Ep #158: Genitourinary Syndrome of Menopause with Dr. Kelly Casperson

Full Episode Transcript

With Your Host

Dr. Sonia Wright

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Welcome to *The Midlife Sex Coach for Women™ Podcast*, the only show that combines a fun personality, medical knowledge, sexual counseling, and life coaching together. To create unique sex coaching that helps busy women awaken their libidos, address intimacy issues, and learn how to express their sexuality for the rest of their days. Here is your host, certified life coach and sexual counselor, Dr. Sonia Wright.

Dr. Sonia Wright: Hey, hello, hello, hello, Diamonds. It's Dr. Sonia and I am here. I am so excited. I'm so excited for this podcast episode. I have the amazing Dr. Kelly Casperson with me. If you don't know her, now, you know, and you definitely need to know all about her. So, I'm actually going to have her introduce herself, because I'm not going to do justice to all the things that she is about.

I can tell you, she's a magnificent neurologist. She's an author of an incredible book called "You Are Not Broken." Also, she is a TED Talks speaker, and I know there's even more. So, Kelly, I'm going to have you introduce yourself, and then I've got all sorts of questions for you.

Dr. Kelly Casperson: Thank you. Thank you so much. I'm a urologist. I trained in Minnesota, which you know and love, because that's where you practice. I went to the University of Minnesota for med school, and then did residency in Colorado for urology.

I was about seven years into a urology practice when I had a life-changing patient, who basically changed the trajectory of my life, because it got me curious about female sexual health, sexual dysfunction, what do we know, what don't we know. I just dove deep into that. Got into coaching because of sex, basically, and then started a podcast three and a half years ago; it's doing amazing. TED Talks, book, helping all the people.

Sonia: So good, so good. I asked you specifically on this call, because I want to talk to you about GSM (Genitourinary Syndrome of Menopause.)

Kelly: We have talk about this.

Sonia: It's well past the time. I was about to say the time has come to talk about it.

Kelly: It's time.

Sonia: Well past the time to talk about it. It should have been talked about like hundreds of years ago, it should have been. So, at this point in time, for everybody that doesn't know, and even for those that do know, tell us what is GSM?

Kelly: Yeah, GSM is the rebranded "vulva vaginal atrophy." So, GSM is Genitourinary Syndrome of Menopause. There was one urologist at the table when they rebranded this. People didn't like how atrophy sounded. Plus, it didn't describe why it happened, and it didn't encompass everything that happens in the pelvis with menopause changes.

So, Genitourinary Syndrome of Menopause tells you why it's happening. It's basically what happens to the pelvis when our hormones go away, or change. Not everybody loves GSM, because GSM-like symptoms can happen when you're pregnant, when you're breastfeeding, when you've gotten cancer treatments or radiation, or when you're on birth control pills.

There are a lot of these symptoms that can happen because of low hormones, not always just because of menopause. So, now people are like, "I don't like that you're limiting it to menopause." And I'm like, people just need to know.

Before vulva vaginal atrophy, believe it or not, it used to be called the "senile vagina."

Sonia: Oh, my goodness!

Kelly: We're continuing to get better. Yeah, I actually researched that. I went down this rabbit hole tangent for a second. I went down this rabbit hole because I was so sick of the internet saying "use it or lose it." I was

like, where did that come from? Show me the evidence. So, I actually went back and had a medical librarian photocopying old journals of the one crappy study, which did not prove “use it or lose it.” But in the 80s they were calling it “senile vagina.”

Sonia: Senile vagina. Seriously? There's a lot of senile going on, but it has nothing to do with the vagina. Who are these people choosing these words, and not really being there to help women?

Kelly: Yeah, we've come a long way baby.

Sonia: We have come a long way. We don't need to smoke a cigarette, either. We’ve come that far. That's a reference for people that might be my age or older.

Kelly: For people that didn’t pick up on that one.

Sonia: It used to be for a Virginia Slims commercial, back in the 70s. So, you have to be in your 50s or older. But that was cigarette that was marketed to women, and it was a really long, thin cigarette. Like, thin is better in all things, except your vulva. You don't want that to be thin.

Kelly: You know that if a physician who went through medical school, who then did six years of pelvic surgery training, didn't know that labia minora resorb, or go away, or dissolve, or whatever word you want to call it... I just thought all these women in their 70s were born without a labia minora; because I do tons of exams, right?

