

Current views on etiology, diagnosis and the treatment of pain connected with sexual intercourse at women

Współczesne poglądy na etiologię, diagnostykę i leczenie bólu związanego ze współżyciem seksualnym u kobiet

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Summary

Painful intercourse at women is a diagnostically and therapeutically difficult issue, but most of all there is no accordance to the etiology of this health problem. At present there are six classification systems by means of which one tries to describe this issue. The layout of presented work is based on International Classification on Female Sexual Disorders, which in point four, includes Sexual Pain Disorders - dyspareunia, vaginismus and pain disorders not connected with sexual intercourse, but caused by other type of sexual stimulation. In context of current views on painful intercourse seen as the pain unit not as the sexual dysfunction, the crucial role of a gynaecologist in the diagnosis of this affliction has been underlined.

Key words: **dyspareunia / vaginismus / gynecological examination /**

Streszczenie

Ból związany ze współżyciem seksualnym u kobiet jest zagadnieniem diagnostycznie i terapeutycznie trudnym i nie ma zgodności, co do etiologii tego zdrowotnego problemu. W chwili obecnej funkcjonuje sześć klasyfikacji zaburzeń seksualnych u kobiet, które usiłują w pewien sposób usystematyzować to zagadnienie. Prezentowana praca oparta jest o International Classification on Female Sexual Disorders wg. zespołu ekspertów American Foundation for Urologic Disease (1998). Punkt czwarty tej klasyfikacji Zaburzenia Seksualne Związane z Bólem obejmują – bolesne współżycie seksualne /dyspareunia/, pochwicę /vaginismus/ i zaburzenia seksualne związane z bólem niezwiązane z dopochwowym stosunkiem seksualnym, ale występujące w różnych rodzajach stymulacji seksualnej. Zgodnie z obecną wiedzą ból towarzyszący współżyciu seksualnemu nie jest dysfunkcją seksualną. W diagnostyce bólu towarzyszącego aktywności seksualnej podkreśla się kluczową rolę ginekologa i badania ginekologicznego.

Słowa kluczowe: **dyspareunia / pochwica / zaburzenia seksualne /**

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There is no consensus regarding the optimal approach for identification and evaluation of sexual problems in men and women in primary care or general practice. Three concepts underlie sexual medicine management:

1. holistic approach to the patient – centred framework for evaluation and treatment;
2. application of general medicine principles in diagnostic and treatment planning;
3. using a unified management approach in case of both, men and women [1].

Approximately 15% of women suffer from chronic dyspareunia, a disease which is poorly understood, infrequently cured, often highly problematic and distressing. Chronic dyspareunia remains an urgent health problem [2].

Although painful intercourse may result in great personal conflict and be a source of anxiety, only a small number of women who have dyspareunia raise the issue with their physicians.

Dyspareunia is a symptom of multiple and varied disorders and may have multiple causes, with elements of both organic and psychiatric dysfunctions.

An attempt to present current views on etiology, diagnosis and treatment of pain accompanying sexual intercourse in women has been undertaken in order to help a general practitioner (GP) or a gynaecologist to diagnose the problem and conduct the treatment on the basis of present state of knowledge. Needless to say, the views in question often contradict those accepted so far.

At present there are six classification systems widely used in sexual medicine [3].

According to the new *International Classification on Female Sexual Disorders* they fall under the category of “Sexual Pain Disorders”, coital pain being the leading symptom of two major sexual disorders, namely dyspareunia and vaginismus [4, 5].

1. **Dyspareunia:** recurrent genital pain connected with sexual intercourse.
2. **Vaginismus:** can be defined as an involuntary contraction of the pelvic muscles surrounding the outer third of the vaginal barrel, particularly the perineal and levator ani muscles, and a conditioned reflex provoked by attempts at penetration. Vaginismus may be the reason of personal distress.
3. **Sexual disorders connected with pain but not connected with sexual intercourse:** recurrent genital pains caused by sexual stimulation, not connected with vaginal penetration [6].

Vaginismus and dyspareunia

Vaginismus and dyspareunia have been typically classified as sexual dysfunctions. In practice and research, this conceptualization has led to a focus on sexual and interpersonal issues after biological causes were excluded. Although this approach has been very useful, it has not led to significant theoretical or therapeutic progress in the last 20 years [7].

Kruiff et al attempted to identify clinical similarities and differences in patients with vaginismus and dyspareunia. They showed that neither the interview nor the physical examination produced useful criteria to distinguish vaginismus from

dyspareunia [8]. A multi-axial description of these syndromes is suggested, rather than viewing them as two separate disorders [9].

