

# Female dyspareunia

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Sexual Health Research**

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# Female dyspareunia

- Terms and definitions
- Prevalence
- Etiology
- Evaluation and differential diagnosis
- Therapy
- Research

# Terms and definitions

<b>Dyspareunia</b>	Painful sexual intercourse. Recurrent or persistent genital pain associated with sexual intercourse (DSM-IV)
<b>Superficial/entry dyspareunia</b>	Pain at the introitus during intercourse
<b>Deep dyspareunia</b>	Deep pain associated with intercourse
<b>Vaginismus</b>	Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse (DSM-IV)
<b>Vulvodynia</b>	Chronic vulvar discomfort

# Alternative definitions

<b>Dyspareunia (2)</b>	Persistent or recurrent pain with attempted or complete vaginal entry and/or penile vaginal intercourse
<b>Vaginismus (2)</b>	The persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger, and/or any object, despite the woman's expressed wish to do so. There is often (phobic) avoidance and anticipation/fear/experience of pain, along with variable involuntary pelvic muscle contraction. Structural or other physical abnormalities must be ruled out/addressed
<b>Vulvodynia (1)</b>	Vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder

1. ACOG Committee on Gynecologic Practice. ACOG Committee Opinion: Number 345, October 2006: vulvodynia. *Obstet Gynecol.* 2006 Oct;108(4):1049-52.

2. Basson R et al. Revised definitions of women's sexual dysfunction. *J Sex Med.* 2004 Jul;1(1):40-8.

# Common sexual problems in women and men in the UK (Family Practice 1998 15: 519-24)

Problem	Current (%)	Lifetime (%)
<b>Women (N=979; Age 18-75 years)</b>		
Never or rarely climax	27	
Pain during intercourse	18	45
Vaginal dryness	28	49
Problems with arousal	17	
Sex never or rarely pleasant	18	
Any of these	41	
Any lifetime problem		68
<b>Men (N=789)</b>		
Difficulty getting erection	21	23
Difficulty maintaining erection	24	25
Either or both of these	26	39
Premature ejaculation	14	31
Sex never or rarely pleasant	9	
Any of these	34	
Any lifetime problem		54

**EO Laumann, A Paik, RC Rosen. Sexual dysfunction in the United States: prevalence and predictors. JAMA 1999 281: 537-544**

Question	Percent
<b>Women (N=1749; Age 18-59 years)</b>	
Lack interest in sex	32
Unable to achieve orgasm	26
Experience pain during sex	16
Sex not pleasurable	23
Anxious about performance	12
Trouble lubricating	21
<b>Men (N=1410)</b>	
Lack interest in sex	15
Unable to achieve orgasm	8
Climax too early	31
Sex not pleasurable	8
Anxious about performance	18
Trouble achieving or maintaining erection	10

**Danielsson I, Sjoberg I, Stenlund H, Wikman M. Prevalence and incidence of prolonged and severe dyspareunia in women: results from a population study. Scand J Public Health. 2003;31(2):113-8**

**AIMS:** The principle aim of this study was to investigate the prevalence and incidence of prolonged ( $\geq 6$  months) and severe dyspareunia in a non-patient population of women.

**METHODS:** A total of 3,017 women aged 20-60 participating in a screening program for cervical cancer answered a questionnaire about possible painful coitus.

**RESULTS:** The prevalence was 9.3% for the whole group and 13% for women aged 20-29 and 6.5% for the women aged 50-60, with a risk ratio of 2.0 (95% CI 1.4-2.8) for the youngest age group compared with the oldest. Of the women who had ever had prolonged and severe dyspareunia 28% had consulted a physician for their symptoms; 20% recovered after treatment, while 31% recovered spontaneously.

