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Part (III)

(1) Female Sexual Pain: Theoretical Considerations and Suggestions for Treatment

Associate Prof. Marieke Dewitte

Maastricht University, the Netherlands

Abstract

Sexual pain is a prevalent, complex and disabling health problem in women. Efforts to study this chronic pain condition have been complicated by the fact that genital pain is heterogeneous and operates at the intersection of different biopsychosocial disciplines. In this talk, will discuss theoretical ideas and empirical findings on how physical and psychosocial factors impact the development and maintenance of the problem, the reporting of symptoms, and the choice of treatment. Although considerable advances are made, there is still confusion concerning aetiology and treatment.

This has important theoretical & clinical implications because inconsistent criteria and empirical disagreement may lead to misdiagnoses and interfere with the development of sound theoretical models and effective treatments to manage the pain and its suffering. One of the most remarkable findings is that sexual pain is often studied within an individual framework, whereas women most often have sex within a relationship and are therefore reactive and responsive to relational variables and input from their partner. We must go beyond the study of individual processes and include a dyadic perspective to understand and amend sexual pain problems .

(2) Vaginismus as a Cause of Unconsummated Marriage

Prof. Abdelmaguid Ramzy

Kasr Al-Aini, Cairo University

Abstract

Unconsummated marriage is one of the causes of infertility among our patients. Lately we noticed an increase in the number of patients requesting intra-uterine insemination under general anaesthesia to overcome their fear of intercourse.

Vaginismus, or involuntary spasm of the entry muscles of the vaginal introitus, is not an uncommon condition. This problem seem to be more common among Middle Eastern

conservative societies. It may be contributed to the conservative upbringing related to the preservation of virginity till marriage. As a secondary outcome of vaginismus, we have cases presenting with EO among the male partner. Many of our patients have already tried the conventional methods of treatment, however remain resistant 10 these treatment modalities. I will present our experience of a case series of an innovative technique to treat these resistant cases of vaginismus. We included in our series cases referred from Gynaecology, infertility as well as Andrology clinics. Our experience started in 2013 and included 175 cases, with follow-up period of one year. Our technique involves the injections of Botulinum toxin type A (BTXA) into the hypertonic perineal muscles under local anaesthesia, Some of our cases needed General anaesthesia. We prepared initially all our patients with several sittings of sex education and orientation, as well as psychological support to feel confident and consent/comply with our treatment plan. "The injection is used to aid in relaxing the perineal musculature to be followed by an active dilatation program of the weakened muscles. The patient compliance as well as the results of this technique is encouraging. I will discuss this problem and will present the technique and the results of our study in my presentation.

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(4) Female Extragenital Erogenous Zones

Prof. Ehab Younis
Benha University

Abstract

Erogenous zones may be genital or extra-genital. Female body has a greater variety of erogenous zones, compared to male one. In the context of this article, it is important to examine this issue in conjunction with problems of sexual dysfunctions. Scientific research in the area of extra-genital erogenous zones is scarce. Defining extra- genital erogenous zones with the most powerful excitatory effect and hoe to stimulate them was the aim of this work.

This work was a cross-sectional cohort study where a self-report questionnaire was used. Usable questionnaires were obtained from 150 married women with regular sexual activity.

The questions covered epidemiological data, assessment of female sexual functions, and information about extra-genital erogenous zones.

Extra-genital erogenous zones are present in the vast majority of women. Even 12% of women said that they can orgasm following stimulation of these zones. Female complaining of difficulty to achieve orgasm may benefit from informing their partners about the extra-genital erogenous zones and methods to stimulate them.

(5) Can Obesity Affect Female Sexuality?