It wasn't until I went to an ISSWSH Conference; ISSWSH is International Society for the Study of Women's Sexual Health. Basically, they do a Fall course for any provider who's interested in this. It's exceptional. One of the lectures was like, “Yeah, and you can see that genital structures dissolve, or go away, with low estrogen. And I'm like, “I'll be damned! Nobody ever told me this. I just thought they were born without them.”

Sonia: Basically, people born in 1941 and earlier, or 1950 and earlier, for some reason didn't have a labia minora. The fact that we're not taught this, this is the real concern. People think that medical doctors know a lot of information about women's sexuality and their vulva. We're not taught in medical school.

If you've gone six years of training in pelvic surgery, and things like that, and you still didn't know that; we need to be aware of this. We need to be talking about this everywhere. That's why we're talking about this today. So, thank you so much in joining me here in this conversation. Thank you.

Kelly: Recurrent urinary tract infections are in the top 10 reasons that people go to their primary care doctor, right? This is a huge problem. We have a medication that decreases UTIs by 60%, it's called vaginal estrogen. I hear over and over, when women go to the doctor, "Why do I keep getting these recurrent urinary tract infections?" The doctor's like, "I don't know."

But when you lose estrogen your pH changes. Your vagina is less acidic so you don't have your healthy microbiome. Your labia resorbs, your urethra becomes less protected, your urethra gets pronounced outwards; what's called "telescoping;" not protecting it from the micro trauma that happens down there. And so, once people understand it, it makes perfect sense why these people get way more urinary tract infections than your 25-year-old.

Sonia: Exactly. And we need to be aware that a urinary tract infection is not a minor thing. This can lead to some major health issues. And so, if we are focused on the preventative side of things, then we prevent the urinary tract infections, we can prevent sepsis, we can prevent a lot of things that are happening, that we're just not addressing. Especially when it's women's overall health, and definitely the vulva health as well.

Kelly: Yeah, absolutely. People die because of urinary tract infections. I like to tell people this, the only people who never get a UTI are dead people. I can't make you never have one, but our goal is less and less. And we know

that just taking an antibiotic makes you more susceptible to another urinary tract infection, because you've killed your microbiome, right? And so, it's trying to space these out, decreasing your risk, and optimizing as much as you can.

Sonia: So good, so important. Why is nobody talking about this? Why?

Kelly: I just posted, the clitoris has no place in the medical current medical paradigm, neither does the labia minora, right? But I think we are starting to talk more about prevention for UTIs. I think we're starting to talk more about hormones, which is good. I think female sexuality is really not discussed, besides the disease and pregnancy part of it, in the medical paradigm.

So, I think that's part of it. Because people are like, “Oh, what's such a big deal about vaginal dryness?” And I'm like, have you had dry eyes? Have you had a dry mouth, where your tongue is sticking to the… Dryness is very bothersome. I think a lot of it gets dismissed. But the amount of vulvar itching, perianal itching, that is all low hormones. The suffering is real.

I think our tolerance for female suffering is a lot higher than our tolerance for male suffering. I'm a urologist, so I see it all the time. Like, “Oh, my god, your testosterone is low. Here you go, have some testosterone,” right? Whereas with women we’re like, “Are you suffering enough?”

Sonia: “Is it just a little something? Why do we need to really address this?” You are a urologist, and I love that. I'm going to ask you about something, this blue pill. It's being prescribed all over the place. By blue pill, I mean Viagra and the other type of medications that are out there.

When somebody comes to you and they they're looking for this blue pill… The majority of people that are coming to you are probably heterosexual, and then there's going to be another person, another partner, female in this instance if they're heterosexual, are you having discussions with about their counterpart? Like, is anything going on with their partner? Is their partner having any problems?

When somebody comes in ask you for the blue pill, is it just a matter of prescribing the blue pill, or being that you are Kelly Casperson, do you go a step further?

Kelly: Well, yeah, they get me now, and all of my training. But for the longest time, it was like, “You have erection issues? Here's the little blue pill,” or it's cousin. I think it's fascinating. I've talked to other urologists about this. I actually want to see a debate on, if you give Viagra should there be a conversation about… if your goal is partnered sex, is your partner being cared for as well?