# Etiology

## Superficial dyspareunia

### Vulvodynia

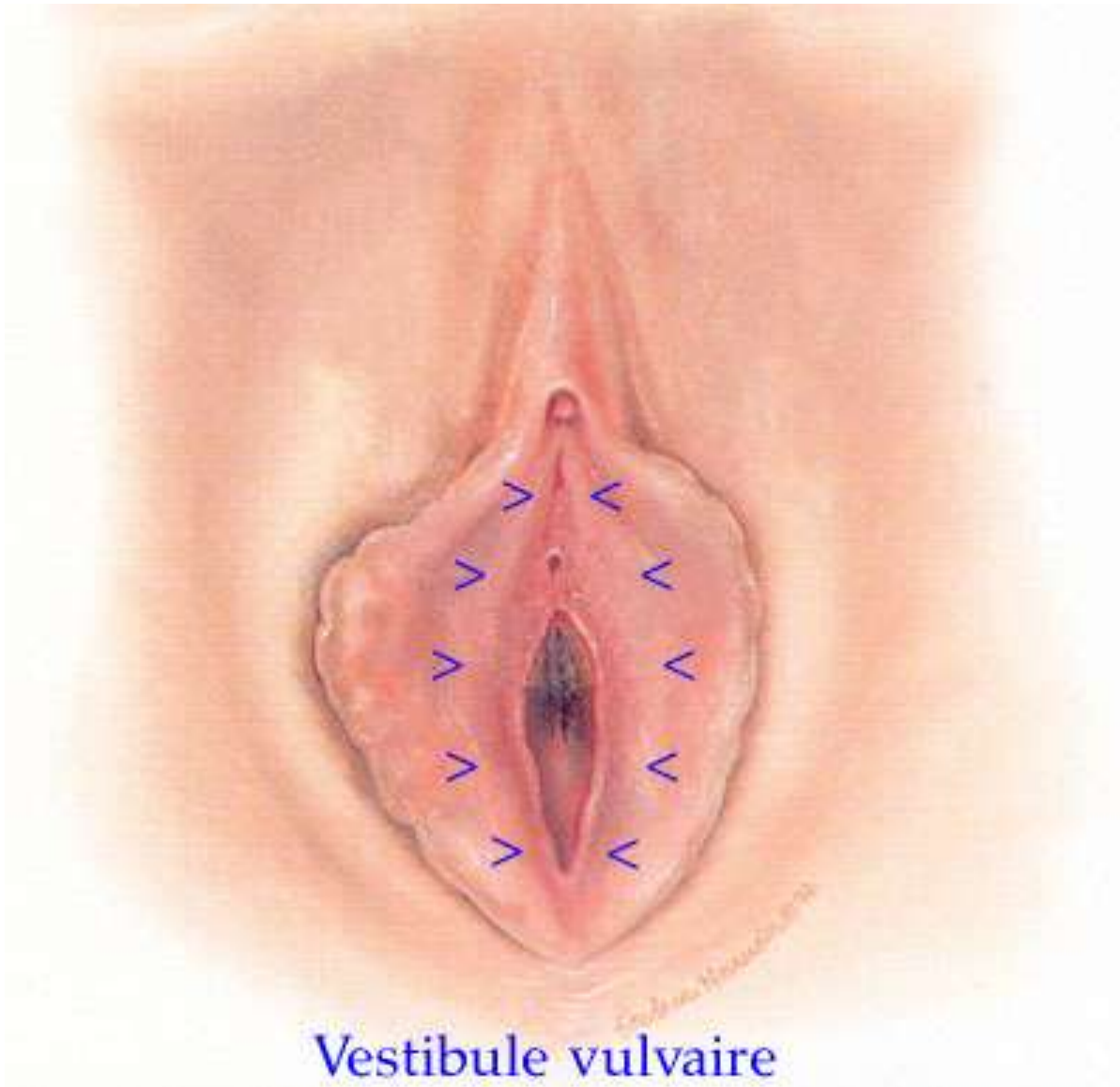
- Dysesthetic vulvodynia (essential vulvodynia)
- Vulvar vestibulitis (vestibulodynia)
- Cyclic vulvovaginitis (candidiasis)
- Vulvar dermatoses
- Neoplastic vulvar lesions
- Vestibular papillomatosis



# Dysesthetic vulvodynia (essential vulvodynia)

- Usually postmenopausal or perimenopausal
- Burning/pain not limited to the vestibule and may occur without touch/pressure
- Usually no erythematous cutaneous changes

