Letters

I FOUND THE HUMANITIES ARTICLE 'On death and dying' by Dr Iyengar published in the *Australian Journal of General Practice* in the August 2023 issue somewhat underwhelming with respect to representation of the spiritual beliefs in our country.[1]

The latest census data indicates that currently nearly 44% of the Australian population identify as Christian.[2] However, there was no mention of a Christian perspective on death and dying in Dr Iyengar's reflection.

Indeed, to read John Donne's 'Death, be not proud', one of his 'Holy Sonnets', without taking into account his Christian point of view (he was an Anglican minister in the Church of England) is to entirely miss the point of the poem. The final two lines of 'Death, be not proud',

> *One short sleep past, we wake eternally*
> *And death shall be no more;*
> *Death, thou shalt die,*[3]

are a clear allusion to the biblical concept that 'The last enemy to be destroyed is death' (1 Corinthians 15:26, as cited in Dickson, 2017).[4] Donne wrote this poem out of conviction of the certainty in Jesus Christ's victory over death (1 Corinthians 15:57), not ambiguity of the unknown.[4] For those who share Donne's faith, the poem is an expression of hope in death and an exhortation to 'not grieve like the rest of mankind, who have no hope' (1 Thessalonians 4:13).[5]

Granted, there has been a decline in the proportion of the Australian population who affiliate with Christianity.[1] However, Christian thought and values have profoundly influenced Australian society for over 200 years. Regardless of our own personal faith, we would do well to appreciate the historic and continuing influence of Christian belief, including that on death and dying, on our Australian culture.

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Competing interests: None.

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Reply

I would like to thank the correspondent for their comments. The purpose of this brief inquiry into death and dying was to reflect on the multifaceted nature of death to spark discussion about death among general practitioners (GPs). This is important to provide whole-person care for patients throughout their journey of life, including dying, as the biomedical perspective dominates medical rhetoric.

A literary analysis of Donne's sonnet and spiritual aspects of death are important but comprehensive topics that require in-depth analysis and are beyond the scope of a medical journal.

I welcome your reflection on death, and as acknowledged by Donne,[1] who for many represents the Christian perspective, appreciate that some will find comfort knowing that they shall wake eternally.

Donne's poetry also invites the reader to embrace body and spirit. The unique, personal and enigmatic nature of death invites GPs, as the clinical situation might demand, to step away from rigid frameworks and listen to their patient's perspective. Human values and trajectories can evolve over time. Critical inquiry and reflection on difficult topics such as death should be encouraged, as death resists neat biomedical categories, and these narratives can collectively enrich medical literature and clinical practice.

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Competing interests: None.

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THE ARTICLE on vulvovaginal complaints by Dennerstein published in the July 2023 issue of AJGP does not reflect current practice and guidelines on the management of vulvovaginal symptoms.[1]

For example, the article recommends against the use of vaginal lubricants for sexual activity. This is at odds with current recommendations.[2] The warning against topical vaginal oestrogen for menopausal women is also inappropriate, with multiple guidelines recommending the use of vaginal oestrogen.[2] All of Dennerstein's eight references have himself as first author, and he does not refer to current guidelines or the broader evidence base.

While accurate diagnosis is important, 'do it yourself microscopy' is not feasible for most doctors.

Menopause is referred to as an 'endocrine disorder'. This is not correct for the majority

of women, for whom it is a natural event, not a 'potentially nasty disease'. Dennerstein recommends using oestradiol and follicle-stimulating hormone levels to adjust the doses of menopausal hormone therapy. This is inconsistent with current practice advice where the dose is adjusted to symptoms, and blood tests are not usually needed.[3]

The author uses outdated language, for example when implying that the sexual partner will always be male, and terms such as 'sexual arousal failure', which can be stigmatising. The author also claims that 'proper arousal' means that the woman is producing her own lubrication. This is incorrect.[4] While it is important to discuss vulval care with women, the statement that 'women need to be taught how to look after their genitals' is an inappropriate admonition. In addition, the exhortation to 'not treat any symptoms yourself without seeing a doctor' is not patient-centred care.

Dennerstein's opinion on the use of the term 'vulvodynia' is not in keeping with current recommendations. In 2015, the International Society for the Study of Vulvovaginal Diseases, the International Society for the Study of Women's Sexual Health and the International Pelvic Pain Society formed a consensus for the terminology and classification of persistent vulvar pain.[5] The consensus acknowledges the complexity of the clinical presentation and pathophysiology involved in vulvar pain and incorporates information derived from evidence-based studies.

Although we recognise that opinion pieces allow for an author to give their personal opinions, it is essential that recommendations are based on current evidence. This is particularly important for the readership of *AJGP*, especially general practitioners early in their careers, who might view the article as a reflection of current best practice in Australia.

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Reply

I understand that my article could be controversial because vulvovaginal disorders have been relatively neglected in clinical training and often require the involvement of multiple specialties, most commonly gynaecology, dermatology, pathology, psychology and oncology. Hence the frequently conflicting opinions on the subject. My experience in this field and my fortune of having worked closely with the above specialties are why I was prompted to write this article (and co-author *The vulva and vaginal manual* – reference 3 in my article).[1] Having gained my experience in both the public and private sectors, I have been able to follow up patients long term, many for over 40 years.

Guidelines are useful to fill gaps in training and experience but vary in accuracy depending on the robustness of the studies used in their creation.

The reader's comments on vaginal lubricants and vaginal oestrogen are addressed in my article in the section 'Sex' and in reference 5.[2] Understanding sexual response, and its lack, is essential for the management of many women with vulvovaginal disorders. I am sorry the reader did not like my means of expression of this aspect, but again, my experience has supported my recommendations under 'Sex'. I thank the reader for raising this issue; I agree that these principles apply to all women regardless of sexual orientation or marital status, and the language chosen was not intended to be marginalising.

Patients presenting with symptoms resulting from oestrogen deficiency, of which menopause is the commonest cause, do indeed have an endocrine disorder. They are best treated with replacement of the hormone, which has to be done correctly (blood tests being one means) for the best and safest outcome.

In the reader's reference 5, 'without clear identifiable cause' is mentioned in regard to the term 'vulvodynia'.[3] Having been a member of the International Society for the Study of Vulvovaginal Disease since 1983 (and, inter alia, chaired the Psychosexual Committee), I have witnessed the evolution of the term. Management of vulvar pain without an identifiable cause is one of the reasons why 'empirical treatment' and 'diagnostic requirements' are discussed at the beginning of my article. Incidentally, I omitted to mention biopsy, an essential investigation in many of these cases and certainly one of the means of avoiding having to resort to 'vulvodynia'.

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