arthritis
RBBB right branch bundle block
RBC red blood cell
RCT randomised controlled trial
RF rheumatic fever
Rh rhesus
RIB rest in bed
RICE rest, ice, compression, elevation
RIF right iliac fossa
RPR rapid plasma reagin
RR relative risk
RSV respiratory syncytial virus
RT reverse transcriptase
rtPA recombinant tissue plasminogen activator
SAH subarachnoid haemorrhage
SARS severe acute respiratory distress syndrome
SBE subacute bacterial endocarditis
SBO small bowel obstruction
SBP systolic blood pressure
SC/SCI subcutaneous/subcutaneous injection
SCC squamous cell carcinoma
SCG sodium cromoglycate
SIADH syndrome of secretion of inappropriate antidiuretic hormone
SIDS sudden infant death syndrome
SIJ sacroiliac joint
SL sublingual
SLE systemic lupus erythematosus
SLR straight leg raising
SND sensorineural deafness
SNHL sensorineural hearing loss
SNRI serotonin noradrenaline reuptake inhibitor
SOB shortness of breath
sp species
SR sustained release
SSRI selective serotonin reuptake inhibitor
SSS sick sinus syndrome
stat at once
STI sexually transmitted infection
SVC superior vena cava
SVT supraventricular tachycardia
T3 tri-iodothyronine
T4 thyroxine
TB tuberculosis
tds, tid three times daily
TENS transcutaneous electrical nerve stimulation
TFTs thyroid function tests
TG triglyceride
TIA transient ischaemic attack
TIBC total iron binding capacity
TM tympanic membrane
TMJ temporomandibular joint
TNF tissue necrosis factor
TOF tracheo-oesophageal fistula
TORCH toxoplasmosis, rubella, cytomegalovirus, herpes virus
TPHA Treponema pallidum haemoglutination test
TSE testicular self-examination
TSH thyroid-stimulating hormone
TT thrombin time
TV tidal volume
U units
UC ulcerative colitis
U & E urea and electrolytes
µg microgram
UMN upper motor neurone
URTI upper respiratory tract infection
US ultrasound
UTI urinary tract infection
U ultraviolet
VC vital capacity
VDRL Venereal Disease Reference Laboratory
VF ventricular fibrillation
VMA vanillyl mandelic acid
VSD ventricular septal defect
VT ventricular tachycardia
VUR vesico-ureteric reflux
VWD von Willebrand's disease
WBC white blood cells
WCC white cell count
WHO World Health Organization
WPW Wolff-Parkinson-White
XL sex linked

CHAPTER (17)

SEXUAL HEALTH PROBLEMS

- Introduction and Relevance to General Practice
- Objectives of General Assessment
- Creating a Safe Space for the Patients
- Taking Sexual History from Every Patient
- History Taking from the Patients with Sexual Health Problems
- Physical Examination
- Sexual Dysfunction (Sexual Health Concerns)
- Hypoactive Sexual Desire Disorder
- Female Sexual Arousal Disorder
- Dyspareunia
- Female Orgasmic Disorder
- Erectile Dysfunction
- Andropause/Male Menopause
- Premature Ejaculation
- Health Care for Transgender and Gender-diverse Persons
- The Small Penis Syndrome
- Sexuality in the Elderly
- Intimate Partner Violence and Sexual Violence

INTRODUCTION AND RELEVANCE TO GENERAL PRACTICE

- Family doctors are often asked to provide advice and help for sexual concerns and are continually challenged to detect such problems presenting in some other guise. Most of the cases are usually encountered as" hidden agenda".
- Although some patients may present directly with a complaint of sexual dysfunction, many will be less direct and use some other pretext or complaint as a 'ticket of entry' for their sexual concerns.
- Family physicians should use a proactive, integrated, patient-centered approach to sexual health that includes, not only disease identification and treatment, but also providing a safe environment in which patients can consensually discuss issues related to sex and sexuality across their life span.

SEXUAL HEALTH (current working definition)

- "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." *(WHO, 2006a)*

SEXUALITY

- Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. *(WHO, 2006a)*

OBJECTIVES OF GENERAL ASSESSMENT ARE TO:

- Create a safe space for the patients.
- Establish a constructive relationship with the patient to enable patient and doctor to communicate effectively and serve as the basis for any subsequent therapeutic relationship.
- Determine whether the patient has a sexual health problem and, if so, what that is.
- Find out (where possible) what caused that problem.
- Assess the patient's emotions and attitudes towards the problem.
- Be aware of signs of anxiety/distress. Recognize non-verbal cues.
- Establish how it might be treated.
- Confidentiality issues should be emphasized.

CREATING A SAFE SPACE FOR THE PATIENTS

- An initial self-assessment of physician's own comfort by discussing sex with various patient groups and identifying any unrecognized or implicit biases that they might have.
- Physicians should focus on creating a welcoming environment by training staff and clinicians in culturally sensitive terminology, using gender-inclusive language on forms and displaying diverse images in marketing and waiting areas.

- using the two-step method (asking two questions regarding both gender identity and sex assigned at birth) or using self-identified pronouns.

HISTORY TAKING FROM THE PATIENTS WITH SEXUAL HEALTH PROBLEMS

- Use open questions at the start becoming directive when necessary.
- clarify, reflect, facilitate, listen.
- ***Ask about:*** *Presenting complaint in* chronological account and concerns.
- If appropriate, ask about:
    - Vaginal or urethral discharge
    - Dysuria/other urinary symptoms
    - Dyspareunia -pain on intercourse
    - Erectile dysfunction
    - Genital skin problems - soreness, itching, ulceration, warts
    - Perianal/anal symptoms
- Other symptoms, e.g. pelvic/abdominal/groin pain, deformity of the penis, haematospermia, retrograde ejaculation
- Past medical history
    - Similar symptoms - for suspected sexually transmitted infections (STIs), ask about previous STI, date of diagnosis, and treatment.
    - Obstetric history for women
    - Urological problems and treatments or pelvic surgery
    - Chronic medical problems – endocrine, cardiovascular.
    - HIV testing
- Vaccination history: Hepatitis B, Human papilloma virus
- Drugs
    - Prescription drugs, e.g. drugs associated with erectile dysfunction
    - Illicit drugs - may be associated with erectile dysfunction, and history of injecting drug misuse is associated with increased hepatitis/HIV risk.
- Allergies
- Social history
- Smoker?
- Alcohol consumption
- Travel abroad - if suspected STI, ask whether the patient had sexual intercourse abroad other than with their travelling partner, and with whom.
- Attitudes and beliefs
    - How does the patient see the problem?
    - What does he/she think is wrong?
    - How does he/she think his/her partner views the situation?
    - What does the patient want you to do about it?

TAKING SEXUAL HISTORY FROM EVERY PATIENT

- Obtaining an accurate and detailed sexual history is essential for proper screening for sexually transmitted infections (STIs).
- While this conversation may be uncomfortable for both physician and patient, a comprehensive sexual history should be part of routine, preventive health care.
- The sample script below can help physicians with a standardized approach to obtaining a sexual history.
- **Step 1: Set the Stage:**

- Introduce the topic and explain confidentiality.
- It is a good idea to set the stage for the conversation before jumping into questions about a patient's sexual health. You can help put a patient at ease by assuring them that obtaining a sexual health history is a routine part of a physical exam/medical visit and that everything shared will remain confidential.
- Here is a sample opener or a conversation starter for a conversation on sexual health:
- *"I am going to ask you a few questions about your sexual history. I ask everyone these questions, as they are important to understand your health. Everything you tell me is confidential."*

- **Step 2: The Questions to Ask Patients (as appropriate)**
  - Have you ever been sexually active?
  - What is/are the sex and gender of your partner(s)?
  - How many partners have you had in the last 12 months?
  - What types of sexual activity do you have (oral/anal/vaginal/use of sex toys/other)?
  - When was the last time you got tested for STIs?
- **Step 3: Respond to the History**
  - Based upon the patient's answers, determine if a more detailed risk assessment is needed. Use the **5 P's approach:**
    - **P**artners: What are the genders of your partners? How many partners in the past 6 months? Your lifetime? long-term or casual partner.
    - **P**ractices: What type of sexual activities do you participate in? Do you participate in vaginal sex? Oral sex? Anal sex?
    - **P**ast history/**P**rotection from STIs: Have you ever had any sex-related diseases? Do you have, or have you ever had, any risk factors for HIV? Have you ever been tested for HIV? Would you like to be? What do you do to protect yourself from contracting HIV?
    - **P**regnancy plans: Are you trying to become a parent? Would you like to get pregnant (or father a child)? What method do you use for contraception?
    - **P**leasure: Do you ever have pain with intercourse? Do you have any difficulty with lubrication? Do you have any difficulty achieving orgasm? Do you have any difficulty obtaining and maintaining an erection? Do you have difficulty with ejaculation? Do you have any questions or concerns about your sexual functioning? Is there anything about your (or your partner's) sexual activity (as individuals or as a couple) that you would like to change?

