The Coalition Talk Show with Dr. Shani Belgrave: Myths About Mojo with Peahen Gandhi MD Transcript

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Show Introduction and Guest Welcome

Welcome to The Coalition. This is a talk show dedicated to discussing health, wellness, and inspiration. I'm your host, Dr. Shani Belgrade. Hello, everybody.

Thank you for joining The Coalition. I'm your host, Dr. Shani Belgrade. I am a bariatric emergency basic surgeon. You can get connected with me and learn about what I do at I'm excited to welcome to the show today Dr.

Peehan Gandhi. Dr. Peehan Gandhi is an accomplished neurobiologist and founder of religion, women's wellness, and cosmetic pathology based in Alpharetta, Georgia.

She joins the show today to let us know what we should know about women's sexual health. The topic of today's show is myths surrounding armogeo. Dr. P.

Hingandi, thank you so much for joining the show. Thank you so much for inviting me. I'm so excited. You have such a great show. Thank you. I appreciate it.

So, Dr. P. Hingandi, as you know, the show is all about health, wellness, and inspiration. And so I'm grateful that you are here to share your perspective as a urology oncologist on sexual health.

So please get started by telling us a little bit about who you are and what you do. Yes, I'm a gynecologist board certified, and I have a special interest in helping women through the menopause transition, but I also see women for general gynecology because your gynecology is.

quite expansive. It affects women of younger age, of midlife age.

Dr. Gandhi's Practice and Women's Health Focus

So I am very passionate about just helping them understand their pelvic health as it relates to hormone changes and physical changes and emotional changes because we hold a lot of energy in our pelvis.

I feel that way. I really appreciate you having this topic on your show. I think it's really important to be able to freely talk about it. Absolutely.

That's what the show is all about, fostering collaboration and dialogue surrounding health, wellness, and inspiration. So Dr. P and Dondi, before we get into it, can you please tell us a little bit about your practice?

Yes. My practice is located in Alpharetta, Georgia. We're full scope general gynecology, urogynecology practice, focused on treating not only pelvic health issues, but hormonal issues and metabolic disease.

So I have patients that come in because I'm also board certified in obesity medicine. So I have patients that come in with metabolic conditions like polycystic ovarian syndrome.

And as it relates to sexual health, a lot of patients that have fertility issues, they come to me. And we have to kind of tackle that, especially patients that, younger patients that may be going through IVF.

And then I also see a lot of sexual pain disorder patients, patients that may have had issues with endometriosis as I still do general gynecology. And then I see the menopause transition patients who are having, you know, unwanted changes in their body.

And I assist them through that phase of their life too. All right. Well, I am looking forward to getting into these myths. So you're going to kind of explain what's true and false surrounding some of these ideas.

The myth number one is low libido. If someone has low libido, that just must mean that there's something wrong with their relationship, true or false.

Yeah, definitely false. This is such a good one because I think people don't realize how prevalent libido issues, low sexual desire is. 40% of women through their lifetime will have issues surrounding low sexual desire, low sexual arousal, and that spans from the younger years, the childbearing years, and the menopause transition because of changes that occur in our body, we have biological changes, we have psychological changes, and then social changes that occur too.

And all of those things come into play when we talk about libido issues. So no, it doesn't mean that there's necessarily something wrong with your relationship, But I think the problem is people don't communicate in their relationships about this issue.

And so that is why at the base level, this is false. But when I counsel my patients, communication is the most important thing because it really breaks my heart when everything is great.

You know, they have a loving relationship, but then they're not able to talk about this. Communication. Myth number two, if you do not have spontaneous desire, you are broken.

Myth 1: Low Libido and Relationship Problems

So is that a myth that you have heard? Oh, yes. I have a lot of patients that come in that say exactly this. Dr. Gandhi, I really don't feel like having sex anymore.

And then I'll follow up and I'll say, are you able to be aroused by erotic media or self stimulation or even when your partner is, you know, during foreplay?

Oh, yeah. Oh, yeah, that's fine. But I never really initiated. So because women feel like they don't initiate intercourse or intimacy, they feel almost as if that is reactive or responsive arousal is not normal.

And it totally is. I feel like patients need to know that. That is something next to communication. realizing that responsive arousal is normal. It doesn't always have to be spontaneous.

And you shouldn't seek treatment so that you only have spontaneous arousal and desire. I think a lot of women feel pressured to have spontaneous arousal and desire.

So they come to me for medications or procedures, and I have to remind them and tease that out from responsive arousal or desire and helping them with that portion and normalizing that for them versus there being an issue that requires treatment.