Because how many stories you hear where the woman returns the Viagra; the woman's mad at the doctor for giving Viagra. A lot of urologists will tell you, “I'm treating the patient in my clinic. It's up to them to have those conversations. I'm treating the person in front of me. The person in front of me wants an erection.”

Now that they get me, I'm like, “Your partner? What gender? Blah, blah, blah. Do they want an erect penis in their life?”

Sonia: Has anybody asked them?

Kelly: Right? I know. Have you asked? And so, now I ask the guys this. Nine times out of 10, they've not even talked to their partner about their plans for a super penis.

Sonia: They have not talked about it, right? Because you don’t have…

Kelly: What is your plan for the super penis?

Sonia: The Super Penis has arrived! It's got like a little cape on and it's ready to go. Everybody else is like, “It's a bird! It's a plane! It's an erect penis that I never asked for.” Going to have a good day.

Kelly: Yeah, maybe she was perfectly happy not having a penis in her vagina. And certainly if you’re past… 40% of men will have erectile dysfunction by age 40, according to the Cleveland Clinic. This is a big

problem. It's not talked about a lot, enough. But is she being treated? Is she on vaginal estrogen? Is sex comfortable for her? Is it pleasurable? Does he care about her pleasure, or does he just care about his erect penis? So certainly, I put a lot more… I tell guys, “I'll give you Viagra. But you need to communicate.”

Sonia: It's almost like it should have a cosign. Like, if you go to buy property or something, you have to cosign it with your partner.

Kelly: Or if you want to put it in a vagina. If you just want to get it hard by yourself, go for it. Who cares? But don't go in assuming she's going to welcome you with open arms if it's been eight years.

Sonia: Yeah, or longer. Very often, a number of years. And then, all the sudden.

Kelly: Very often, it's years.

Sonia: And then, it's a whole different thing. Yeah.

Kelly: Believe me, I'm on Team People Wanting to Have Sex. But you're an adult, and your communication sucks.

Sonia: Yes, and there it is. Because as you say, this is impacting at least 40% of men or more. And yet, very often, their partner doesn't even know why sex stopped. Because they didn't even admit to their partner that it has to do with their penis not working the way they wanted it to. So, their partner’s over there blaming themselves very often, has no idea what's happening, and sadly, Mr. Super Penis shows up.

But now there's layer upon layer of all these thoughts and feelings that are out there, because there hasn't been sex for a year or longer. The partner has spent a large majority of that time thinking that there's something wrong with them, because this communication is not happening. Now, all the sudden, super penis has arrived and now we will resume what we were doing before, right?

But there's a year or more in their thoughts about, "Maybe I'm not attractive anymore." Even if their body is functioning, the vulva health is 100% where it needs to be, but now they have all these thoughts in their mind because their partner never told them exactly what was going on. And so, they've had to come up with reasons and ideas. And very often, female partners tend to blame themselves when things are going wrong.

Kelly: That's right. We don't know why, so we create stories in our heads. Usually, which are which are mean. Communication is key. Our sex ed is so bad, in the country and the world. Communication is very important.

Sonia: So, you talk a lot about adult sex ed, right? That we need to do a do-over, basically. There's all these rules and laws, and each state has different rules and laws about sex ed for teenagers or people in school. So, it seems that there should be some sort of mandatory adult sex ed. Talk a little bit more about that.

Kelly: Yeah, I mean, I don't really know where this concept came to me, but it turned into a TED Talk. That's how much I care about it now. We really did get a disease and pregnancy prevention plan. If you were lucky, you got that.

Sonia: Yeah, it wasn't a very good one. It was like, "Don't do this. Don't get pregnant." You don't even know how to get pregnant, so how are you supposed to figure out how not to get pregnant?

Kelly: Yeah, yeah, absolutely. What we've done, is we've tried to fill in the gaps with Hollywood movies, the top 10 country hits. Porn is becoming more and more ubiquitous. Thirty percent of the internet broadband use in this country is porn downloads.

Sonia: Yes, 30%. It's at least 30%. So, basically…,

Kelly: We're getting a sex education, it's just not accurate.

Sonia: It's not accurate, at all. I don't necessarily say porn is good or bad. But it is fantasy. It is entertainment. It is not actuality.

Kelly: It's production.

Sonia: Yeah, yeah. And then, usually by age 10, most kids have had at some… Even if they're looking for Minecraft, just googling Minecraft, suddenly, it's porn on Minecraft that comes up, right? So, they're going to get exposed to this at some sort of age. And by the time we're an adult, we have many years of being exposed to this in one form or another, and it's not accurate.