Table 1. BEST PRACTICE TIP: Language is important

AVOID	INSTEAD USE
Are you married?	What is your current relationship status?
You're married so you don't need STI testing, right?	Have you had any new sexual partners in the last year?
Do you think your partner is cheating on you?	Does your partner have other partners?
Do you sleep with a lot of people?	How many sexual partners have you had?
Are you an IV drug user?	Have you ever injected drugs?

Ref: Taking an Accurate Sexual History Sample Script: www.aafp.org/sti

PHYSICAL EXAMINATION

- Physical examination is mandatory.
- Examine the external genitalia and perianal area.
- Check groins for lymphadenopathy if STI is suspected.
- For women, perform pelvic and vaginal speculum examination.
- Consider digital rectal examination if indicated.

- *Explain the need for and offer a suitable medically qualified chaperone for the examination of all patients.*
- *Record if a chaperone is declined.*

ACTION

1. Summarize the history back to the patient and give an opportunity for the patient to fill in any gaps.
2. Check that the patient has no other concerns.
3. Develop a problem list and outline a management plan.
4. Further investigations and interventions are guided by the findings on history and examination - so a good history and examination is essential.
5. Set a review date.

SEXUAL DYSFUNCTION (SEXUAL HEALTH CONCERNS)

- Between 50% and 98% of women report at least one sexual health concern, including interest in sex, difficulty with orgasm, inadequate lubrication, dyspareunia, body image concerns, unmet sexual needs, the need for information about sexual issues, physical and sexual abuse, and sexual coercion.
- Around 40% of men report at least one sexual health concern, most commonly erectile dysfunction, or premature ejaculation.[5]
- Not all sexual health concerns are related to genital issues. Chronic conditions, including pulmonary disease, cardiac disease, osteoarthritis, and mental health issues, and diabetes mellitus (27-55%) can affect sexual activity and satisfaction.
- It is most appropriate to enquire about these issues in the post-myocardial infarction, the post-prostatectomy, the patient taking antihypertensives or other drugs, and the post-mastectomy or post-hysterectomy patient.
- Sexual problems may have a physical or psychological basis, but *all* develop a psychological aspect in time.
- Both partners have a problem in 30% cases.

Assessment

- A caring and compassionate physician who is comfortable discussing sex, who knows the patient and has seen her before, and who seems concerned about her sexual health is one with whom patients will feel most comfortable discussing sex.
- A brief set of questions or a screening questionnaire (Table 2) should be used for an initial approach to the patient.

Table 2. Brief sexual symptom checklist for women

Sexual Symptom Checklist for Women	
Please answer the following questions about your overall sexual function:	
1.	Are you satisfied with your sexual function: □ Yes □ No
If no, please continue.	
2.	How long have you been dissatisfied with your sexual function?_____.
3.	Mark which of the following problems you are having, and circle the one that is most bothersome:
	□ Little or no interest in sex
	□ Decreased genital sensation (Feeling)
	□ Decreased vaginal lubrication (Dryness)
	□ Problem reaching orgasm
	□ Pain during sex
	□ Other: _____
4.	Would you like to talk about it with your doctor? □ Yes □ No

History of the problem

What is the problem? If new, when did it start? Why consult now? What outcome does the patient want? Is the patient complaining or is his/her partner?

Sexual history

Details of sex knowledge; attitude towards sex; past history of sexual problems (or lack of problems)
It is important to be alert for psychiatric disorders and situational factors and not to predict a person's sexual disposition.
Avoid being too formal or too familiar.
Ideally, it is best to see a couple together if the problem is occurring within a steady relationship.
Doctors may recognize such an association and initiate a tactful psychosocial history that includes questions about sexuality.

Medical history

Chronic diseases, chronic back pain, pelvic pain, vaginal discharge; tiredness, insomnia, tension headache, psychiatric problems; current medication.

Social history and recent life events

Always consider psychological aspects
Poor self-image; anger or resentment relationship/financial difficulties, children, parents, work stress; ignorance or misunderstanding; shame, embarrassment, or guilt - view that sexuality is 'bad', sexual abuse; anxiety/fear about sex- fear of closeness, vulnerability, letting go, loss and failure.

Examination

BP measurement, genital examination and neurological examination where indicated.
A careful vaginal and pelvic examination should be an opportune educational experience for the patient and an exercise in preventive medicine.

Investigations

No particular routine tests are recommended. Tests for male erectile dysfunction(impotence) may help exclude significant causes of low libido are those for diabetes, liver dysfunction, thyroid dysfunction and endocrine dysfunction (prolactin, free testosterone, FSH, LH and oestradiol estimations.)
Other investigations may include pelvic ultrasonography, colposcopy, or laparoscopy.

Basic sexual counselling

The family doctor can learn to be an effective sex counsellor. Sex counselling can be emotionally demanding and, while good interviewing skills, interest, support, and basic advice are important.
The Ex-PLISSIT counselling model can be used.

Ex-P: Extended Permission giving
LI: Limited Information
SS: Specific Suggestions
IT: Intensive Therapy

Throughout the conversation, the family physician is encouraged to give the patient permission to be curious and to ask open-ended questions such as, “Many people are concerned about how this condition might affect their sex life. What is your experience?”

The patient's response determines what information the physician offers about the diagnosis and sexual function connection. Physicians should confirm patient understanding before using shared decision-making to brainstorm ideas to address any specific concerns.

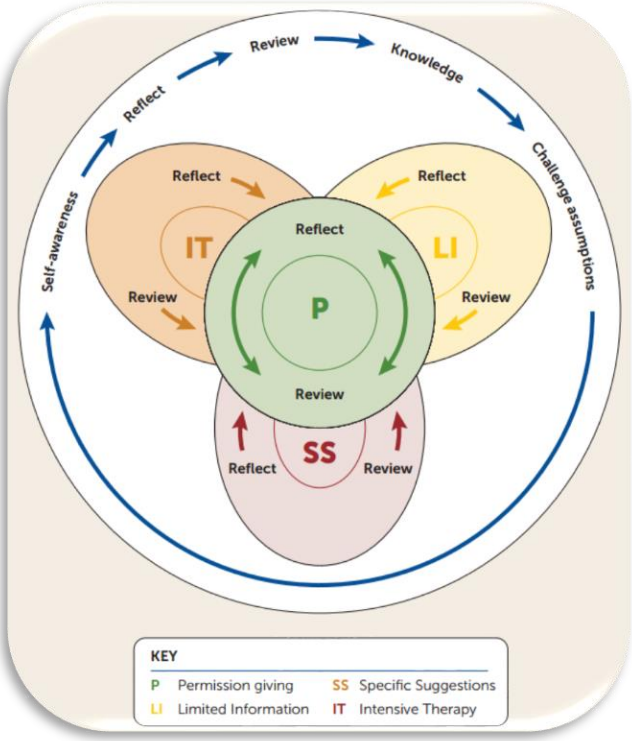

Fig. 1. The Ex-PLISSIT (extended permission giving, limited information, specific suggestions, and intensive therapy) model.