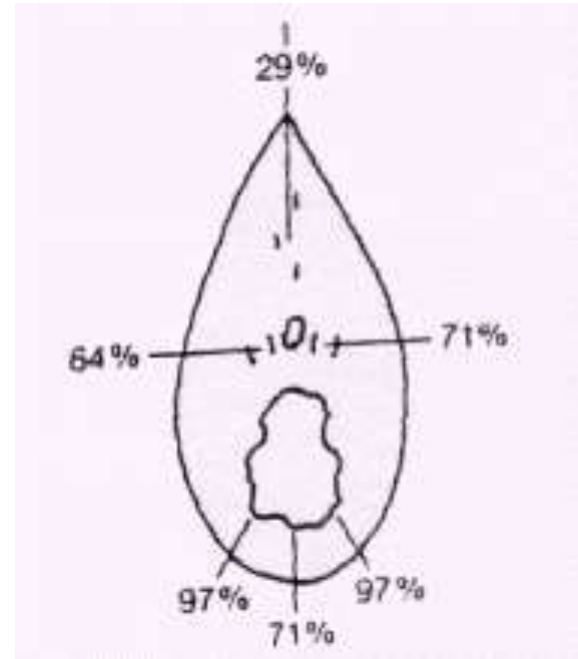
# Vulvar vestibulum



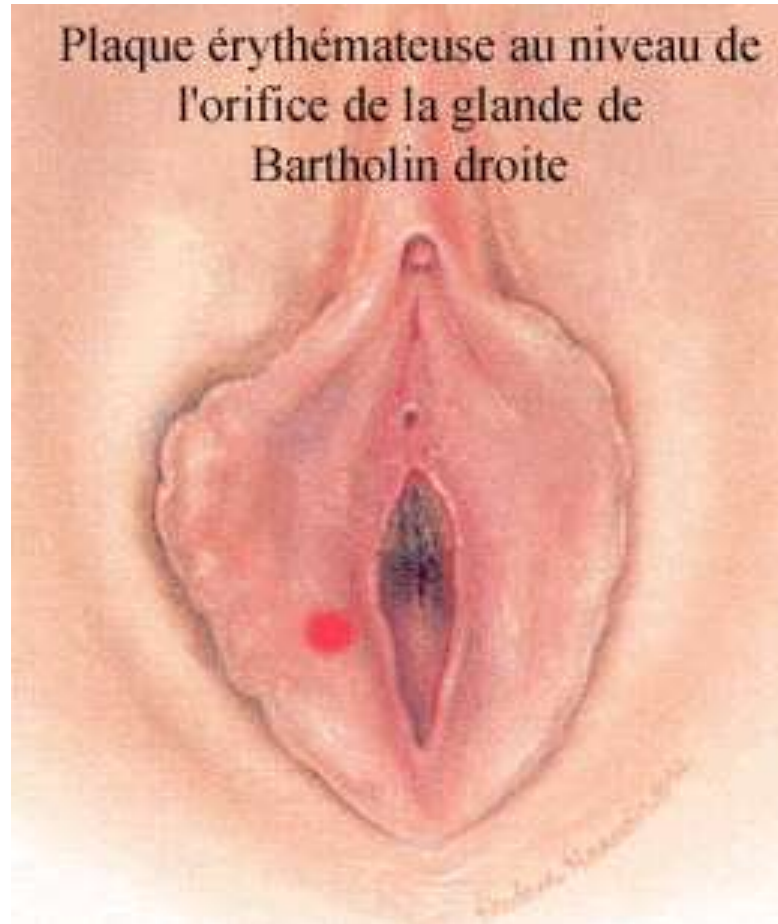
# Vulvar vestibulitis



# Vulvar vestibulitis – Swab test



# Vulvar vestibulitis - Erythema



# Cyclic vulvovaginitis

- Pain is worse just before or during menses
- Caused by a hypersensitivity reaction to Candida

# Vulvar dermatoses



Psoriasis



Lichen planus



Lichen sclerosus et atrophicus

# Vulvar dermatoses



Seborrheic dermatitis



Allergic dermatitis



Pemphigus vulgaris



Vestibular  
papillomatosis



# Vulvodynia

<b>Etiology</b>	<b>History</b>	<b>Physical findings</b>
Dysesthetic vulvodynia	Usually postmenopausal or perimenopausal. Diffuse, unremitting burning pain that is not cyclic. Less dyspareunia or point tenderness than in vulvar vestibulitis.	Usually no erythematous cutaneous changes.
Vulvar vestibulitis (vestibulodynia)	Usually premenopausal. Entry dyspareunia or pain with insertion of tampon. Possible history of carbon dioxide laser therapy, cryotherapy, allergic drug reactions or recent use of chemical irritants.	Positive swab test (vestibular point tenderness when touched with cotton swab). Focal or diffuse vestibular erythema.
Cyclic vulvovaginitis (hypersensitivity reaction to Candida)	Pain is worse just before or during menses. Pain is exacerbated by intercourse (especially on the next day). Some relatively symptom-free days. Frequent use of antibiotics for other conditions.	Variable erythema and edema. Minimal vaginal discharge.