Now, this becomes the basis of what we think sex and sexual intimacy looks like. Right? It's a lot of pounding, and it's a lot of penetration. There's not much talk about the clitoris and foreplay. Everything happens in three seconds.

Kelly: Yeah, it's pretty bad sex education. It certainly doesn't teach you how to communicate. It doesn't teach you how to talk about uncomfortable things, and when things go wrong, and all the good stuff. But I'd say, all the necessary stuff, if you want to have a sex life continue through the years for you, right?

Because inevitably, there's going to be health issues, and there's going to be menopause, and there's going to be erectile dysfunction. If we don't talk about it when it's good, that'll set us up for not being able to talk about it when there are some issues.

Sonia: There's going to be issues like that. What percentage of people do you think make it through life without any issues at all around sex, sexual intimacy? Yeah, I would say zero. There are issues.

Kelly: Zero. Four. Somebody on Instagram, they're going to be like, "I'm 82, I've had no issues." I'll be like, "Nice to meet you." There's one of you.

Sonia: Nice to meet you. Right. I was like, "I haven't had sex either."

Kelly: Yeah. It's incredible. This is normalizing it for people. "You guys, this is hard for everybody. There aren't unicorns. This is a skill. It's okay."

Sonia: Yeah, 100%. So, if you had a do-over for a sex education for adults, what would you make sure is in there? It sounds like a communication course. What else would you put in there?

Kelly: Well, it's the biopsychosocial. Right? So, "body" is, how our bodies work. That clitorises are important. They're as equally as important as penises are, in the role of pleasure and arousal. That everybody has erectile tissue. How dopamine works. We only seek out things worth desiring, so if your sex is crap don't expect to desire it. So, bio.

Then "psycho" is, your brain. Your thoughts about sex. Is sex bad? Is sex for you? Is sex too hard? Is sex dirty? All of the brain thoughts. That's where all the good coaching comes from.

Then "social" is, inequality, unequal work distribution. Who's allowed to desire, who's not allowed to desire. The amazing paper on low desire, "The Heteronormativity Theory of Low Sexual Desire in Women Partnered with Men." Is it insane to anybody else that the people having the most orgasms are the heterosexual men, and their partner are the people having the least amount of orgasms, which is the heterosexual female? That's insanity, right?

I'd love to teach about that. So, it's really the biopsychosocial. I did a masterclass online, you can get it at my website, a kind of a primer to adult sex ed that's not hours and hours of stuff. We just need to solve some simple problems, give some simple education, empower people to communicate, and you're off running. Know that you can try and fail, and try again. And fail, and try again. And you're off and running.

Sonia: So good. I like that. Try again, just try again. You don't have to make it mean anything. Just figure out what you like, what you don't necessarily like, and make sure you get the information that you need.

I wanted to circle back to GSM, because we didn't talk about the incredible vitamin that everybody should be taking if you have a vulva, or a vagina. Vitamin E, can you talk a little bit more about that?

Kelly: Everybody is going to go buy Vitamin E now. It's estrogen.

Sonia: Vitamin Estrogen, exactly.

Kelly: Vitamin Estrogen. It's over the counter in a lot of countries. I like to say that… It's amazing, and I don't think that's coming. We still I have a very scary FDA black box warning on vaginal estrogen, which we are actively trying to get removed. That already failed once in 2018. So, I don't see this going over the counter anytime soon.

But the good news is the price is dropping, and there are some really great online pharmacies. The Mark Cuban Cost Plus Drugs; $20. Amazon Pharmacy; $20. The GoodRX coupon, GoodRX app on your phone, should be $20 - $30. Nobody should be paying more than that for their vaginal estrogen.

Because this is a lifelong… It's not like you put on sunscreen once and then you're good. Right? It's a skincare. It's skincare for life. I used to tell people, "Use it until you die." I think they thought I was too morbid, so now I tried to lighten it. I say, "Use it three days until you die." You get a laugh out of it, right? If you're going to die in three days, just stop.

Sonia: Like, "Oh waah, I only got three days." But, just in case the estimate is not correct, you might want to just continue.