HYPOACTIVE SEXUAL DESIRE DISORDER

Hypoactive sexual desire disorder (i.e., persistent or recurrent deficiency or absence of sexual desire or receptivity to sexual activity) is the most common sexual dysfunction in women, with an estimated prevalence between 5.4 and 13.6 percent. The disorder peaks in women 40 to 60 years of age and in those who have undergone surgical menopause.

In younger women, this disorder is often associated with situational circumstances, such as dysfunctional relationships, frustrating partner's performance (e.g. ED), chronic disease, depression, gynecologic disorders, posttraumatic events, and use of certain medications (e.g., selective serotonin reuptake inhibitors [SSRIs], oral contraceptives, corticosteroids).

In older women it may be situational, such as in depression or chronic disease (e.g., endocrine disorders with adrenal insufficiency), or it may be associated with medication use.

Treatment

Psychotherapy and antidepressants for patients who have associated anxiety. Transdermal testosterone is also effective for short-term therapy; however, there is little evidence to support long-term use (longer than six months).

FEMALE SEXUAL AROUSAL DISORDER

- It is an inability to complete sexual activity with adequate lubrication occurs in approximately 5 percent of U.S. women. It often affects women with gynecologic or chronic medical conditions and those who are taking certain medications (especially SSRIs).

Treatment

Treatment of the underlying condition or adjustment of the medication.

DYSPAREUNIA

Recurrent or persistent painful sexual intercourse, which is a source of considerable distress both physically and psychologically for the patient, and also for her partner. It may be one of the 'hidden agenda' presentations with a vague complaint.
Dyspareunia is a complex disorder often involving both psychosocial and physical conditions, requiring a detailed genitourinary examination and clinician knowledge of risk factors and the multifactorial nature of the disorder.

Risk factors

- **Demographic risk factors:** younger age, lower socioeconomic status, and being in the postpartum, perimenopausal, or postmenopausal period.
- **Psychosocial risk factors:** depression, anxiety, low sexual satisfaction, and a history of sexual abuse or intimate partner violence.
- **Obstetric and Gynecological Risk Factors:** a vacuum-assisted or forceps vaginal delivery, breastfeeding, or pelvic floor surgery
- **Others:** irritable bowel syndrome, musculoskeletal disorders, and fibromyalgia.

History Taking

In a safe and welcoming environment where patients feel comfortable discussing their sexuality.
A detailed history includes asking patients to describe:

- the characteristics of the pain (e.g., location, intensity, duration)
- symptoms involving other organs, such as the bladder, bowel, or musculoskeletal system.
- sexual behaviors that cause pain
- psychological history and symptoms
- current medical conditions.

Management

Table 3. Causes of Dyspareunia & Management

Ref; Dyspareunia in Women: American Family Physician: Volume 103, Number 10 ◆ May 15, 2021

Diagnosis	Entry or Deep	Historical clues	Treatment options
Vulva and Vagina			
Dermatologic diseases (e.g., lichen sclerosus, lichen planus, contact dermatitis)	Entry	Burning, dryness, pruritus	Usually topical steroids; depends on diagnosis

Inadequate lubrication	Both	Dryness; history of diabetes mellitus; history of chemotherapy or use of progestogens, aromatase inhibitors, tamoxifen, or gonadotropin-releasing hormone agonists	Discontinuation of causative medication if possible; use of vaginal moisturizers or lubricants
Pelvic floor dysfunction	Both	Difficulty evacuating stool or emptying bladder; aching after intercourse; pain in lower back, thighs, or groin	Pelvic floor physical therapy, gabapentin, trigger point injections with local anesthetics or onabotulinum toxin A (Botox), neuromodulation
Vaginal atrophy	Both	Burning, dryness	Vaginal moisturizers or lubricants, topical estrogen, ospemifene (Osphena), prasterone (Intrarosa)
Vaginismus	Entry	Difficulty achieving penetration; possible history of anxiety, sexual abuse or trauma, or other causes of painful penetration; sometimes no prior risk factors are present	Multidisciplinary approach includes cognitive behavior therapy, psychotherapy, relationship and sexual counseling, lubricants, sequential vaginal dilators, a sensate focus program, and onabotulinumtoxinA injection
Vaginitis	Both	Discharge, burning, or odor	Antibiotic or antifungal therapy according to diagnosis
Vulvodynia	Entry	Chronic burning, tearing, aching, or stabbing vulvar pain of at least three months' duration	Patient education about vulvar hygiene and using cotton underwear and pads, 2% lidocaine jelly or ointment applied by cotton ball placed on vulva at bedtime, amitriptyline, oral or compounded vaginal gabapentin, compounded vaginal muscle relaxants, estrogen, selective serotonin or norepinephrine reuptake inhibitors, pelvic floor physical therapy,cognitive behavior therapy, amitriptyline, surgical excision
Bladder			

Interstitial cystitis	Deep	Urinary urgency, frequency, and nocturia	Dietary modification; antispasmodics; cimetidine; amitriptyline
Uterus and adnexa			
Ovarian masses	Deep	Lateralized pain with intercourse	Observation or laparoscopy as indicated
Uterine retroversion	Deep	Pain may be related to sexual position; may be associated with endometriosis	Modify sexual positions; vaginal pessary; hysterectomy
Pelvis			
Adhesions or chronic pelvic inflammatory disease	Deep	May have lateralized, sharp pain; history of pelvic inflammatory disease or pelvic surgery	Nonopioid analgesics; laparoscopic adhesiolysis
Endometriosis	Deep	Family history; dysmenorrhea common	Nonopioid analgesics, combined oral contraceptives, progestogens, levonorgestrel-releasing intrauterine system elagolix, laparoscopic excision

FEMALE ORGASMIC DISORDER

- Female orgasmic disorder (i.e., persistent or recurrent delay in or absence of orgasm after a normal excitement phase) occurs in 3.4 to 5.8 percent of U.S. women. It can be either primary (i.e., patient has never achieved orgasm) or secondary (i.e., resulting from another sexual dysfunction, typically hypoactive sexual desire disorder).

Table 4. Female Orgasmic Disorders

Type of Orgasmic Disorder	Possible causes	Treatment
Primary	May be genetic Often associated with a history of trauma or abuse.	Psychotherapy and couples counseling No effective therapy for unexplained primary orgasmic disorder
Secondary	Hypoactive sexual desire disorder or other sexual dysfunctions	typically resolves with treatment of the primary dysfunction. Adjunctive education on masturbation techniques may be helpful.

ERECTILE DYSFUNCTION

- Erectile dysfunction (impotence) is the inability to achieve or maintain an erection sufficient for satisfactory sexual intercourse.
- Erectile dysfunction is a common problem. US data shows the prevalence to be 39% of males at 40 years and 67% of males aged 70.
- 50% men aged 40-70yr experience inability to obtain/maintain sufficient rigidity of the penis to allow satisfactory sexual performance.
- In the past, ED was commonly believed to be caused by psychological problems. It is now known that ED is caused by physical problems for most men, usually related to the blood supply of the penis.