Okay. Myth number three. This one I found to be interesting. If you don't have sex regularly, you will lose your libido forever. Da, da, da. True or false?

Obviously false. Obviously false. This is such a good one because people say this all the time. If you don't use it, you will lose it. That is just not true because there's a sexual peak in our later years.

And I know people don't believe that, but studies have shown that artesostrone waxes and wanes. And it can decrease starting at the age of 25, 30. But then there's a surge.

in women in their 60s and 70s. And I think that there's a protective effect of testosterone on our bones, our muscular health. But interestingly, it also secondarily affects our libido and our sexual health.

Myth 2: Spontaneous Desire vs Responsive Arousal

So it's not true. However, I will say most women don't realize that a lot of our libido issues also come from our general health. If generally we're not healthy, we're not treating maybe depression, we're not treating our hypertension, we have uncontrolled diabetes, all of those things affect blood flow to the area.

And by self-stimulation or having sex frequently does improve lubrication and blood flow to the area. And that helps keep tissue revitalized. But there are other ways that you can improve your general health.

So I think it's really, really important to make sure you're generally healthy. You're putting good nutrients in your body. and you're trying to be at a normal weight, you're making sure that you're not indulging in processed foods.

All of those things affect our general health, it increases inflammation and decreases blood flow to our general organs. Yes, so that's a topic that's come up many times on the show is really reducing the limiting processed foods.

I think it would have a negative impact on our health or sexual health. It's our general health. But when you talk about libido, this is something I kind of wanted to hone in on a little bit, is how do women know if something's normal or at all?

Like, what defines it being a problem? Is it a problem when a patient comes to you and says that it's a problem? And if so, what is the work? I think that there's different types of female sexual desire disorder.

So firstly, it is very important to take a history because low libido or low sexual desire is a problem when the woman says it's a problem. If for her, Having a normal interval of intimacy is once or twice a month, that's normal for her.

I think a lot of times women feel pressurized because of the commercialization of sexuality in media and I think they feel a lot of pressure. And that is one thing that anytime a woman comes in, I take a sexual health questionnaire because I think it's important part of their pelvic health.

A lot of times when patients come to me for urinary incontinence or vaginal laxity or pelvic prolapse, they will concurrently have issues about sexual health.

Myth 3: Sex Frequency and Losing Libido

And so the workup includes an extensive history and making sure that we do a physical exam because of those three factors, the biological, the psychological, and the social factors.

And if I have somebody that really has an unexplained change in their libido, and I suspect that there could be relationship issues or social factors, it's really important for them to have a sex therapist I refer everybody to a sect or the American Association of sexuality educate educators counselors and therapists.

There's actually a website that patients can go to and I will give that to them where they can find a therapist near them. And it's so, so important to have that in your repertoire because we can treat patients with their hormonal issues, their anatomic issues, and their psychological factors.

But if you don't have a sex therapist in your toolbox to help you navigate through this whole transition, or even I have patients that have had history of sexual trauma, and it's very, very important to have a therapist.

So, as part of the workup, yes, we take an extensive history and the physical exam is important, but it's also important to have another team member that can go in a little bit from a different angle, talking about the social factors that may be affecting the patient's libido.

So what are some of the treatments? I know you mentioned the therapist. You also give hormones, but what are some of the things that you offer to women that are dealing with this issue?

Well, there are two FDA approved medications right now for premenopausal women. It's been tested in postmenopausal women, but it's not FDA approved for postmenopausal women.

We don't have an FDA approved medication for postmenopausal women. But there are both. So one is phlebancerin. So that is ADDI, the pink pill. And that is taken every day.

It's an oral medication. And both ADDI and the second one that I'm going to mention, which is brimelanotide. And that works on melanocortin receptors in the brain.

They both work on neurotransmitters that are excitatory. So things that are like oxytocin and dopamine. And, you know, unlike the ADDI, the Bremelanotide or Vilece is an injection that you give about 45 minutes before intercourse.

Its effects last for about 24 hours, but it helps increase the nitrous oxide infiltration to the general area and also works on neurotransmitters in the brain that help kind of put you in the mood, if you will, again, a responsive arousal mechanism.

And the addy, one of the side effects of it are sometimes blood pressure issues. So you do wanna take it at night. The injection, the main side effect is nausea.

So when I have a patient who's premenopausal and they may be on birth control pills or maybe they are on medications like SSRIs, that can affect libido because serotonin and GABA, they are like anti libido helpers.