Kelly: You want to keep trying it. Yeah, yeah, any age can do it. ACOG (American College of Obstetrics and Gynecology) has a statement online saying it's safe for breast cancer survivors. Yes, there's very few people that cannot be on vulvovaginal estrogen. And, it should be cheap.

Sonia: Yeah, and I love how you said vulvovaginal estrogen, because a lot of people just think it's vaginal estrogen. We're preoccupied with the

vagina, and not with the vulva. Most people wouldn't even know the name of the vulva. Right? Most people are just thinking that women are roaming around with a vagina, basically a potential space, a hole.

Kelly: I mean, what a way to erase female sexuality, to not allow these words to be even spoken on Instagram. It's insane. The dearth of medically accurate images online... Women are like, "How do I know what normal is?" And I'm like, "Usually, just assume you're normal, unless it itches, or burns or something, and then get checked out." But most people are normal.

That's why, vulvovaginal estrogen, that's why I like the cream. I always say I have a cream bias. Especially in sexually active people, that six o'clock spot on entrance is notoriously thin and ouchy. Especially during perimenopause, menopause, breastfeeding, birth control. And so, I love getting the cream there.

It's like skincare. If you just happen to put a tab, Vagifem tab, up in your vagina, that skin might not be treated. I love treating the clitoris. I see plenty of clitoral atrophy and clitoral phimosis post menopause that I just think, what if we just do preventative skincare? Western medicine, why do we wait for problems to come up? Why can't we prevent them in the first place?

Sonia: Yeah, I think it's just how we're focused on the fixing of the problem, right? We're not as focused on the prevention. But it does need to be something that is a prevention focused area.

Kelly: I think so.

Sonia: One hundred percent, and we need to get the word out to women. And that's why I asked you to be on this podcast, because if somebody listened to this podcast is in their 20s, 30s, whatever, they need to know before the time happens. So many women I talked to are in their 50s, 60s and beyond, and they're like, "Why hasn't anybody told me this? Why is it?"

Or, if they have heard about estrogen, it's vaginal estrogen. And they have not specifically heard that we also need to make sure that we're treating the vulva, and making sure that the vulva is protected. I love how you say that it's skincare, skincare for the vulva.

Kelly: I mean, women care about skincare. It's a $6 billion industry. So, skincare for down there.

Sonia: Exactly. That's so good. Once again, if we're looking at porn and that's where we're getting our information from, and we think that our vulva is supposed to look a certain way, that we see in porn, that also does have misinformation.

Because there's a lot of labiaplasty, there's a lot of other things that are happening, and we may not look like that. Then, we don't know if there's something wrong with us, or there's something that we need to talk to somebody about. Then, we don't necessarily even feel comfortable talking to anybody about.

So, I think that all the way around, this is something we need to talk about and be comfortable talking about, and make sure that women of all ages are aware of this information.

Kelly: Yeah, totally. I would just add, it's all genders. The penises in porn are not our average either, right? Nobody's getting an accurate representation of how things work down there.

Sonia: Nobody's getting representation at all, that's definitely true. Okay. Yes. Is there anything that we didn't touch on. I want to make sure, and I love that phrase "touch on," but I want to make sure that if you had five seconds with somebody, what is it that you want to make sure that they know, out of all the stuff that you talk about?

Kelly: That estrogen, which is a compound, a hormone that your body naturally makes, is not trying to kill you. I think we're still trying to claw back, 20 years later, after the Women's Health Initiative, that estrogen is

bad. You can’t encourage somebody to use vaginal estrogen if they still think estrogen is trying to kill them. Right? The FDA black box warning says on there, amongst other things, “probable dementia.” Probable dementia is the FDA black box warning. Yeah, it's horrific.

And so, a woman goes to her doctor, if the doctor doesn't say, “I'm going to give you this product. The FDA black box warning is wrong. There is *no* data to support that vaginal estrogen causes dementia, heart attack, stroke,” so much misinformation. But if the doctor doesn't say that… I tell most people that, because I know.

This woman came back, she was so upset with me that I was trying to kill her with the vaginal estrogen. I'm like, “I'm so sorry you are believing the FDA on this. But you have to believe me more. Because I am not an expert in a lot, but I've read *lots* of papers on vaginal estrogen at this point.”