Causes

Organic causes (>80%)

- Cardiovascular: CHD- multi-vessel than single-vessel coronary artery disease; peripheral vascular disease, Hypertension
- Diabetes Mellitus: 35 - 50% of diabetic men have erectile dysfunction.
- Endocrine disorders (e.g., hypogonadism, testosterone deficiency, hyperprolactinemia, thyroid disorders)
- Genital pain
- Hyperlipidemia
- Metabolic syndrome
- Obesity
- Neurological, e.g. pelvic surgery, spinal injury, stroke, multiple sclerosis, Parkinson disease.
- Prostate cancer treatment (e.g., surgery, radiation, hormone therapy)
- Side effects of prescription drugs: Consider changing medication if onset of erectile dysfunction is within 2-4wk of initiation of drug therapy e.g. thiazides
- Smoking, alcohol, or drug abuse (e.g. amphetamines, barbiturates, cocaine, marijuana, opiates)
- Peyronie' s disease

- Trauma
- Venous leakage (caused by any conditions that changes the architecture of the penile erectile tissue which fails to compress the small veins)

Psychogenic causes

- Performance anxiety
- Depression or stress
- Marital or Relationship failure
- Fear of intimacy
- Guilt
- History of sexual Abuse

Drugs causing erectile dysfunction

- Antihypertensives (e.g. alpha blockers, beta blockers, calcium channel blockers, clonidine, methyldopa)
- Antidepressants (e.g., lithium, monoamine oxidase inhibitors, Selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants)
- Anticonvulsants (e.g., phenobarbital, phenytoin [Dilantin])
- Antihistamines (e.g., dimenhydrinate, diphenhydramine, promethazine)
- Antipsychotics (e.g., chlorpromazine, haloperidol, pimozide, thioridazine, thiothixene)
- Cardiovascular agents (e.g., digoxin, disopyramide, gemfibrozil [Lopid])
- Cytotoxic agents (e.g., methotrexate)
- Diuretics (e.g., spironolactone, thiazides)
- Major tranquillizers (e.g. benzodiazepines)
- Hormones and hormone-active agents (e.g., 5-alpha-reductase inhibitors, androgen receptor blockers, androgen synthesis inhibitors, corticosteroids, estrogens, gonadotropin-releasing hormone analogs, progesterones)
- Immunomodulators (e.g., interferon alfa)
- Cimetidine (Hyperestrogenic side effect due to inhibition of estradiol 2-hydroxylation)

Diagnosis

One of diagnostic options for erectile dysfunction include a single-question self-assessment (Table 5).

Table 5. Single-Question Assessment of Erectile Dysfunction

Impotence means not being able to get and keep an erection that is rigid enough for satisfactory sexual activity. How would you describe yourself?		
A	Not impotent	Always able to get and keep an erection good enough for sexual intercourse.
B	Minimally impotent	Usually able to get and keep an erection good enough for sexual intercourse.
C	Moderately impotent	Sometimes able to get and keep an erection good enough for sexual intercourse.
D	Completely impotent	Never able to get and keep an erection good enough for sexual intercourse.

The five-question International Index of Erectile Function (IIEF-5) allows rapid clinical assessment of ED and can measure the effectiveness of ED treatments.

Table 6. International Index of Erectile Function-5 (IIEF-5)

Over the Past 6 months:					
1. How do you rate your confidence that you could get and keep an erection?	Very low 1	Low 2	Moderate 3	High 4	Very high 5
2. When you had erection with sexual stimulation, how often were your erections hard enough for	Almost never/never 1	A few times (much less than half the	Sometimes (about half the time) 3	Most times (much more than half the	Almost always/always 5

penetration?		time) 2		time) 4	
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never/never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always/always 5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Extremely difficult 1	Very difficult 2	Difficult 3	Slightly difficult 4	Not difficult 5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never/never 1	A few times (much less than half the time) 2	Sometimes (about half the time) 3	Most times (much more than half the time) 4	Almost always/always 5

IIEF-5 Scoring

The IIEF-5 score is the sum of the ordinal responses to the 5 times.

22-25: No erectile dysfunction
17-21: Mild erectile dysfunction
12-16: Mild to moderate erectile dysfunction
8-11: Moderate erectile dysfunction
5-7: Severe erectile dysfunction

Evaluation

History

Medical and surgical history, sexual history, use of medications and other substances, and an assessment of psychological and relationship health are key components of the patient history.

Ensure the presenting problem is erectile dysfunction and not other sexual difficulties; identify risk factors and distinguish psychogenic from organic causes.
Ask about nocturnal and early morning erections. ED of mixed organic and psychogenic origin is common. Psychogenic causes are more likely when the patient has normal erections with masturbation or when nocturnal penile tumescence is normal.
Many patients with organic erectile dysfunction develop a psychogenic component which perpetuates symptoms.

Physical examination

Essential parts of the physical examination include measurement of blood pressure, body mass index, and waist circumference to assess abdominal obesity; peripheral pulses; a genital examination; and an assessment of male secondary sex characteristics.
Also Check the cremasteric and bulbocavemosus reflexes.

Psychological assessment

Consider depression or anxiety screening.

Investigations

- The A1C or fasting glucose level
- A lipid panel
- A thyroid-stimulating hormone level
- Routine measurement of testosterone levels is controversial. (Morning total testosterone measurement may be considered for men with small testes, lack of male secondary sex characteristics, significantly low libido, or a history of inadequate response to phosphodiesterase-5 (PDE-5) inhibitors)

Treatment options for erectile dysfunction

Lifestyle modifications

- Regular exercise, weight loss in obese or overweight men, and improved control of diabetes, hypertension, and hyperlipidemia can improve International Index of Erectile Function-5 (IIEF-5) scores in men with ED. Statin use seems to improve ED, as measured by IIEF-5 scores.
- Tobacco cessation is highly recommended. The risk of ED is increased by 51% in current smokers and 20% for ex-smokers) Current smoking is significantly associated with ED, and smoking cessation has a beneficial effect on the restoration of erectile function (Recommendation A)
- Men with metabolic syndrome should be counseled to make lifestyle modifications to reduce the risk of cardiovascular events and ED. (Recommendation B)

Medications

- Phosphodiesterase-5 inhibitors are the first-line treatment for ED. (Recommendation A).
- The PDE-5 inhibitor helps to maintain the erection by enhancing the vasodilatory effects of endogenous nitric oxide.
- All are effective within about one hour of dosing and are typically used on an as-needed basis. The effects may be delayed or decreased if the patient has recently eaten a fatty meal, particularly for sildenafil and vardenafil.
- The patients should be taught how to titrate dose to effect (most people with DM need the maximum dose); warn the patient he may need up to 8 attempts before a satisfactory erection occurs; side effects include headache, flushing, and acid reflux. PDE-5 inhibitors are contraindicated in men using nitroglycerin or other nitrates because of the risk of catastrophic low blood pressure.

Table 7. PDE-5 Inhibitors for Treatment of Erectile Dysfunction

Medications	Dosage	Minimum time from dosing to sexual activity	Elimination half-time	Availability
Avanafil	50, 100, or 200 mg once daily as needed	15 minutes	Five to 10 hours	NA
Sildenafil	20, 25, 50, or 100 mg once daily as needed	30 minutes	Three to five hours	Available
Tadalafil	10 or 20 mg once daily as needed. 2.5 or 5 mg once daily	30 minutes	17.5 hours	Available
Vardenafil	10 or 20 mg once daily as needed	60 minutes	Four to five hours	NA

Do not prescribe testosterone to men with erectile dysfunction who have normal testosterone levels. (American Urological Association)

Procedural therapy

- Second-line treatments for ED include alprostadil (Caverject) and vacuum devices.
- These treatments can be used to establish an erection before sexual stimulation. They should be avoided in men who are receiving anticoagulants or who have sickle cell disease or other bleeding or clotting disorders.
- Alprostadil is available in injectable and intraurethral forms and can be used in combination with PDE-5 inhibitors.
- Patients should be warned to seek emergency urologic treatment if an erection **lasts four hours or longer.** Penile fibrosis is another possible adverse effect; in one study, persistent fibrotic changes occurred in 4.9% of patients using intracavernosal alprostadil for four years.

- Vacuum devices consist of a tube that is placed over the penis and sealed at the base with lubricant. Vacuum devices can be cumbersome, require several minutes to produce an erection, may lead to bending at the base of the penis. However, success and satisfaction rates are fairly high. Vacuum devices can be used in combination with an oral PDE-5 inhibitor or with alprostadil.

Prostheses

- Surgically implanted penile prostheses are a third-line treatment option for ED when other treatments have been ineffective. Semirigid malleable prostheses are the simplest and easiest to implant but they can be difficult to conceal because the penis is always erect.
- Inflatable prostheses typically consist of two tubes that replace the corpora cavernosa, plus a pump in the scrotum and an intra-abdominal reservoir. Mechanical failure or infection may require removal of the prosthesis.

