Dyspareunia
Developing a management plan

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Careful assessment is needed to determine the cause or causes of dyspareunia and to develop a management plan. As well as physical treatments, it may be necessary to arrange for psychological counselling or referral to a sexual counsellor or physician for both the woman and her partner.

Many women struggle to talk to their doctor about sexual difficulties, in particular dyspareunia. During a women's health check or at the time of a Pap smear, asking about urogenital symptoms may give the woman an opportunity to discuss these problems.

Dyspareunia is pain associated with intercourse (before, during or after), and can be present in any phase of a woman's adult life. It may occur early in a young woman's sexual life (primary, with the first intercourse), after childbirth or after the menopause, and also in the context of relationship difficulties or abuse. Dyspareunia may lead to significant distress, both physical and emotional, and to loss of sexual desire and sexual function, as well as to partner distress and relationship conflict. It is estimated to affect between 10 and 20% of women, with the highest prevalence in young women aged in their late teens to mid-twenties.

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Types of dyspareunia

Superficial dyspareunia

Superficial dyspareunia is pain on attempted penetration and is experienced as a burning, tearing feeling. It is due to:

- difference in size between a woman's introitus and the man's erect penis:
  - erect penis is large (size disparity)
  - introitus may be narrow in a young woman (due to an intact or thickened hymen or congenital abnormalities such as a vaginal septum)
  - loss of elasticity in the introitus leading to narrowing (after the menopause or vaginal surgery, or with skin conditions involving the vulva – such as scleroderma, lichen sclerosus)
- loss of lubrication caused by:
  - reduction in oestrogen levels (after childbirth when breastfeeding, after the menopause, following chemotherapy for cancer, with prolonged use of medicines such as depot medroxyprogesterone acetate or aromatase inhibitors)
  - lack of arousal (due to many reasons including stress, anxiety and partner issues)
  - prolonged vigorous or repetitive intercourse
  - erectile dysfunction causing introital trauma
  - infection, inflammation or skin disorders of the vulva and vagina from any cause (e.g. candidal infections, genital herpes, lichen planus or sclerosus, eczema and allergies to soaps, bath products, antiseptics and condoms)
- vaginismus – spasms of the pelvic floor muscles lead to a narrowing of the vaginal entrance
- vestibulodynia – there is no known cause for pain arising from the vestibule (around the vaginal entrance)
- pudendal nerve neuralgia or nerve entrapment – a rare cause.

DYSPAREUNIA: CASE STUDIES

Vignette 1
A 47-year-old woman presented with superficial dyspareunia since commencing a new relationship after years of being single. She had a past history of sexual abuse and drug addiction but was now living a normal life free of drugs. After several years of counselling, she was able to have a relationship with a very caring man. However, intercourse was too painful each time. Examination revealed vaginismus.

The woman was treated successfully with pelvic floor relaxation, trigger point therapy and dilators. At the same time, she recommenced therapy with a sexual counsellor.

Vignette 2
A 59-year-old woman presented with superficial dyspareunia caused by introital narrowing due to postmenopausal atrophy and scleroderma. The use of local oestrogen cream improved lubrication but the tightness persisted.

After much discussion, she and her husband decided that she would not have any treatment (such as a Fenton's procedure) to enlarge the vaginal entrance and they would cease having penetrative sex.

Vignette 3
A 24-year-old woman presented with increasing dysmenorrhoea and the onset of deep dyspareunia initially only with deep thrusting but now every time she has intercourse. She has seen doctors for dysmenorrhoea since she was 17 years of age but has never had any investigation. Vaginal examination revealed a tender nodule in the region of the left uterosacral ligament.

She was referred for transvaginal ultrasound and then to a gynaecologist for an operative laparoscopy to treat deep infiltrative endometriosis.

Deep dyspareunia

Deep dyspareunia is pain with penetration deep into the vagina associated with thrusting. It is felt as a burning, tearing, aching or sharp pain, and may continue after intercourse for a variable period of time. It is due to:

- normal anatomy with a retroverted uterus, especially premenstrually
- pelvic disease – caused by endometriosis, adenomyosis, fibroids, ovarian cysts, pelvic inflammatory infection or disease, bowel disease (such as inflammatory diseases), cystitis, adhesions following previous pelvic surgery or genital tract cancer.

History and examination

Diagnosing a cause or causes of the pain is essential when developing a management plan for a woman with dyspareunia.

A careful history should be taken, including the duration of the dyspareunia and the patient's past surgical and medical history as well as menstrual, obstetric and other gynaecological events, including sexually transmitted diseases. A psychosexual history that includes the woman's relationships and family is also necessary.

General examination may reveal abnormalities in the abdomen such as an abdominal mass or tenderness. A sensitive and careful gynaecological examination may elicit or provoke the pain and allow diagnosis. Normal anatomy does not preclude a diagnosis related to the pelvic tissues. For example, the introitus may look normal but mild stretching may cause the same sensations of burning and tearing that the woman experiences during intercourse. If the woman refuses examination because of pain then she may agree to examination under anaesthesia.

Management

Management of a woman with dyspareunia depends on the presentation, the woman's wishes in terms of outcome and the ability to provide appropriate management. Three case studies are discussed in the Box.

Treatment depends on the cause of the dyspareunia. As well as physical treatments, it may be necessary to arrange for psychological counselling or referral to a sexual counsellor or physician for both the woman and her partner, depending on the history.

Superficial dyspareunia

When a patient with superficial dyspareunia has tightness of the pelvic floor muscles, referral to a pelvic floor physiotherapist is recommended. The therapy may also include pelvic floor relaxation, trigger point therapy and dilator therapy.

If the vagina has signs of atrophy or dryness then lubricants, vaginal moisturisers and oestrogen vaginal preparations will improve lubrication.

Sometimes perineal massage with cream may help to stretch the vaginal entrance. If the introital tightness does not respond, referral to a gynaecologist for surgery such as a Fenton's procedure under local or general anaesthesia to enlarge the vaginal entrance would be recommended.

If a skin disorder, infection or inflammation is diagnosed then treatment of the specific condition is necessary, with possible referral to a dermatologist with an interest in vulval skin conditions.

Deep dyspareunia

Pelvic pathology needs to be excluded by investigating for the cause. Transvaginal ultrasound and referral to a gynaecologist for a diagnostic laparoscopy is appropriate. Once the diagnosis is made, the condition can be treated accordingly.

Conclusion

Dyspareunia is a distressing symptom that impacts on the woman's sexual desire and function as well as her sense of self-image and her relationship with her partner. Careful assessment is needed to determine the cause or causes and to develop a management plan. A multidisciplinary approach may be necessary. MT

Further reading

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