# Vulvodynia

<b>Etiology</b>	<b>History</b>	<b>Physical findings</b>
Papulosquamous vulvar dermatoses	Itching is prominent. Variable chronic symptoms.	Erythema. Thick and/or scaly lesions. May have additional skin lesions elsewhere on body. Biopsy required.
Vesiculobullous vulvar dermatoses	Itching or burning. Variable chronic symptoms.	Blisters or ulcers that are not related to scratching. Biopsy may be required.
Neoplastic vulvar lesions	Variable persistent lesion.	Variable; possible white plaques, ulcers or erythema. Biopsy required.
Vestibular papillomatosis	Normal anatomic variant. Variable history of human papillomavirus infection. Many are asymptomatic.	Papillomatous appearance of mucosal surfaces. Biopsy to rule out koilocytosis or human papillomavirus infection if symptomatic or questionable.

# Etiology

## Superficial and vaginal dyspareunia

- Causes of vulvodynia/chronic vulvar pain, vulvovaginal infections
- Psychogenic causes
- Inadequate lubrication
- Vulvovaginal congenital anomalies
- Female genital mutilation
- Obstetric causes (episiotomy scars, vulvar varicosities)
- Vulvovaginal atrophy
- Urologic disorders (interstitial cystitis, urethritis)
- Bowel disorders (constipation, proctitis)
- Neurologic disorders (pudendal nerve lesions)
- Muscular disorders (pelvic floor hypertonus, fibromyalgia)
- Sjögren syndrome
- Iatrogenic and traumatic causes