It's topical. It's a very low dose. It's literally for your skin, for your bladder, for the areas surrounding it. It does not go into your brain, your heart, anything like that. But going back to your question. We have to still keep chipping away at this “estrogen is bad” thing before we can get people to be like, “Oh, what can I do to help myself? Because I think a lot of people are like, “Can I just use lube? Can I just use a moisturizer?”

I saw this great reel on Instagram. It was somebody being like, “The difference between your grandmother's homemade pasta and SpaghettiOs is the difference between vaginal estrogen and lube.” Okay, the lube kind of helps, it does kind of moisturize temporarily. Right? But it's not actually keeping these structures healthy and functionally.

Sonia: Yes. I was talking to somebody about using topical estrogen. I'm very familiar with this topic. They brought up the fact that for some women, when they first start to use it, the tissue is being rejuvenated but it can feel like a burning sensation. It a can feel irritated. I was surprised by that. Me personally, I experienced that. Nobody had told me that before.

So, is this something that you're aware of, that you've heard of, or that you tell people that sometimes this feeling can happen or what?

Kelly: Yeah, and the biggest reason for it is the tissues are already so thin, irritated, and sensitive, that the cream is a kind of little shock to the system. As that skin heals and gets stronger and gets more resilient, gets less absorptive, the cream's absolutely fine. So, that tends to go away.

I tell people, "Bear with it, that's your skin…" It's like putting something on a sunburn, right? Like, it's ouchy until it heals to the point where no, it's not ouchy anymore. If that still persists, say two months in, three months in, then I'm like, okay, maybe you have a sensitivity or an allergy to one of the additives in the cream. We can switch products. We can go compounded. Take some of the preservatives out.

But by and large, this is why we're giving you estrogen. It's because your skin is sensitive, it is irritated, it is thinner, and as that heals the product is much less bothersome.

Sonia: I just wanted to make sure that we had that part of the discussion. Because I've been on estrogen for a number of years, and nobody has ever told me that. I've gotten to different sexual health medicine people, as well. And so, I'm glad that that's something that you're telling everybody.

For the women out there that may have just gone to get the localized estrogen, but haven't necessarily had that discussion with somebody, I wanted to make sure that that they could listen to this podcast and hear that information. Because I think it's something that's important.

I think women might stop it. They're like, "Ooh, this is a burning sensation. This can't be a good thing."

Kelly: This can't be good for me.

Sonia: Yeah, exactly. Especially with a black box warning, right? Then, on top of that, it's starting to feel irritated. So, between those two things they

might be scared and just stop altogether. When that is really what's needed.

Kelly: Yeah, I mean, the other thing that can happen is a small risk of yeast infection early on because it is changing your microbiome, right? It is changing your vaginal pH. I tell people, “Just back off, use a smaller amount. Treat the yeast infection. Let's get through it. As your microbiome adjusts, you're going to be able to stay on this. But we’ve got to get through the adjustment of your microbiome.”

I think the other thing that I see, and this is why I don't… So, the traditional dosing is a “loading dose” of every day for two weeks and then twice a week. That's your traditional prescription. I don't do loading doses for two reasons.

Number one, I think it's too confusing for the average person. “Okay, for how many weeks every day? And it's kind of messy and it burns.” I think it's just confusing. I just tell people, “Twice a week, till three days before you're dead.”

The second reason is, when you do have that thin skin, you're actually going to absorb a decent amount of product upfront. You will get women say, “I got headaches. I got some breast tenderness.” They're absorbing it, because it's a lot of product. And so, I don't want that. I don't want any systemic side effects. I don't want the phone calls. I don't want the stress for the women. So, that's the other reason that I do not do a loading dose.

Sonia: That's good to know. Thank you. I appreciate that. What about this thing about having estrogen and testosterone in the cream that you put on your vulva? Are more people talking about that, as well?

Kelly: Yeah, I mean, it's like the next step. Now we're talking masterclass, instead. Vaginal estrogen is like English 101. Now, we're getting into a kind of master class, Master's degree level stuff. So, the vulva is a different organ than the vagina. The vulva has many, many androgen receptors. It's very testosterone sensitive.

We can see this in hormone-mediated vestibulodynia, several other pain conditions. And some vulvas… Remember, all bodies have testosterone. I always have to kind of go back to give the education to where we can talk about this. All bodies have testosterone. When we go through perimenopause, menopause, testosterone goes down also.