Managing psychogenic ED

- Psychogenic ED occurs at all ages but is most common in men younger than 40 years. Although men and their partners may resist a psychological explanation for ED, counseling can be effective.
- When ED coexists with depression or anxiety, treatment of the mood disorder may be the most appropriate first step. If antidepressants are used, the specific agent should be one that is less likely to worsen ED (e.g., bupropion, mirtazapine, fluvoxamine).
- PDE-5 inhibitors are effective in men with depression and can be used in combination with treatments for mood disorders.

ANDROPAUSE/MALE MENOPAUSE

- The term "male menopause" has been used to describe decreasing testosterone levels related to aging. But aging-related hormone changes in women and men are different. In men, production of testosterone and other hormones declines over a period of many years and the consequences aren't necessarily clear. This gradual decline of testosterone levels is called **late-onset hypogonadism** or age-related low testosterone.
- For men older than 35 years, testosterone declines at an average rate of 1.6% per year. There is no cutoff for low testosterone, although a level of 300 ng per dL (10.41 nmol per L) is used in most trials.
- But most older men still have testosterone levels within the normal range and only an estimated 10% to 25% having levels considered to be low.
- Testosterone levels can be checked by a blood test, but tests aren't routinely done. And many men who have low testosterone levels experience no symptoms. In addition, the signs and symptoms associated with low testosterone aren't specific to low testosterone.
- They can also be caused by a person's age, medication use or other conditions, such as having a body mass index of 30 or higher.

PRESENTATION

Signs and symptoms suggestive of low testosterone include:

- Reduced sexual desire and activity
- Decreased spontaneous erections or erectile dysfunction
- Breast discomfort or swelling
- Infertility
- Height loss, low trauma fracture or low bone mineral density
- Hot flushes or sweats
- Other possible symptoms include decreased energy, motivation and confidence, depressed mood, and poor concentration. It's also possible to experience increased sleepiness, sleep disturbances, mild unexplained anemia, reduced muscle bulk and strength, and increased body fat.

Management

- In 2020, the American College of Physicians (ACP) recommended following guidelines for testosterone treatment in adult men with age-related low testosterone.
- 1a) Doctors consider starting testosterone treatment in men with sexual dysfunction **who want to improve their sexual function**, after explaining the risks and benefits.
- 1b) Clinicians should discontinue testosterone treatment in men with age-related low testosterone with sexual dysfunction in whom there is no improvement in sexual function is seen.
- 1c) ACP suggests that clinicians consider intramuscular rather than transdermal formulations when initiating testosterone treatment.
- 2) ACP suggests that clinicians **not initiate** testosterone treatment in men with age-related low testosterone to improve energy, vitality, physical function, or cognition.
- Testosterone therapy might stimulate growth of metastatic prostate and breast cancer. Testosterone therapy may also increase the risk of heart attack and stroke and contribute to the formation of deep vein thrombosis.

PREMATURE EJACULATION

- Premature ejaculation is defined as 'ejaculation that occurs sooner than a man or his partner would like during sex'.
- In the U.S., about 1 in 3 men between 18 to 59 years old have problems with PE. The problem is often thought to be psychological, but biology may also play a role. It may not be clearly described by the patient so a careful history is necessary to define the problem.
- Sometimes PE is a problem for men who have erectile dysfunction. Since an erection goes away after ejaculation, it can be tough to know if the problem is PE or ED. ED should be treated first. Premature ejaculation may not be a problem once the ED is treated.

Cause

- Though the exact cause of PE is not known, serotonin may play a role. High amounts of serotonin in the brain increase the time to ejaculation. Low amounts can shorten the time to ejaculation, and lead to PE.

Treatment

- There are many approaches to treatment but they are aimed either at prolonged ejaculatory control or at satisfactory sexual activity without preoccupation with ejaculation and anticipation of better control with time and experience.
- Psychological therapy, behavioral therapy and drugs are the main treatments for PE.

Psychological therapy

- Psychological therapy is a way to work through the feelings and emotions that may lead to problems with sexual relationships. The goal of this type of therapy is to learn the source of problems and find solutions that may help PE by lowering performance anxiety, building sexual confidence and understanding to help the partner's satisfaction.

Behavioral therapy

Behavioral therapy uses exercises to help build tolerance to delay ejaculation. The goal is to help the patient train his body away from PE.

- The Squeeze Method

The patient or the partner stimulates his penis and firmly squeeze it when close to ejaculation, so the erection partly goes away. The goal is to become aware of the sensations leading to climax and delay climax on his own.

- The Stop-Start Method

The patient or the partner stimulates the penis and stop until the urge to climax lets up. And start stimulating penis again as the patient regains control, This process is repeated 3 times and let ejaculate on the fourth time. Repeat this method 3 times a week until the patient has gained more control.

The medications and others

- The SSRIs have also been reported as effective - using fluoxetine 20 mg or sertraline 50 mg or paroxetine 20 mg, all once daily - but are "off-label" use and still being evaluated. Pre-intercourse dosing regimen is generally not effective. Trial the agents for 3-6 months and then slowly titrate down to cessation.
- Dapoxetine 30 mg, not more than 60 mg OD (taken 2-3 hours before intercourse) is also being evaluated for approval.
- Numbing creams or sprays: lignocaine 2.5 %, prilocaine 2.5%, and sprays may be put on glans penis about 20 to 30 minutes before sex. Wash the cream off the penis 5 to 10 minutes before sex.
- Wearing a condom can also help dull sensation.

HEALTH CARE FOR TRANSGENDER AND GENDER-DIVERSE PERSONS

- In Myanmar, sexuality and gender identity remain taboo topics, and those that identify as LGBTQI can face discrimination in many aspects of their lives. A 2020 study revealed that 1-in-3 people of a national sample did not accept or support LGBTQI people.[13]
- The data from a large observational study suggests that 24% of transgender persons report unequal treatment in health care environments, 19% report refusal of care altogether, and 33% do not seek preventive services.

Gender-related terminology

- **Affirmed gender** - When one's gender identity is validated by others as authentic
- **Agender** - Person who identifies as genderless or outside the gender continuum
- **Gender expression** - External display of gender identity through appearance (e.g., clothing, hairstyle), behavior, voice, or interests
- **Gender identity** - Internalized sense of self as being male, female, or elsewhere along or outside the gender continuum; some persons have complex identities and may identify as agender, gender nonbinary, genderqueer, or gender fluid
- **Cisgender** - Not transgender; a person whose gender identity and/or expression aligns with their sex assigned at birth
- **Transgender** - General term used to describe persons whose gender identity or expression differs from their sex assigned at birth
  - Transgender female - a transgender person designated as male at birth
  - Transgender male - a transgender person designated as female at birth
- **Genderqueer** - Umbrella term for a broad range of identities along or outside the gender continuum; also called gender nonbinary
- **Gender diverse** - General term describing gender behaviors, expressions, or identities that are not congruent with those culturally assigned at birth;
  May include transgender, nonbinary, genderqueer, gender fluid, or non-cisgender identities.
  May be more dynamic and less stigmatizing than prior terminology (e.g., gender nonconforming); this term is not used as a clinical diagnosis.
- **Gender dysphoria** - Distress or impairment resulting from incongruence between one's experienced or expressed gender and sex assigned at birth; DSM-5 criteria for adults include at least six months of distress or problems functioning due to at least two of the following:
  - Marked incongruence between one's experienced or expressed gender and primary and/or secondary sex characteristics
  - Strong desire to be rid of one's primary and/or secondary sex characteristics
  - Strong desire for the primary and/or secondary sex characteristics of the other gender
  - Strong desire to be of the other gender
  - Strong desire to be treated as the other gender
  - Strong conviction that one has the typical feelings and reactions of the other gender
- **Gender incongruence** - The discrepancy between a person's experienced gender and assigned sex but does not imply dysphoria or a preference for treatment.[The International Classification of Diseases, 11th revision (ICD-11)]
- **Sexual orientation** - An enduring physical and emotional attraction to another group; sexual orientation is distinct from gender identity and is defined by the individual.