# Vulvovaginal infections



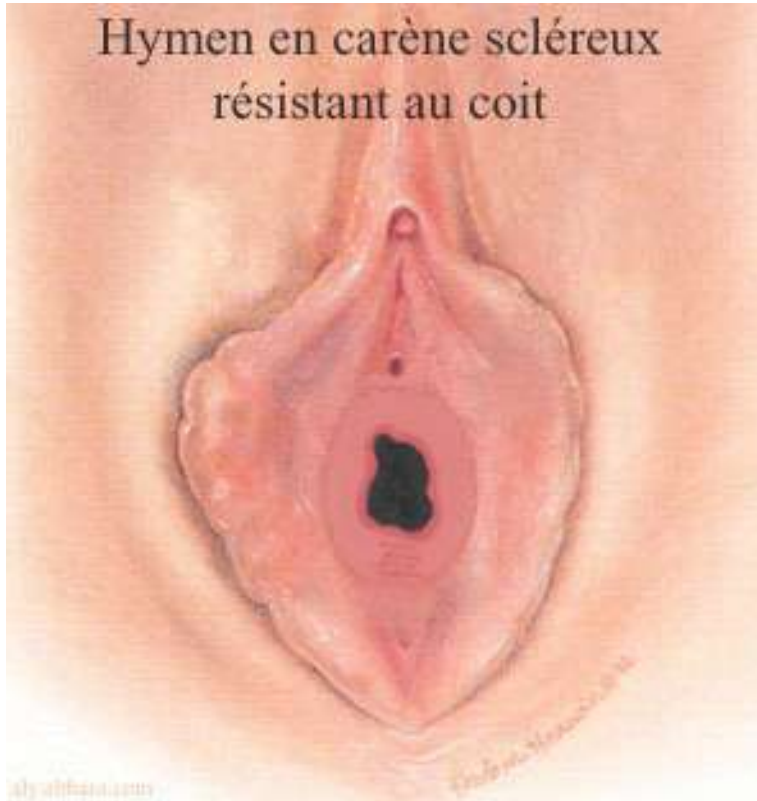
Candida albicans



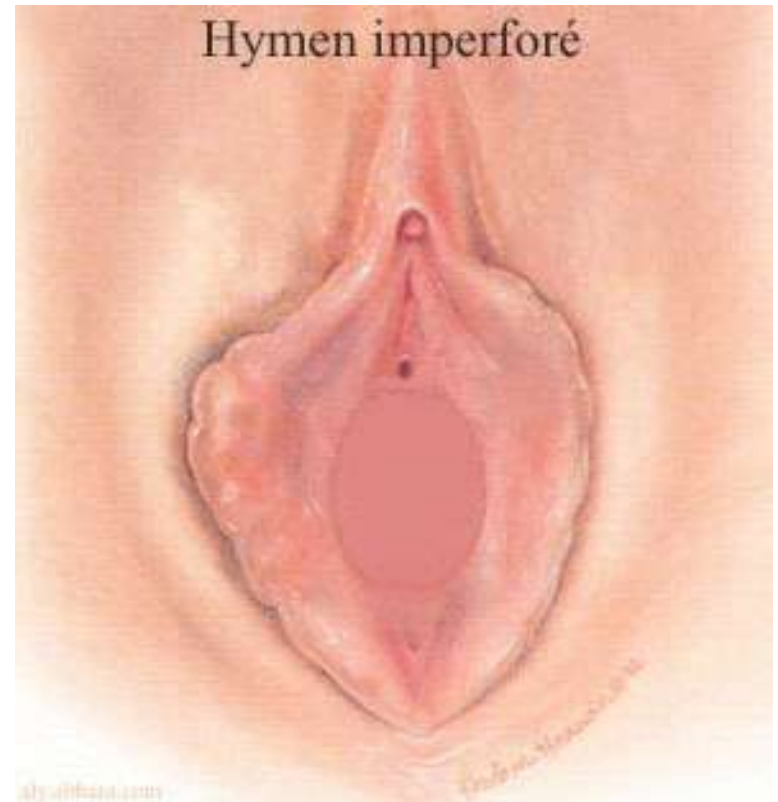
Herpes genitalis

# Congenital anomalies of the hymen

Hymen en carène scléreuse  
résistant au coit



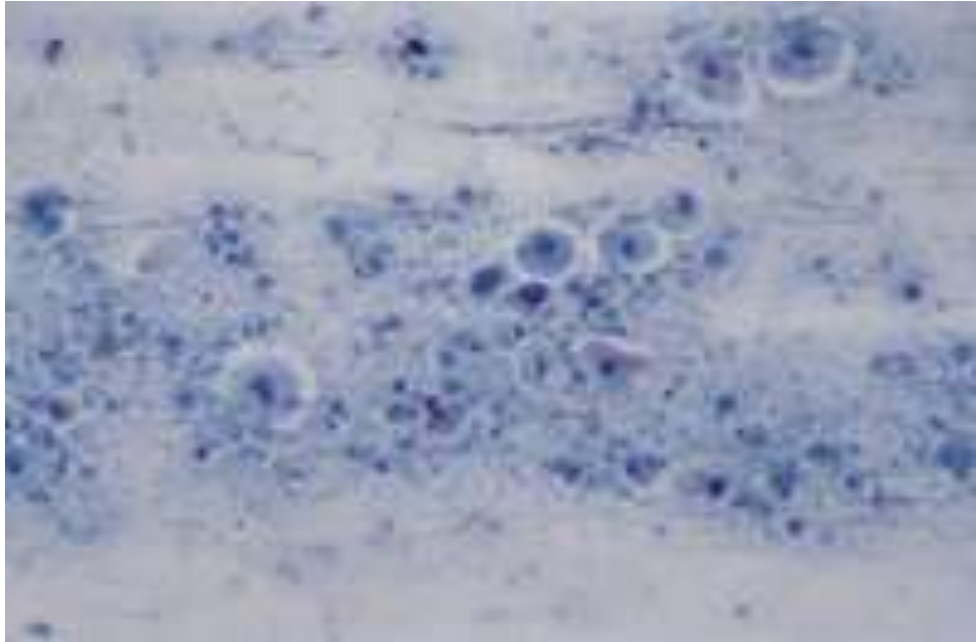
Hymen imperforé



The effects of mediolateral episiotomy on pelvic floor function after vaginal delivery  
(Obstet Gynecol. 2004 Apr;103(4):669-73)

	Group A episiotomy (n=254)	Group B no episiotomy (n=265)	Odds ratio (95% CI)
Stress urinary incontinence (%)	12.9	12.1	1.01 (0.61, 1.69)
Anal incontinence (%)	2.8	1.9	1.47 (0.46, 4.7)
Dyspareunia (%)	7.9	3.4	2.43 (1.08, 5.45)
Perineal pain (%)	6.7	2.3	3.09 (1.2, 7.99)

# Atrophic vaginitis



**Nappi RE, Verde JB, Polatti F, Genazzani AR, Zara C. Self-reported sexual symptoms in women attending menopause clinics. Gynecol Obstet Invest. 2002;53(3):181-7**

Age, years (n=355)	Pain during intercourse
46-50 (n=115)	26 (22.6%)
51-55 (n=188)	57 (30.3%)
56-60 (n=52)	23 (44.2%)
Time since menopause, years (n=295)	
<1.1 (n=72)	18 (25.0%)
1.1-2,1 (n=72)	15 (20.8%)
2.2-5.2 (n=78)	22 (28.2%)
>5.2 (n=73)	38 (52.1%)