So, these vulvas can get very, very sensitive because vulvas really need some testosterone to feel more normal. We don't have the level of science to check your androgen receptor sensitivity; we don't know, right? So, sometimes it's like, "Hey, I've been doing the estrogen cream, still really sensitive. Maybe I just need a little more. I want to plump up the clitoris. I'm seeing a lot of clitoral atrophy."

You can add testosterone to the product; compounded, because there's not an FDA-approved combo estrogen testosterone cream. It's compounded, But especially for vulva, more so than vagina. There is an FDA product called Intrarosa, or DHEA. DHEA is basically a pre-hormone that will convert to estrogen and testosterone. So, DHEA is awesome. The prescription FDA approved is Intrarosa; Prasterone is what it's called.

The biggest problem with it is, it's pricey. But you either can get compounded, or if you want to go totally, totally cheap, you're not going to get a cream out of it. But some people will just do that over-the-counter DHEA supplements and put it in the vagina.

Sonia: Oh, interesting.

Kelly: So, lots of different options. Again, you're getting into supplement products now. So, are they regulated as well? Do you trust what's in them? All the issues that come along with supplements. But that's why DHEA can be so great for people. Because it's giving you both the estrogen and testosterone.

Sonia: That makes sense. That definitely makes sense. I appreciate that. Now, I wanted to ask you one last question. Not every woman is going to be lucky enough to end up in your office. I wish we all could go there. But

then you would never sleep. The line's out the door and down the road; it would be so far.

So, for the women… and I do talk a lot on this podcast about advocating for yourself. Like, my Diamonds need to advocate for themselves. So, if they were going to any doctor, what are the things that they should have on their list to advocate for, to ask for, to ask questions about, to be knowledgeable about? What would you put on the list for them?

Kelly: Yeah, I would say, "Hey, I'm experiencing X, Y, and Z." Not to put words in their mouth, but if you can kind of say it in a medical way, like overactive bladder, frequent urination, frequent UTIs, dryness, you're basically describing GSM. I wouldn't say all doctors know what GSM is.

You're not good to go in and be like, "I need estrogen." You've got to give them a reason. "I'm experiencing these symptoms. I've been reading a lot about menopause, and I would really like to *try* this vaginal estrogen product." What I really like about that, is you're suggesting what you want, and you're saying, "I'm just going to try it. I'll come back in three months. Let's check in. Let's see if it was right for me."

Most providers are going to be like, "That sounds like a reasonable plan." I just think it's a nice approach.

Sonia: Yeah, I think it's a very nice approach as well. I think that it's important for all women to be able to advocate and understand what's going on with their body. I think for too long, with our bodies, with our health, and also with our sexuality and our pleasure in general, it's been handed over to other people.

I think it's something that's very important, that we need to have ourselves, have authority over it, and to have ownership. To be like, "This is my body. This is what I need to know about my body. This is what I'm asking for." Also to be aware of that if, for some reason, that provider doesn't know or understand what you're telling them, you can always go to another provider. It doesn't necessarily end at that point.

Kelly: Yeah, and you can bring in podcast episodes. You can bring in this podcast episode. If you're a breast cancer survivor, you can bring in the ACOG online guidelines about vaginal estrogen and its safety. The American Urologic Association is developing currently, Genitourinary Syndrome of Menopause guidelines. So, that's going to be great to have.

Interestingly enough, who's creating those guidelines? Urology. Gynecology has not developed GSM guidelines. So, it's very cool.

Sonia: It's very interesting.

Kelly: Good job, urology.

Sonia: Yes, definitely.

Kelly: It's so much Urology; overactive bladder… Vaginal estrogen is equivalent to anticholinergics, in overactive bladder. Why don't urologist know that? Because the studies are published in the menopause journals.

Sonia: Tell me a little bit more about that. So, for the Diamonds that may be dealing with overactive bladder, I know you just explained it, but explain it in terms that we can all get. So, they're postmenopausal or perimenopausal and their estrogen is lacking, or gone, basically. They're feeling like they need to urinate all the time? They're having frequency urgency? What exactly are they having, and how does estrogen help that?

Kelly: It just kind of starts out slowly and slightly bothersome. “I just feel like I pee a little bit more than I used to. I've got this urgency but then I go and there's not a lot there. Why do I have all this urgency?” Getting up more at night. A little bit of leakage; stuff like that. So, that's overactive bladder; urge, urge leakage. It's called “urge incontinence.”