Creating optimal clinical environment

It is important for clinicians to establish a safe and welcoming environment for transgender patients, with an emphasis on establishing and maintaining rapport. The following are transgender friendly actions for clinicians.

- ***Advocate for the patient in the community*** - Foster sources of social support, provide information on community resources and appropriate referrals.
- ***Approach the patient with sensitivity and awareness*** - Build rapport and trust by providing nonjudgmental care. Examine how aspects of one's identity (e.g., gender, sexual orientation, race, ethnicity, disability) intersect in creating one's experience. Treat all patients with empathy, respect, and dignity.
- ***Create a transgender-friendly clinical environment*** - Ask staff to perform a personal assessment of internal biases. Consider including the two-step method (two questions to identify chosen gender identity and sex assigned at birth) to collect gender identity data. Ensure that intake forms and records use gender-neutral or inclusive language (e.g., partnered instead of married). Designating at least one gender-neutral restroom, displaying LGBT-friendly flags and posters.
- ***Maintain open communication with the promise of confidentiality*** - Establish openness to discuss sexual and reproductive health concerns, inquire about unfamiliar terminology to prevent miscommunication, minimize threats to confidentiality.
- ***Provide culturally sensitive adolescent care*** - Ensure timely referral for puberty suppression if feasible and mental health services, obtain an age-appropriate and confidential psychosocial histor.

Evaluation

- When assessing transgender patients for gender-affirming care, the clinician should evaluate the magnitude, duration, and stability of any gender dysphoria or incongruence. This is ideally accomplished with multidisciplinary care and may require several visits to fully evaluate.
- Efforts to convert a person's gender identity to align with their sex assigned at birth (so-called gender conversion therapy) are **unethical and incompatible** with current guidelines and evidence. (Recommendation C)
- Ex-PLISSIT model of counseling (see above) can be used also for transgender health in primary care.

Physical examination

- Examinations should be based on the patient's current anatomy and specific needs for the visit, and should be explained, chaperoned, and stopped as indicated by the patient's comfort level.
- In the absence of gender-affirming hormone therapy, an initial examination may be warranted to assess for sex characteristics that are incongruent with sex assigned at birth. Such findings may warrant referral to an endocrinologist or other subspecialist.

Mental health

- Clinicians should consider routine screening for depression, anxiety, posttraumatic stress disorder, eating disorders, substance use, intimate partner violence, self-injury, bullying, truancy, homelessness, high-risk sexual behaviors, and suicidality. However, it is important to avoid assumptions that any concerns are secondary to being transgender. (Recommendation C)
- The clinicians should provide first-line treatments for depression or anxiety and refer patients to subspecialists when warranted.

Preventive care

- Preventive services are similar for transgender and cisgender (not transgender) persons. Detailed recommendations are based on the patient's current anatomy, medication use, and behaviors.
- Screening recommendations for hyperlipidemia, diabetes mellitus, tobacco use, hypertension, and

obesity are according to the respective guidelines in this book. Clinicians should be vigilant for signs and symptoms of venous thromboembolism (VTE) and metabolic disease in the patients receiving hormone therapy. Screening for osteoporosis is also based on hormone use.

- Cancer screening recommendations are determined by the patient's current anatomy. Transgender females with breast tissue and transgender males who have not undergone complete mastectomy should receive screening mammography based on guidelines for cisgender persons.
- Screening for cervical and prostate cancers should be based on current guidelines and the presence of relevant anatomy.
- Recommendations for immunizations (e.g., human papillomavirus) and, screening and treatment for sexually transmitted infections (including human immunodeficiency virus) are based on sexual practices. Pre- and postexposure prophylaxis for human immunodeficiency virus infection should be considered for patients who meet treatment criteria including men who have sex with men.

Gender-affirming hormone therapy

- Feminizing and masculinizing hormone therapies are partially irreversible treatments to facilitate development of secondary sex characteristics of the experienced gender. Not all gender-diverse persons require or seek hormone treatment; however, those who receive treatment generally report improved quality of life, self-esteem, and anxiety.
- Patients must give consent to therapy after being informed of the potentially irreversible changes in physical appearance, fertility potential, and social circumstances, as well as other potential benefits and risks.
- Feminizing hormone therapy includes estrogen and antiandrogens to decrease the serum testosterone level below 50 ng per dL (1.7 nmol per L). Masculinizing hormone therapy includes testosterone to increase serum levels to 320 to 1,000 ng per dL (11.1 to 34.7 nmol per L).

Gender-affirming surgical treatments

- Gender-affirming surgical treatments may not be required to minimize gender dysphoria, and care should be individualized. Mastectomy or breast augmentation, facial and laryngeal surgery, voice therapy, or hair removal are the surgical treatment options.

Transgender youth

- Some gender-diverse prepubertal children subsequently identify as gay, lesbian, or bisexual adolescents, or other identities instead of transgender, as opposed to those in early adolescence, when gender identity may become clearer. Clinicians may preferentially focus on assisting the child and family members in an affirmative care strategy that individualizes healthy exploration of gender identity.
- The clinician should advocate for supportive family and social environments. Unsupportive environments in which patients are bullied or victimized can have adverse effects on psychosocial functioning and well-being.
- Transgender adolescents may experience distress at the onset of secondary sex characteristics. Clinicians should consider initiation of or timely referral for a gonadotropin-releasing hormone agonist (GnRHa) therapy to suppress puberty when the patient has reached stage 2 or 3 of sexual maturity. No hormonal intervention is warranted before the onset of puberty.
- Some persons prefer to align their appearance (e.g., clothing, hairstyle) or behaviors with their gender identity. The risks and benefits of social affirmation should be weighed. Transmasculine postmenarcheal youth may undergo menstrual suppression, which typically provides an additional contraceptive benefit (testosterone alone is insufficient). Breast binding may be used to conceal breast tissue but may cause pain, skin irritation, or skin infections.
- Multiple studies report improved psychosocial outcomes after puberty suppression and subsequent

gender-affirming hormone therapy. A study shows that (98%) people who had started gender-affirming medical treatment in adolescence continued to use gender-affirming hormones at follow-up.[15]

THE SMALL PENIS SYNDROME

- In general practice it is not uncommon to counsel men and adolescent males for anxiety, sometimes pathological, about the relatively small size of their penis and its possible impact on sexual adequacy.
- This attitude is related to the myth that a man's sexual performance depends on the size of his penis. The patient may present with minor (often trivial) non-sexual complaints as a 'ticket of entry' into the consulting room or perhaps as a manifestation of anxiety or depression related to preoccupation with penile size.

MEASUREMENT

- Irrespective of physique or facial configuration most men are concerned about penile size. However, as for all parts of the body, there is considerable variation in size and shape of the penis.
- The average adult penis, when measured from the symphysis pubis to the meatus, is 7.5-10.5 cm (3-4 inches) long when flaccid.
- The erect penis has an average length of 15 cm (6 inches) with a range of slightly more than 2.5cm (1 inch).

Psychological factors

- Virility and performance are not related to the size of the penis. Orgasm in the female does not depend on deep vaginal penetration. Penile size was found to have little relationship to a partner's satisfaction from sexual intercourse. The vagina, which is 10 cm (4 inches) long in the unstretched state, tended to accommodate itself to the size of the penis.

Counselling

- Counselling the male with fears about sexual inadequacy related to penis size is based on providing reassuring information about the preceding anatomical and physiological facts. The reasons for the patient's concerns should be explored. It should be pointed out that the feeling of inadequacy often follows comparisons with unreal images of macho men portrayed in the media.
- It is important to emphasize that there is no way of physically enlarging a penis and this includes regular masturbation and coitus.
- Furthermore, it should be explained that size generally has no relationship with physical serviceability or with the capacity to satisfy a partner.