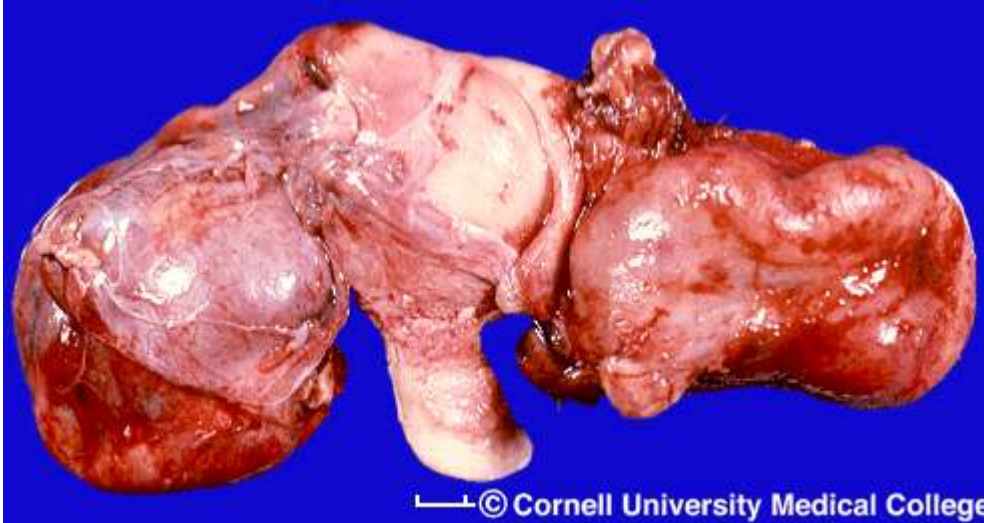


# Etiology

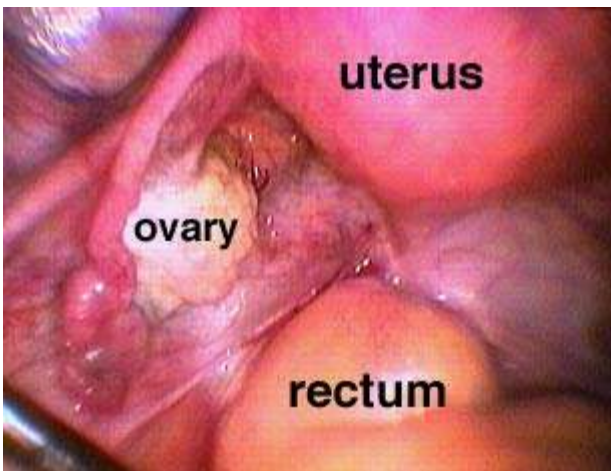
## Deep dyspareunia

- Genital infections: cervicitis, pelvic inflammatory disease
- Pelvic adhesions
- Endometriosis
- Retroverted uterus, uterine fibroids
- Postpartum: Allen-Masters syndrome (broad ligament laceration)
- Pelvic congestion
- Genital prolapse
- Inflammatory bowel disease

# Deep dyspareunia - Etiology



Pelvic inflammatory disease



Endometriosis



Adenomyosis

Adenomyosis. Note thickened wall of uterus which can be mistaken for fibroids.