Anticholinergics are kind of your classic overactive bladder medication. They're actually contra-indicated in age 65+ because there's so many stinking, icky side effects with them. Probable dementia; legit. Risk of falls, things like that. Constipation, dry mouth. So, they're not great meds.

But what they did, they took women with OAB and they randomized this group to anticholinergics, this group to vaginal estrogen, and they had equal improvement. Vaginal estrogen was non-inferior.

Sonia: Wow, that's pretty amazing.

Kelly: Why wouldn't we restore function with the estrogen you used to have, just restoring your function versus drugging for function?

Sonia: Right. And that doesn't even take into consideration all the other issues that could be going on with GSM that's not being addressed with the other medication.

Kelly: Totally. Yeah, anticholinergics aren't going to prevent your urinary tract infections, or help you have better lubrication with sex.

Sonia: Exactly. Alrighty, Dr. Casperson. You are amazing. Incredible. Wonderful. Are there any last words, any last things, any last pearls, drops of wisdom, that you would like to give our listeners here?

Kelly: Yeah, I think in terms of GSM, it is a myth, I see this a lot in menopause care, it is a myth that you have to be done with your periods before you can start taking hormones. There are many, many people who have these symptoms, they're still having periods, and their doctors say, “Well, you can't have this until you're done with your periods.” Not true.

Also, dryness in the vulva, lack of lubrication with breastfeeding, vaginal estrogen works great for that. Some women who are on oral birth control pills, almost have a postmenopausal vulva. They get atrophy, just because of the way that the birth control pills are working on their body. It's like an estrogen blocker down there, testosterone blocker.

So, you're going to see some atrophy or resorption of labia minora, decreased sensitivity. I'll put people on birth control pills, on vaginal estrogen. So, this isn't just a ‘51+, you've got to be done with periods’ medication, it can help a lot of different people.

Sonia: So good. So good. Well, Dr. Kelly Casperson, thank you so much for being on the podcast today. Thank you so much for being here. You are amazing. Where can our listeners find you, if they need to find you?

Kelly: My website's KellyCaspersonMD.com. The podcast is *You Are Not Broken*. The book is "You Are Not Broken: Stop "Should-ing" All Over Your Sex Life."

Sonia: Oh, good. So good. Thank you so much.

Kelly: Thanks for being here. Thanks for having me.

Sonia: Yes, 100%.

Hello, hello, hello, Diamonds. Have you heard the amazing news? Dr. Sonia, that would be me, and my amazing team, has started a sex coaching and life coaching monthly membership program called The Lit Clit Club.

The Lit Clit Club was made just for you. It's a safe place where women can come to create the lives that they want, the life that you want. It's a place where you get to talk openly about your sexual concerns and be heard. There's no judgement, no reprimand, no labels, just acceptance, knowledge and freedom. It's a place where you get to ask all the questions you ever wanted to ask about sex, and about life, too.

You get to dream big and create your life your way, inside and outside the bedroom. You know I love the concept of creating the life that you want inside and outside the bedroom, that soul bursting life that you deserve. So, come to the club for the sexual intimacy coaching, and stay for the empowerment and the freedom.

Do you have questions about libido or menopause? Lord, help us, menopause is no joke. Sexual health, relationships, sexual orientation, pleasure equality and orgasms, religion and intimacy? You know, I am not finished with this list yet.

Maybe you have questions about toys? Maybe about non-monogamy? Perhaps you're interested in BDSM? Maybe self-love, self-pleasure? Maybe you have questions about sexual orientation? Maybe you need to work on healing from trauma?

Maybe body image is something that you want to focus more on? And definitely, embodiment. Perhaps creating a life of your dreams, or journeying to your authentic self? Maybe you just want to stop people pleasing?

Whatever questions you have and concerns you have; we have the answers and the coaching that you need. In all actuality, you have the answers inside of you, and the coaching will help bring that out.

And you know what? You get to choose how you want to be coached. You can be coached by video, by audio only, or you can use the Questions and Answers session. It's whatever works for you. You get to sit back and relax, get the help that you need, and your cameras are off.

Every month we have a new workshop, in addition to our regular coaching sessions. So, click on the link below in the show notes and find out more about The Lit Clit Club. We can't wait to see you there in the club. Come join us. Things are just starting to heat up.

All right, Dr. Sonia out. Love you all, Diamonds.