So we want to increase dopamine. We want to increase oxytocin. And so those medications are targeted for that. But for postmenopausal women, a lot of time we're limited to hormonal treatment with testosterone, which does help sexual vitality desire issues.

But if we have somebody that has an arousal issue, then what we're trying to do is improve blood flow, improve class three and four collagen in the area.

And we can do that with some regenerative therapies that are not FDA approved, but we use it off label.

How Low Libido Is Evaluated and When It Becomes a Problem

And that is PRP. So platelet rich plasma platelet rich plasma is blood that's collected from the patient and we spin it in a very high spin centrifuge and we concentrate the platelets.

And the platelets are a very rich healing component because they are like the first people to go to a wound and they help with the healing process. So when you concentrate the platelets about four to five times the normal amount in your serum and you place it strategically in areas that you can improve blood flow, and neovascularization, it helps with arousal and sensation because it takes women on average 20 to 25 minutes to get aroused and very rarely is that time spent.

in the bedroom to make sure the woman comfortably feels aroused. So a lot of times women are left with feeling slightly uncomfortable. Maybe they don't have the vaginal moisture.

Maybe their cervix and their uterus hasn't lifted away and their vagina hasn't elongated because they haven't spent enough time In the arousal phase due to menopause or hysterectomy, or even birth trauma from last rations during their obstetric delivery.

So we're using things like PRP that we use in other areas. They use an orthopedics, they use it in neurology and dermatology to help with regenerative science and tissue, you know, to help tissue regenerate.

We do the same thing in the genital area. You can also do that with radio frequency energy and ablative techniques using CO2 lasers. Now, I feel like a lot of these things have to be Managed by someone who very much

understands if there's an anatomic problem versus a hormonal problem versus a psychological problem.

So there's not a 1 size fits all. I think it's just so important to me when I have a patient. That I kind of talk to the whole person because when you get into the story a little bit deeper if you have a 55 year old woman who says that my husband's complaining I never feel like I'm in the mood, but I'd really rather just you know drink my wine watch my favorite show and.

You know, call it a night. I'm happy with that, but my husband's not happy and it's affecting our marriage. So then that's the conversation that starts.

You know, okay, if this is bothering you, what do we do next? And it's not a everything. We throw the kitchen sink at it. It's layered. You know, it's a stepwise treatment plan that I most of the time do with my patients because a lot of these, unfortunately, a lot of these treatments are not FDA approved.

Treatment Options for Female Sexual Dysfunction

There's not very many studies in women on sexual health. And the menopause, I'll say revival, you know, right now has really highlighted the lack of studies in women, particularly women of color.

I don't know how many women I see, women of color, that go through menopause the worst. They have the most severe symptoms and they are the least likely to seek care.

Asian women, interestingly, have fewer symptoms and they almost never seek care, but they deal more with sexual health issues. than Caucasian and African-American women.

So there's cultural issues that come into it too, which I find very fascinating. And as an Indian woman, there's a lot about sexuality culturally in my own, I would say population, but a lot of the patients that I see, they come in for sexual pain issues and really it's a hormonal concern.

And so I'm very passionate about it because nobody really talks about it. And when you go to your doctor and you might be, seeing them for 10 minutes at an annual visit, you can't really get into it.

When a patient comes in with low libido, they've seen a lot of doctors. Most of them have told them just to shut it down. It's no big deal. Everybody goes through this.

You're done with childbearing. But it does bother women because some women want to have that sexual vitality into their later years. And also, there's a lot of gaslighting of younger women.

Because more and more younger women are struggling with metabolic disease, like polycystic ovarian syndrome, which is linked to low desire and low libido.

So, you know, I could talk about it forever, but yes, I'm very passionate about increasing awareness for this issue. Yeah, well, thank you so much because the coalition is really meant to give people information, particularly information that they may not otherwise be privy to and it kind of can be a start.

because maybe if you've never even heard that certain things are out there, you wouldn't even look into it or seek that kind of consultation. So thank you so much for sharing your expertise.

I have two follow-up questions. When you were talking about the treatment with the platelets, the PRP, is that being done as an injection? Yes. And how often is that given?

about 8 to 12 months. So once we sequester the platelets, and typically about 30 cc's are drawn, and we apply a numbing medication so that the patient doesn't feel anything.

And while we are spinning the sample down and preparing the sample, it's about 45 minutes while they have this

on, about 30 to 45 minutes. I keep it on quite long because I really don't want my patients to have any pain.