Prof. Sherine H. Abdel Rahman
Benha University

Abstract

This study aimed to assess whether obesity can affect female sexuality A case-control study was carried out on a sample of Egyptian women using a self-filling questionnaire. A group of 60 obese women (BM1<30 kg/cm2) and a matching group of 30 non-obese women (controls) participated in this study. They answered a questionnaire that included 20 questions covering four domains (demographic data, assessment of female sexual function, weight image variables and verbal or physical abuse by husbands). All women were free from diseases known to affect sexual function. Non significant differences were found between obese and non-obese women in terms of arousal, ability to reach orgasm, and occurrence of unprovoked desire to have sex. The most preferred coital positions were rear entry in the obese group & man on top in the lean group The practice of oral and anal sex was uncommon for both groups. Satisfaction with sexual life was significantly higher in the non-obese group. There was a statistical correlation between weight loss and improvement in libido. Three quarters of obese women reported being verbally abused by their husbands because of their body shape.

There is a tendency for obese women to be inferior to their lean counterparts in many aspects of sexual functioning. Weight loss seems to be useful in boosting libido in obese women.

(6) NO Touch Technique as a Mean to prevent Infection at Time of Penile Prosthesis Insertion

Prof. Sebastien Beley

Institute of Urology, Paris, France

Abstract

Penile implant insertion is the gold standard of care for severe Erectile Dysfunction Infection at time of inflatable penile prosthesis insertion is the most feared complication, due to potential severe consequences for the patient and to the high cost of their management. Prevention of infection of operative site has been described by various authors, most of them non urologists, and some recommendations based on strong evidence have to be followed by the prosthetic surgeon. The NoTouch technique consists on avoiding any contact between the implant and the patient's skin or any instrument contaminated by it.

It is an easy, costless and safe technique. Associated with the new coated implants, it allows a rate of infection of 3 % on selected cases.

(7) Laser Prostatic Surgery

Prof. Abdul- Aziz Baazeem

Um Al Qura University, Saudi Arabia

Abstract

Benign prostatic hyperplasia (BPH) is one of the most common urological conditions to affect men's health. It can cause significant morbidity and negatively impact patients' quality of life. For years, transurethral resection of the prostate (TU RP) has been the gold standard for treating BPH in small and medium-sized prostates. However, the incidence of complications of the procedure such as bleeding and the transurethral resection (TUR) syndrome increases with larger glands and longer operative times.

Several new techniques have been introduced over the years in an attempt to improve on the resuits of TU RP. Several of these techniques utilize laser technology. Different lasers have unique qualities that have been used in various ways with mixed results. An overview of several laser prostatic procedures will be given, explaining the potential advantages and disadvantages.

(8) Non-Shortening Correction of Penile Curvature

Prof. Ossama Kamal Shaeer

Cairo University

Abstract

Shortening-free correction of congenital ventral penile curvature by rotation of the corpora cavernosa was first introduced in 2006; (Shaeers Corporal Rotation I). The basic principle was

shifting the concavity of both corpora cavernosa from the ventral aspect of the penis to the lateral aspects, in opposition. Rotation was achieved by approximating short parallel incisions on the dorsum of both corpora cavernosa. In 2008, we reported modification of the technique; (Shaeer Il), where the incisions spanned the whole length of the corpora cavernosa.
The current modification simplifies corporal rotation further and addresses shortcomings; "Shaeer's Corporal Rotation III, the non-corporotomy technique".
This is a retrospective study of 127 cases of congenital ventral penile curvature, 25 to 90° operated upon at Kamal Shaeer Hospital, Cairo, Egypt from 2009 to 2015. The neurovascular bundle is mobilized, and the corpora are rotated by approximating pre-marked respective points on either sides of the deep dorsal vein using Polyester sutures, without incising the tunica albuginea.
On-table measurements showed a mean Pre Rotation erection angle of 66.5° ± 17.9, range 25-90, median 65. Following rotation, angle was 0.47° ± 1.8 (p<O.OO 1), length was 0.06 ± 0.25 cm longer (p=0.007), while girth was 0.77 ± 0.9 cm shorter (p<O.OOI). Complications included 11 cases (8.7%) of ventral wound gaping and 3 (2.4%) with mild recurrence not requiring correction. IIEF was 24.99 ± 0.9, with a 13.35 ± 3.4 increase over the preoperative state (p<O.OO 1). Conclusion(s) Shaeers Corporal Rotation III enables correction of any degree of ventral congenital penile curvature, with neither shortening nor erectile dysfunction.

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