Dyspareunia

Dyspareunia has long been considered to be psychogenic. Contrary to that belief, it has been proven to have solid biological bases: location of the pain and its characteristics are the strongest predictors of its organicity. Biological factors include hormonal, inflammatory, muscular, iatrogenic, neurologic, vascular, connective and immunitary causes. A specific pathology of pain is important when the meaning of pain shifts from the “nociceptive” domain (when it signals ongoing tissue damage,) to the “neuropathic” dimension (when pain is generated within the nervous system itself, with increased peripheral input and/or lowered central pain threshold), as happens in chronic vulvar vestibulitis [4]. Meana et al offer the consideration of dyspareunia as primarily a pain syndrome rather than a sexual dysfunction [10].

Causes of dyspareunia

- **Abdominal disorders** / chronic pelvic inflammatory disease, endometriosis.
- **Congenital Factors** / hymenal stenosis, vaginal agenesis, vaginal duplication, vaginal septation.
- **Gastrointestinal disorders** / chronic constipation, diverticular disease, haemorrhoids, inflammatory bowel disease, proctitis.
- **Lubrication inadequacy** / abuse (past or present), arousal disorders, insufficient foreplay, medications, progesterone-only contraceptives, vaginal atrophy.
- **Pelvic scarring** / episiotomy, surgery.
- **Psychological factors** / anxiety, depression.
- **Trauma** (physical or psychological).
- **Urologic disorders** / Cystitis (acute or chronic), interstitial cystitis, lichen sclerosis, urethral diverticulum, urethritis.
- **Uterine and ovarian disorders** / adenomyosis, leiomyomata of the uterus, ovarian mass, prolapsed adnexa
- **Vaginal disorders** / atrophic vaginitis, vaginismus, vaginitis.
- **Vulvar disorders** / irritation from chemicals, herpes simplex virus infection, hypertrophic vulvar dystrophy, lichen sclerosis, vulvitis, vulvodynia, vestibulitis [11, 12].
- **Sexual arousal** / the role of sexual arousal in the etiology and/or maintenance of superficial dyspareunia is still unclear. Lack of sexual arousal may be both the cause and the result of anticipated pain.

Brauer et al conclude that, with adequate visual sexual stimulation, women with dyspareunia showed equal levels of genital sexual arousal to visual sexual stimuli as women without sexual complaints. Therefore, there was no evidence for impaired genital responsiveness associated with dyspareunia. Also, they found no evidence for a conditioned anxiety reaction in response to exposure to a coitus scene [13].

Following authors conclude that emotional appraisal of the sexual situation determines genital responsiveness in both, sexually dysfunctional and functional women [14].

Vaginismus

Vaginismus, with its associated defensive contraction of perivaginal muscles when intercourse is attempted, is credited to be the pelvic expression of a more general muscular defence posture, associated with a variable phobic attitude towards coital intimacy[4].

Vaginismus is subdivided into primary and secondary types. Primary dysfunctions represent longstanding developmental problems and are usually purely psychological in origin. Secondary dysfunctions occur after a period of normal sexual functioning and may be organic or psychological in origin [15]. Vaginismus may prevent intercourse in the most severe degrees, whilst in the milder ones it becomes a cause of dyspareunia[4].

However, recently research suggest that the spasm- based definition of vaginismus is not adequate as a diagnostic marker for vaginismus. Pain and fear of pain, pelvic floor dysfunction and behavioural avoidance need to be included in a multidimensional reconceptualization of vaginismus [16].

Definition of vaginismus includes “lifelong vaginismus”. Lifelong vaginismus is defined as “having a history of never having been able to experience penile entry of the vagina”.

Etiological factors connected with vaginismus are: sexual and physical abuse, sexual knowledge, sexual self-schema, disgust and contamination sensitivity. More women with vaginismus reported a history of childhood sexual interference, and women with vaginismus and VVS reported lower levels of sexual functioning and less positive sexual self-schema [17,18].

Vaginismus is the most prominent cause of the all cases of the unconsummated marriage. Dysfunction underlying non consummation of marriage is largely treatable. Adaptation to the situation usually occurs and associated factors add to the primary cause. Treatment of the underlying dysfunction can challenge the relationship [19, 20], cognitive-behavioural treatment of lifelong vaginismus was found to be efficacious, but the small effect size of the treatment warrants future efforts to improve the treatment [21]. As treatment based on Masters and Johnson’s therapy is a particularly aggressive kind of management, it is essential for the doctors to encourage vaginismus women and their partners to cooperate, change their attitudes and be more open to treatment [22].

Sexual disorders connected with pain but not connected with sexual intercourse

This group of pain ailments remains out of sphere of gynaecology’s diagnosis and therapy. Patients with such symptoms or complains should be guided to special psycho-sexual centres or pain treatment centres.

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