SEXUALITY IN THE ELDERLY

- The sexual needs of the elderly in our society tend to be ignored or misunderstood.
- They have the same needs as younger people namely, the need for closeness, intimacy and body contact. The same studies have shown that significant numbers of elderly people continue to enjoy both sexual interest and activity throughout their lives.
- Their activity is determined by factors such as marital status, knowledge about sexuality, prior patterns of sexual expression, privacy and physical health. Intercourse in the elderly may be difficult or not possible so it is appropriate to advise 'outercourse' which is an extension of foreplay, and which provides loving body contact and reassuring intimacy.
- Many women require additional lubrication and need advice about the use of oestrogen cream or lubricating jelly. Testosterone cream has been reported to be beneficial for elderly women with vulvar dryness and fissuring.
- The application of the Ex-PLISSIT model applies to the elderly with an emphasis initially on extensive permission.

INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE

- **Intimate Partner Violence** is a pattern of coercive and abusive behaviors used by one partner to maintain power and control over another partner in an intimate relationship.
  This includes people with any current or former romantic involvement, for example dating, previously dating, on again/off again, married, divorced, living together or apart.
  Intimate partner violence can occur between people of any gender identity or sexual orientation, and can include manipulation, threats, or the actual use of physical, sexual, emotional, verbal, psychological, or financial abuse**.**
- **Family Violence** is any abusive behavior that occurs between members of a family or household who are not involved in a romantic relationship. This includes chosen family as well as people related by blood, marriage, foster care, adoption or any other familial relationships. Family violence can include threats or the actual use of physical, sexual, emotional, verbal, psychological, or financial abuse.
- **Domestic Violence** is an umbrella term that encompasses both Intimate Partner Violence and Family Violence.
- **Sexual violence** is a broad term that encompasses all sexual acts, committed or attempted, without consent or that occur when the person is unable to consent, which includes rape or attempted rape, unwanted touching, and sexual coercion.

INTIMATE PARTNER VIOLENCE

- Intimate partner violence (IPV) is a prevalent worldwide health problem, affecting women more commonly than men. It can include physical, emotional, sexual, and financial abuse, as well as control over contraception or pregnancy and medical care. IPV occurs in heterosexual as well as same-sex relationships.
- Patients who are being abused exhibit chronic physical and emotional symptoms in addition to injuries sustained as a result of physical and sexual violence. They are also at risk of death from homicide. IPV is largely underrecognized and underaddressed as a health issue.
- IPV affects pregnancy outcomes and reproductive health, leading to higher rates of miscarriage, preterm labor, and low-birth-weight infants. Children living in homes where they witness IPV have the same risk of significant long-term physical and mental health problems as children who have been abused themselves.

Table 8. Key Recommendation for Practice

Clinical recommendation	Evidence rating
All women of childbearing age should be screened for IPV. There is a low risk of negative effects from screening.	**A**
Women who screen positive for IPV should receive intervention services.	**C**
There are multiple screening tools effective for IPV. (Table 9,10, 11)	**C**

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case serie

- Factors that increase the risk of IPV include alcohol consumption, psychiatric illness, a history of violent relationships in childhood, and academic and financial underachievement.
- The coronavirus disease 2019 (COVID-19) pandemic is exacerbating domestic violence. Family

physicians can mitigate this urgent issue during telemedicine visits by screening every patient for IPV using tools which require only yes or no questions like The STAT model (Slapped, Threatened, and Throw).

Screening tools for IPV

Screening tools are limited by the patient's readiness to disclose the abuse. Some patients may not feel ready to admit that they are in an abusive situation. However, this should not deter physicians from screening patients with one of the multiple screening tools.

Table 9, 10, 11. Some Screening Tools for IPV

STAT (Slapped, Threatened, and Throw) – physician administered
Have you ever been in a relationship where your partner has pushed or slapped you?
Have you ever been in a relationship where your partner threatened you with violence?
Have you ever been in a relationship where your partner has thrown, broken, or punched things?
A positive answer to any of these questions is a positive screen.

HITS (Hurt, Insult, Threaten, Scream) – self report or physician administered
How often does your partner physically hurt you?
How often does your partner insult or talk down to you?
How often does your partner threaten you with physical harm?
How often does your partner scream at you?
Scoring: never = 1 point, rarely = 2 points, sometimes = 3 points, fairly often = 4 points, frequently = 5 points. A score of greater than 10 points is a positive screen.

WAST (Woman Abuse Screening Tool) – self report
In general, how would you describe your relationship? No tension, some tension, a lot of tension?
Do you and your partner work out arguments with no difficulty, some difficulty, or great difficulty?
Do arguments ever result in you feeling down or bad about yourself?
Do arguments ever result in hitting, kicking, or pushing?
Do you ever feel frightened about what your partner says or does?
Does your partner ever abuse you physically?
Does your partner ever abuse you emotionally?
Does your partner ever abuse you sexually?
The physician performs scoring subjectively, using clinical judgment.

Discussing IPV with female patients

- Research shows that patients, with and without a history of IPV, favor physicians inquiring about IPV at wellness visits. The patient should always be clothed when discussing IPV. The patient's partner or children older than three years should not be present.

Approach to patients in an abusive relationship

- Patients who screen positive for IPV may respond in unexpected ways. Many will not be ready to leave the relationship, whether it be for emotional or more practical reasons, such as financial or safety concerns.
- Concern for children and the hope that a partner will change are also common reasons for staying in an abusive relationship.
- Regardless, it is important for physicians to be supportive and provide or refer for intervention services. The risk of immediate harm should be assessed at the time of IPV identification and at all subsequent visits.
- An ongoing relationship with the same physician improves patient openness to discussing IPV

The assessment of the risk of immediate harm

- If patients answer **"yes" to at least three** of these questions, they are at high risk of harm or injury, with a sensitivity of 83% and a specificity of 56%.
  - Has physical violence increased over the past six months?

- Has your partner used a weapon or threatened you with a weapon?
- Do you believe your partner is capable of killing you?
- Have you been beaten while pregnant?
- Is your partner violently and constantly jealous of you?

Physical examination

- The physician should show extra sensitivity with physical examinations (explaining each next step in the examination and getting the patient's approval to move forward is a way of giving the patient back a sense of control over her body).
- It is critical for the physician to document any injuries thoroughly and provide a detailed record of what happened, including direct quotes from the patient when appropriate. This can aid the patient if charges are pressed.

Safety planning

- A safety plan helps prepare the patient to leave if the situation acutely worsens, and they are at immediate risk. It may include:
  - making copies of personal documents
  - making copies of keys
  - securing money, and packing a bag with essential items
  - identifying a safe place to go (e.g., a relative's house, local domestic violence shelter)
  - establishing Code words with trusted friends or family so that the patient can call and alert them to imminent danger in the presence of the abuser.

Prevention

- The World Health Organization recommends legislative reform and media campaigns to increase IPV awareness. School-based education programs dealing with dating violence have been shown to reduce unwanted sexual advances.
- Early intervention services in at-risk families have been shown to reduce mistreatment of children and may reduce violent behaviors later in life.
- Comprehensive services from the health, legal, and law enforcement sectors should be made available to survivors.

SEXUAL VIOLENCE (SV)

- The National Intimate Partner and Sexual Violence Survey (CDC) reported that 43.6% of women experienced sexual violence in their lifetimes, with one in five women experiencing rape or attempted rape.
- Populations at increased risk include people who are physically or mentally disabled, adolescents, college students, homeless people, survivors of child maltreatment, people living in poverty, users of drugs or alcohol, people who engage in sex work, and people living in prisons, institutions, or areas of military conflict.
- Approximately one-half of transgender people and bisexual women experience sexual violence in their lifetimes.
- Among survivors of rape, only 16% to 38% report the crime to law enforcement, with similar percentages presenting for medical evaluation. Approximately two-thirds of survivors will disclose the assault to their primary care physician.

Consequences of sexual assault

- Sexual assault has short- and long-term consequences on women's physical, mental, sexual, and reproductive health.