And the injection is into the glands of the clitoris and then also into the anterior vaginal wall. Because the research on the use of PRP for mild stress urinary incontinence and the benefits, there's a lot of good studies on that.

But for arousal issues, There is not very many great studies. There was a pilot study that was initiated in 2014, still hasn't finished. It hasn't finished recruiting patients.

But I think some of the issues are also getting a high quality sample because a lot of times I will have patients make sure that a few weeks before they've really eaten well, they're in good shape because the quality of the sample is based on the health of the individual.

So if you have an individual who's a smoker, who has poorly controlled diabetes, while I want to do the PRP injection for them, I really want them to improve their health so the sample is better.

And the sample is injected into those two areas and lasts eight to 12 months. It takes three weeks for the recruitment of collagen three and four. And they start feeling things waking up down there.

That is what like almost all of my patients will say. And it's not as if it helps with desire.

PRP Therapy, Costs, and Home Devices

It helps with arousal issues. So it's really important to make sure that the treatment is matching what the issue is. Because if a patient comes in with low desire, and a lot of times it's marketed for that, but that's not truly the best use of it unless you are using it as an adjunct to other treatments because a lot of times purely low desire is not the factor.

You know, it's usually multifactorial why women have female sexual dysfunction. So is that covered by assurance? No, it's not covered by insurance. It is expensive.

You know, it's about a thousand dollars. And for women that it's indicated for, it can be life changing. It also is really good for patients who don't want, who have mild urinary incontinence.

that are not candidates for a sling and they don't want polyacrylamide. It also is a very good option for women that have had breast cancer and maybe they can't have hormone therapy, although vaginal estrogen now has widely been used because of the low systemic absorption.

So it's expensive. A lot of these treatments are very expensive. So you wanna make sure in order To, you know, give the patients the best outcome that you're choosing the right patients, you know, for sure.

But now there is a, there's a number of home devices that use red light therapy. Inter vaginally, one of them is called V fit. And it's a medical device, so your HSA or FSA may pay for it.

And it does similar things to what PRP does. It improves blood flow. It recruits collagen. It recruits healing to that area with continued use. So there's going to be some home devices too that patients can use that aren't as expensive as doing some in-office treatments.

But for those patients who have failed traditional treatments, I think these are good options too. Fascinating. Another question I have is you mentioned hysterectomy.

Yes. What, explain to me, what is the connection between hysterectomy and sexual health? Well, it depends on what type of hysterectomy is done. A total hysterectomy removes the cervix and the uterus.

And sometimes those patients also have removal of their ovaries. Young patients that have removal of their ovaries along with the hysterectomy do suffer issues with low libido and female sexual dysfunction because of the lack of

proper hormonal release.

And so I do think it's really important to know what type of hysterectomy patients have had.

Hysterectomy and Sexual Health

Before, when we were, it's very popular to do supracervical hysterectomies and we were leaving the cervix, there was some benefit sexually to that. There are nerve endings there, there's blood flow there.

And so now that we don't use more slaters as often in removing the uterus and the cervix, sometimes that can shorten the vagina depending on what type of hysterectomy and the approach.

that it's done with and also it affects lubrication for some women. And so initiating hormone therapy for some patients that it's indicated for will help prevent some of these things down the road.

But I do think that that's important. Wow, Dr. P. Hindani, you have really dropped many jabs. Thank you so much. It was a fascinating conversation that I know will help a lot of people.

For people that have enjoyed this conversation and want to learn more, what is the best way for people to reach out to you? They can reach us at Renugen, R-E-N-U-G-Y-N dot com.

I also have an Instagram page. It's Dr. P. Henggandi. And my office number is 470-458-9705. Wonderful. Well, thank you so much, Dr. P. Henggandi. You got to come back to the Coalition another time.

I'm sure there's a lot more things for you to do. Great. So I would love it.

Closing Remarks and Contact Information

Thank you so much. I really appreciate it. Thank you. Wow, everybody. Thank you so much for tuning in to another impactful episode of The Coalition. Very special thank you to Dr.

P. Henggandi. She is an accomplished Eurogynecologist with a passion for women's health. So very special thank you to her for sharing her expertise and making this a very impactful episode.

You can get connected with Dr. P. and Valerie on social media. You can stay connected with me. I'm Dr. Shani Belgrade at Banner Bariatric Surgery. You can stay connected with me at www. DrShaniBelgrade.com.

Make sure that you share this episode with family and friends to raise awareness on myths surrounding your mojo. I'll see y'all next time.