

Editorial

Gynaecological care for sexual minority women

Sexual minority women (SMW) are those whose sexual identity, orientation, or practices differ from the majority in the society. SMW can be lesbians, bisexuals, queers, those who have other non-heterosexual identities, or those who have same-gender partners. They may display a range of gender expressions, from very masculine to very feminine. Many SMW encounter barriers to healthcare because of their concerns about confidentiality, discrimination, labelling, or embarrassment on disclosure of their sexual orientation. Thus, they either do not seek medical care or hide their sexual orientation when they attend sexual health-related medical services. SMW have infrequent use of sexual and reproductive health services, including cervical cancer screening, sexually transmitted infection screening, and contraceptive use^{1,2}.

Sexual health is an important component of women's health care that most gynaecologists are less familiar with. I vividly remember a 42-year-old woman presenting with a 10-year history of painful sex, which developed after a fourth-degree perineal tear during her delivery at the age of 30 years. Despite seeing numerous gynaecologists, her pain persisted and resulted in infrequent and unsuccessful coitus, which she believed was the cause of her marital discord and putting her on the verge of divorce. Although studies have shown that women with obstetric anal sphincter injuries are associated with long-term sexual dysfunction and avoidance of intercourse^{3,4}, it was difficult to determine whether earlier provision of appropriate sexual counselling to this woman could have relieved her from sexual and marital difficulties. Nevertheless, there is no doubt that her sexual difficulties had never been optimally addressed by any healthcare providers whom she had encountered. Some gynaecologists may feel uncomfortable to care for women with sexual issues and may avoid treating such patients or refer them to sexual therapists, who are mostly non-gynaecologists.

Between 2017 and 2018, I participated in a Sex Therapy Professional Certification Course organised by the Hong Kong Association of Sexuality Educators, Researchers and Therapists, the only structured course on sexual therapy available locally. In Hong Kong, there is no formal registration or accreditation for any healthcare providers to be sex therapists. Nonetheless, I encourage practicing gynaecologists to acquire basic knowledge on

sexual medicine, so that they can identify and provide basic help to women with sexual difficulties. During this Certification Course, health issues in relation to SMW were discussed. I encountered SMW and professionals who provided care and realised that basic women's health services are inaccessible for many SMW.

Gynaecologists should be prepared to care for individuals with gender dysphoria (female-to-male transgender) for gender reassignment hysterectomies, with or without salpingo-oophorectomies. The two hysterectomies that I have recently performed for this reason have broadened my clinical experience in caring for these individuals. Some aspects of care are exemplified as follows:

1. Healthcare providers should be familiar with the standards of care for the health of transgender individuals, especially on the assessment and preparation (includes counselling for informed consent) for gender reassignment surgery. Interested readers can refer to the Standard of Care Guidelines published by the World Professional Association for Transgender Health⁵.

2. Clinics and hospital wards should create an appropriate and non-discriminatory environment by increasing the knowledge, understanding, and sensitivity of their staff towards transgender individuals.

3. Long-term testosterone therapy is associated with an increased risk of polycythaemia, but the evidence regarding its role on thromboembolic events is inconclusive⁶. There is also limited evidence that the use of exogenous testosterone is associated with an increased risk of venous thromboembolism or other complications during surgery⁷. Nevertheless, for peace of mind, I did give thromboprophylaxis to a patient with a haematocrit level of 0.52 before laparoscopic hysterectomy despite the lack of supporting evidence.

4. Some transgender (female-to-male) patients may have never had vaginal penetration, so insertion of a vaginal manipulator to facilitate laparoscopic hysterectomy, or vaginal retrieval of the uterus may be difficult, and may require an incision at the introitus (which I prefer not to call episiotomy) or may result in vaginal laceration. This has to

be discussed carefully preoperatively, as some patients may be quite sensitive on knowing the possible need for any of these ‘minor’ technical modifications.

5. The occurrence of postmenopausal symptoms is uncommon after bilateral salpingo-oophorectomy owing to peripheral conversion of exogenous testosterone to oestradiol. However, this possibility should still be discussed prior to surgery, as exceptions do occasionally happen⁸.

As gynaecologists, we should prepare ourselves to care for women of different backgrounds including sexual orientation. Owing to enhanced community awareness and acceptance towards sexual minorities and

more readily expression of sexual concerns, an increasing number of SMW and women with sexual difficulties are anticipated to seek medical care. Although care for these women is generally not emphasised during specialist and subspecialist training, it is time for us to start learning to understand the sexual needs and expectations of patients and to integrate sexual health as part of comprehensive women’s healthcare.

Vincent YT CHEUNG, MBBS, FRCOG, FRCSC

Clinical Associate Professor, Department of Obstetrics and Gynaecology, The University of Hong Kong

President, The Obstetrical and Gynaecological Society of Hong Kong

Email: vyc@hku.hk

References

1. McCune KC, Imborek KL. Clinical care of lesbian and bisexual women for the obstetrician gynecologist. *Clin Obstet Gynecol* 2018;61:663-73. [Crossref](#)
2. Everett BG, Higgins JA, Haider S, Carpenter E. Do sexual minorities receive appropriate sexual and reproductive health care and counseling? *J Womens Health (Larchmt)* 2019;28:53-62. [Crossref](#)
3. Sayed Ahmed WA, Kishk EA, Farhan RI, Khamees RE. Female sexual function following different degrees of perineal tears. *Int Urogynecol J* 2017;28:917-21. [Crossref](#)
4. O’Shea MS, Lewicky-Gaupp C, Gossett DR. Long-term sexual function after obstetric anal sphincter injuries. *Female Pelvic Med Reconstr Surg* 2018;24:82-6. [Crossref](#)
5. World Professional Association for Transgender Health. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. 7th Version. 2012. Available at: https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_English.pdf. Accessed 1 December 2019.
6. Shatzel JJ, Connelly KJ, DeLoughery TG. Thrombotic issues in transgender medicine: a review. *Am J Hematol* 2017;92:204-8. [Crossref](#)
7. Boskey ER, Taghinia AH, Ganor O. Association of surgical risk with exogenous hormone use in transgender patients: a systematic review. *JAMA Surg* 2019;154:159-69. [Crossref](#)
8. Casimiro I, Cohen RN. Severe vasomotor symptoms post-oophorectomy despite testosterone therapy in a transgender man: a unique case study. *J Endocr Soc* 2019;3:734-6. [Crossref](#)