# History

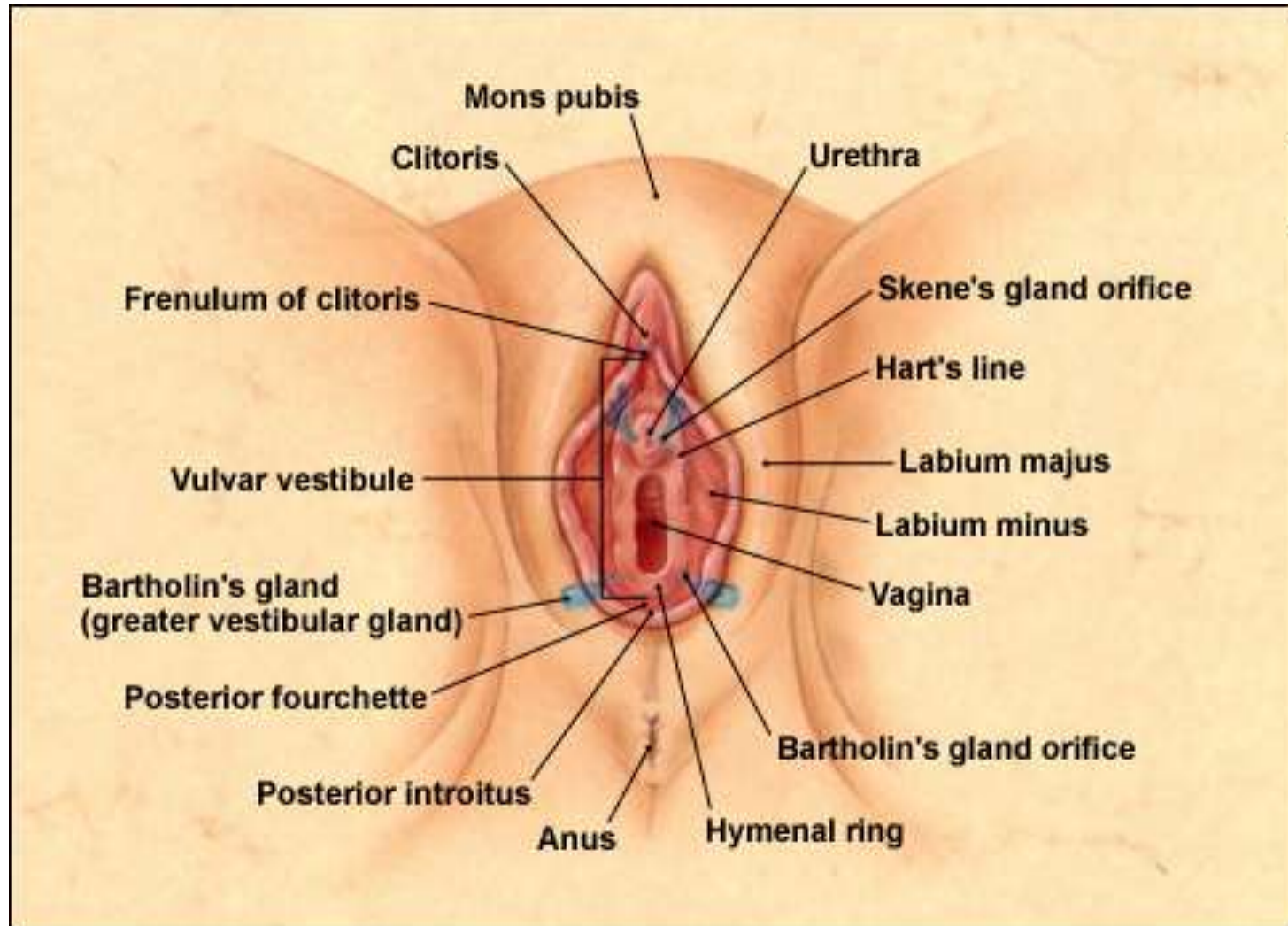
- Age, general history, gynecologic and obstetric history, psychologic factors, sexual history
- Dyspareunia
  - Superficial, vaginal, deep
  - Primary or secondary
  - Permanent or intermittent
  - Situational or generalized (occurs only with certain partners/situations or with all encounters)
  - With or without vulvodynia

# Gynecological exam

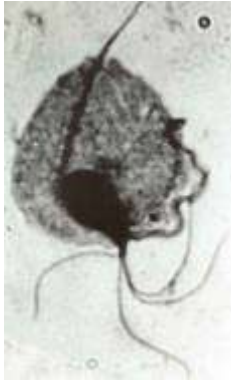

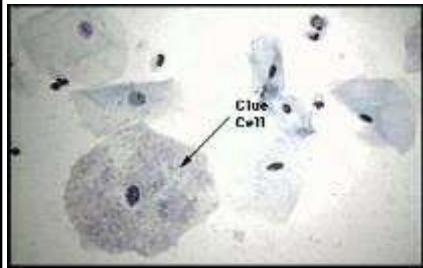
## Perineum, vulva, vagina

- Vaginal stenosis, atrophy, episiotomy scars, signs of vulvovaginitis or other vulvovaginal lesions
- Pain location, swab test
- Vaginal swab
- If indicated: culture, colposcopy, biopsy
- If indicated: pelvic floor electromyography

# Anatomy of the vulva



# Vulvovaginitis

	<b>Trichomonas</b>	<b>Candida</b>	<b>Bacterial vaginosis</b>
Vulvar pain	Present	Important	Absent
Discharge	Copious, malodorous, yellow-green (or discolored), pH $\geq$ 4.5	Thick, white ("cottage cheese"), normal pH	Gray or yellow, positive whiff test, pH $\geq$ 4.5
Vaginal swab			

# Gynecological exam

## Cervix, uterus, adnexa

- Cervix
  - Signs of cervicitis, hypertrophy, obstetric scars
  - Cervix tender to palpation
  - If indicated: cervical swab, culture
- Uterus
  - Position, size, consistency, tenderness
  - If indicated: vaginal ultrasound
- Adnexa
  - Size, tenderness
  - If indicated: vaginal ultrasound, laparoscopy