Short-term health implications:

- *Acute physical injuries* - range in severity from abrasions and bruises to concussions, fractures, and bullet wounds.
- Sexually transmitted infections (STIs) - Chlamydia trachomatis, gonorrhea, trichomoniasis, and HIV
- *Pregnancy* (5%) - more likely to choose to terminate the pregnancy

Long-term health implications:

- Chronic pelvic pain, other chronic pain syndromes, sexual dysfunction, dysmenorrhea, menorrhagia, headaches, irritable bowel syndrome, and fibromyalgia.
- **Psychological implications:** Posttraumatic stress disorder (PTSD), depression, anxiety, substance use disorders, eating disorders, sleep disorders, contemplation of suicide, and attempted suicide.

Screening SV

- The World Health Organization, American Medical Association, and American College of Obstetricians and Gynecologists recommend screening all women for a history of sexual violence.
- **Two-Question Screening Tool** is a validated tool that can be implemented in primary care. It includes one screening question each for intimate partner violence and sexual violence.

Box 1. Two-Question Screening Tool for IPV and SV

- ***Have you ever been hit, slapped, kicked, or otherwise physically hurt by your partner?***
- ***Have you ever been forced to have sexual activities?***

- Another validated tool to screen and evaluate the SV victims is **the SAVE model** (screen, ask, validate, evaluate).

Box 2. The SAVE Model

The SAVE Model

SCREEN all patients for sexual assault- Assure confidentiality.

ASK direct questions in a nonjudgmental way - Make eye contact. Do not minimize the experience. Never blame a patient.

VALIDATE the patient -Use language that validates, supports and empowers such as:

- *Thank you for telling me.*
- *It took a lot of courage to share this with me.*
- *I am really sorry that happened to you.*
- *It is not your fault. You did not do anything to deserve this.*

EVALUATE, educate, and refer - Evaluate for present danger from the assailant. Evaluate the physical and psychological impact. Evaluate for suicidal ideations. Refer the patient to survivor advocacy and crisis support agencies.

Evaluation of acute presentation

- Most sexual assault survivors who present acutely will go to an urgent care center or emergency department. If patients contact their physician before visiting their office, the patients' concerns must be noted, and their autonomy supported. Patients should receive information on where to report for care and be advised that bathing, changing clothes, urinating, defecating, douching, and delays in seeking care could alter evidence collection.
- Clinicians who evaluate survivors acutely must adhere to medical and legal requirements, and those with limited or no experience should request assistance from trained personnel.
- **Initial assessment** includes evaluation for life-threatening conditions, serious injuries, or psychiatric emergencies. Patients may require urgent stabilization and hospitalization or surgery.
- When assessing and treating injuries, precautions should be taken to prevent destruction or contamination of evidence (e.g., wear nonpowdered gloves, avoid obtaining urine specimens, avoid giving oral or rectal medications unless needed for stabilization).
- **History:** a complete history is crucial. The clinician should use a supportive and nonjudgmental approach, and documentation should include the patient's own words. Details of the assault, including about sexual contact and exposure to bodily fluids, should be documented.
- **Physical examination:** it begins with an assessment of injuries. Physical injuries are noted in approximately one-half of all reported sexual assaults, with non-genital injuries more common than genital ones. The clinician should perform a detailed examination of the entire body and photograph or draw injuries. In the absence of major trauma, evidence collection is done concurrently with the physical examination.

Testing after sexual assault

Table 12. Suggested Tests and Timing

Test	Timing
Urine pregnancy	On presentation, repeat if missed menses
Serum HIV	On presentation, consider repeat at six weeks
Serum hepatitis B antigen	On presentation, Repeat at six months
Serum rapid plasma reagin for syphilis	On presentation. Consider repeat at four to six weeks and three months
Serum hepatitis C	On presentation. Consider repeat at three and six months.
Urine drug screen	When concern for drug-facilitated sexual assault.

Treatment after sexual assault

- All sexual assault survivors should receive timely treatment for pregnancy and disease prevention,

as indicated in table 13.

Table 13. Treatment Regimen

Treatment	When to consider	Regimen
Pregnancy prevention/emergency contraception	All survivors with a negative pregnancy test result	Levonorgestrel 1.5 mg up to 72 hours after assault Or Copper intrauterine device inserted within five days of assault.
Empiric sexually transmitted infection treatment for chlamydia, gonorrhea, and trichomoniasis	All survivors	Ceftriaxone 250 mg intramuscularly in a single dose plus Azithromycin 1 g as a single dose plus Metronidazole 2 g as a single dose or Tinidazole 2 g as a single dose
Hepatitis B postexposure prophylaxis	All survivors who have been previously vaccinated and Have known hepatitis B antigen negative status and Assailants with known hepatitis B antigen negative status	Not recommended
	All survivors who have been previously vaccinated and Have unknown hepatitis B antigen status or Assailants with unknown hepatitis B antigen status	Hepatitis B vaccination as a single booster only
	All survivors with unknown vaccination status or unknown immunity and Have assailants with unknown hepatitis B antigen status	Hepatitis B vaccination series only
	All survivors known to be hepatitis B antigen positive or Have assailants known to be hepatitis B antigen positive	Hepatitis B vaccination series plus Hepatitis B immunoglobulin
HIV postexposure prophylaxis	Survivors with significant exposure: Direct contact of the vagina, penis, anus, or mouth with the semen or blood of assailant with or without physical injury or tissue damage, Broken skin or mucous membranes of the survivor have been in contact with blood or semen of	Preferred three-drug regimen*: Tenofovir, 300 mg per day and Emtricitabine 200 mg per day and Raltegravir 400 mg twice per day or Dolutegravir 50 mg per day

	the alleged assailant, Bites that result in visible blood	
Tetanus vaccination	If skin abrasions present and immunization status is unknown or greater than 10 years If high-risk wound and immunization status unknown or greater than 5 years	Tetanus booster
Human papilloma-virus vaccination	All survivors nine to 26 years of age who have not previously completed vaccine series Shared clinical decision-making for patients 26 to 45 years of age.	Age-appropriate vaccine series

Delayed presentation

- Delayed presentation is common, particularly when the initial disclosure is in the primary care setting.
- Helpful responses include validating the disclosure, providing emotional support, and providing tangible aid and informational support, and avoiding blaming the survivor and treating the survivor differently after disclosure.

Prevention

- Primary prevention of sexual violence requires a comprehensive approach with interventions to address individual, relational, community, and societal factors. The Centers for Disease Control and Prevention has developed STOP SV, a technical package highlighting effective strategies for prevention (Table 14).
- Programs mobilizing boys and men as allies and focusing on **bystander approaches** can prevent sexual violence.
- Empowerment-based training for college-aged women has been shown to decrease the risk of victimization. Transportation policies, campus safety programs, and crime prevention programs have been shown to decrease the sexual assault.

Table 14. STOP SV Model

Sexual Assault Prevention Strategies: STOP SV Mnemonic		
S	Promote social norms that protect against violence	Bystander approaches can empower young people to intervene in peer groups Mobilizing boys and men as allies
T	Teach skills to prevent sexual violence	Implementing social-emotional learning to change the way children and adolescents think and feel about violence Promoting healthy sexuality through comprehensive sex education that includes consent and respect Teaching healthy safe dating and relationship skills to adolescents through effective programs like Safe Dates Empowerment-based training to increase participants' ability to identify and reduce exposure to risky situations.
O	Provide opportunities to empower girls and women	Strengthening economic supports for women and families Strengthening opportunities for leadership and empowerment for girls
P	Create protective	Improving safe physical spaces and increasing staff monitoring in

	environments	schools Establishing safe workplace policies and taking proactive measures to reduce harassment and violence in the workplace
SV	Support victims to lessen harms	Survivor-centered services like rape crisis centers Comprehensive treatment for sexual violence survivors, including mental health services Treatment for children who were exposed to violence in their homes and communities and are at risk of violence perpetration.

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