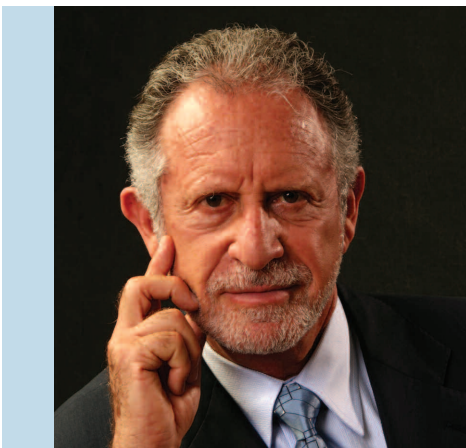


From the EDITOR



Dr. Wulf H. Utian, consultant in women's health and reproductive endocrinology, has served as Editor-in-Chief of *Menopause Management* since its inception in 1988. The Arthur H. Bill Professor Emeritus of Reproductive Biology and Obstetrics and Gynecology, Case Western Reserve University School of Medicine, he is also Consultant, Obstetrics, Gynecology and Women's Health Institute at the Cleveland Clinic, and Executive Director of The North American Menopause Society (NAMS). He is Chairman of the Advisory Board of Rapid Medical Research, Cleveland. He received his medical degree from the University of Witwatersrand, Johannesburg, South Africa, and his PhD from the University of Cape Town, South Africa, and is a Fellow of the Royal and American Colleges of Obstetricians and Gynecologists, as well as the International College of Surgeons. In 2007 he earned the DSc(Med) degree from the University of Cape Town, its highest degree and only awarded 11 times in over 100 years.

A pioneer in Women's Health issues and menopause research, in 1967 he established the Groote Schuur Menopause Research Clinic in Cape Town, the world's first such clinic. He was one of the three original founders of the International Menopause Society in 1976, of which he is Honorary Past President, and founded the North American Menopause Society in 1989.

He is the recipient of numerous national and international awards and research grants, and is still an active investigator with multiple grants. Dr. Utian has written over 200 papers related to the reproductive system in women and has authored five books on menopause and its effects on women. He is editor of *Menopause: The Journal of The North American Menopause Society*.

Lesbian Women Traversing Menopause

During the poisonous political season late last year, I was constantly struck by the repetitive use of the terms "Joe, the plumber" and "Joe six-pack," as if Joe represented the average American. Where, I wondered, was the reference to "Jane" or, indeed, many other names, ethnic origins and cultures? Indeed, thinking more specifically of healthcare providers in day-to-day clinical practice, and especially women as they traverse menopause, I wondered whether many of us do not consciously or subconsciously let bias intrude into our words and actions. This led me to consider the issue of sexual orientation. Do you subconsciously presume all the women you care for are heterosexual?

The Background

It is absolutely essential that we take into consideration that about 5% of women will have their primary emotional and sexual relationship with other women.¹ Beyond that, lesbian (homosexual, gay) women vary in the same way in almost every other respect to the general population in terms of age at menopause, ethnic origin, education, religious persuasion and all the other differences that make us all so interesting. Even their sexual behavior may range from abstinence/celesty to bisexuality, or intermittent hetero- and homosexual relationships.

There is some evidence to suggest that lesbian women experience higher rates of some chronic diseases after midlife, including cardiovascular disease and some cancers. This may be attributable to relevant lifestyle risks. The latter was confirmed in the data from the various groups within the Women's Health Initiative (WHI), demonstrating a higher incidence of risk factors like smoking, obesity and alcohol consumption. Another reason might be less frequent use of healthcare services; that might, in part, be explained by

fear of insensitivity or lack of confidentiality when lesbian women avail themselves of health care.

Inappropriate assumptions—such as lesbians not having had heterosexual encounters and, therefore, having less exposure to sexually transmitted diseases (STDs), or that they are less subject to physical and sexual abuse, and are therefore

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less susceptible to psychological trauma—account for some of the inappropriate medical management provided to these women. In fact, lesbians do develop cervical cancer, and increased nulliparity may be a risk factor for breast and ovarian cancer. Moreover, over one-third of lesbian women report some form of childhood sexual abuse, and intimate partner violence does occur (albeit less frequently than in heterosexual relationships). Furthermore, antigay verbal abuse and discrimination may result in higher levels of anxiety and mood disorders.

Providing Appropriate Care

The important lesson for clinical practitioners is that the correct questions must be asked when the medical history is taken upon entry into a practice, that all appropriate screening tests must be considered and followed through, and that special care needs to be taken in acquiring information and ensuring confidence when counseling lesbian menopausal women.

For starters, be certain that your office staff is well trained and able to obtain a detailed sexual history with a nonjudgmental attitude. The staff must be able to instill confidence and to assure confidentiality of all information obtained. An office questionnaire should include questions about sexual orientation and behavior such as: “Are you sexually active?” “Are you in a relationship?” “Is your current partner male, female?” “Do you have both male and female partners?” “Do you have multiple partners?” Useful information

that would be gleaned from these questions includes likelihood of acquiring STDs, pregnancy risk and potential need for contraception, exposure to physical abuse, and so forth. Finally, sexual dysfunction is not limited to heterosexual relationships, and appropriate sexual function questions should be addressed.

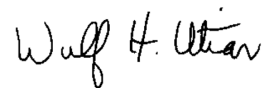
Recommended screening tests obviously should include Pap smears and mammographic examinations. Screening for STDs is also important. Trichomonas vaginitis, bacterial vaginosis, herpes virus infection and human papillomavirus can be spread woman to woman. HIV transfer is unlikely unless there is intravenous drug abuse or bisexual contact.

Be Sensitive

Finally, be sensitive to the reality of gender and marital status bias. Discussions must respect the role of the lesbian partner, particularly when major illness occurs. Respect the right of the partner to be present when discussing treatments or surgery and ensure complete hospital access and visitation rights. Counsel women on issues like healthcare power of attorney or durable power of attorney.

We have come a long way toward equal rights and respect for all in the past few decades; in some instances, however, we still have a way to go.

Remember, do unto others as you would have them do unto you.



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Reference

1. The North American Menopause Society. *Menopause practice: a clinician's guide, 3rd Edition*. The North American Menopause Society 2007, 279-80.