# Therapy

<b>Etiology</b>	<b>Therapy</b>
Dysesthetic vulvodynia	Tricyclic antidepressants, anticonvulsants (gabapentin), biofeedback of pelvic floor musculature
Vulvar vestibulitis (vestibulodynia)	Local anesthetics, local estrogens, tricyclic antidepressants, biofeedback, vestibulectomy
Cyclic vulvovaginitis	Antifungal treatment
Papulosquamous vulvar dermatoses	Topical corticosteroids or testosterone (lichen sclerosus)
Vulvovaginal atrophy	Estrogen therapy
Contact vulvitis	Removal of the causative agent
Infections	Specific antimicrobial treatment
Endometriosis	Pharmacological or surgical treatment
Retroverted uterus, fibroids, adhesions	Surgery



# Initial skin management for women with vulval pain or itching

- Avoid irritants
  - Body fluids: sweat, vaginal secretions, urine and semen
  - Hygiene products: soaps, gels, bath oils, bubble bath, douches, perfumes, deodorants, depilatory creams and sanitary pads
  - Medicaments: disinfectants, tea tree oil, preservatives in creams, antifungal creams, topical anaesthetics and topical antibacterial agents
  - Lubricants and contraceptives: spermicides, condoms and diaphragms
  - Physical items: sanitary pads and tampon strings, tight clothing, synthetic underwear, toilet paper, overzealous cleansing and scrubbing, shaving and plucking of hair
- Moisturise dry skin with creams such as Sorbolene or aqueous cream
- Use barrier creams, such as zinc and castor oil cream or Vaseline, if there is incontinence or vaginal discharge
- Reduce scratching as much as possible by applying cold compresses
- Application of potassium permanganate solution
- Ensure there is adequate arousal and use lubricants for limited sexual intercourse; vegetable oils are less irritant than water-based lubricants

# PubMed: Dyspareunia OR Vulvodynia

February 10, 2008

- **Meta-Analyses**

- Fernando R, Sultan AH, Kettle C, Thakar R, Radley S. Methods of repair for obstetric anal sphincter injury. *Cochrane Database Syst Rev.* 2006 Jul 19;3:CD002866.
- Hart RJ, Hickey M, Maouris P, Buckett W, Garry R. Excisional surgery versus ablative surgery for ovarian endometriomata. *Cochrane Database Syst Rev.* 2005 Jul 20;(3):CD004992.
- Huetting WE, Gooszen HG, van Laarhoven CJ. Sexual function and continence after ileo pouch anal anastomosis: a comparison between a meta-analysis and a questionnaire survey. *Int J Colorectal Dis.* 2004 May;19(3):215-8.
- Kettle C, Hills RK, Ismail KM. Continuous versus interrupted sutures for repair of episiotomy or second degree tears. *Cochrane Database Syst Rev.* 2007 Oct 17;(4):CD000947.
- Langer B, Minetti A. Immediate and long term complications of episiotomy. *J Gynecol Obstet Biol Reprod (Paris).* 2006 Feb;35(1 Suppl):1S59-1S67.
- Latthe P, Mignini L, Gray R, Hills R, Khan K. Factors predisposing women to chronic pelvic pain: systematic review. *BMJ.* 2006 Apr 1;332(7544):749-55. Epub 2006 Feb 16.
- Maher C, Baessler K, Glazener CM, Adams EJ, Hagen S. Surgical management of pelvic organ prolapse in women. *Cochrane Database Syst Rev.* 2007 Jul 18;(3):CD004014.
- Zondervan KT, Yudkin PL, Vessey MP, Dawes MG, Barlow DH, Kennedy SH. The prevalence of chronic pelvic pain in women in the United Kingdom: a systematic review. *Br J Obstet Gynaecol.* 1998 Jan;105(1):93-9.

# PubMed: Dyspareunia OR Vulvodynia

## Randomized controlled trials (114) – February 10, 2008

<b>Main subject of the study</b>	<b>N. of papers</b>
Endometriosis	38
Menopause	20
Labor complications	15
Urinary or fecal incontinence/genital prolapse	8
Vulvar vestibulitis	6
Chronic pelvic pain/dysmenorrhea	4
Genital infections	4
Hysterectomy	3
Vulvodynia	3
Breast cancer	2
IUD	2
Uterine fibroids	2
Diabetes	1
Interstitial cystitis	1
Lichen sclerosus	1
Male circumcision	1
Radiotherapy	1
Retroverted uterus	1
Sexual inadequacy	1