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When sex is not on fire: a prospective multicentre study evaluating the short-term effects of radical resection of endometriosis on quality of sex life and dyspareunia

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ABSTRACT

Objective: The aim of the current study was to evaluate the effect of surgical removal of endometriosis on dyspareunia, sexual function, quality of sex life and interpersonal relationships.
Study design: A questionnaire-based multicentre prospective study was conducted in six tertiary referral centres in Austria and Germany. Ninety-six patients with histologically proven endometriosis and dyspareunia were included. Before surgery and averagely 10 months postoperatively (range 9–12 months), the Female Sexual Function Index (FSFI) and the Female Sexual Distress Scale (FSDS) were used to screen women's sexuality. Additionally, we evaluated psychological parameters and pain intensity during/after sexual intercourse via a self-administered questionnaire.
Results: Pain scores measured via NAS during/after intercourse decreased significantly after surgery. Frequencies of interrupted sexual intercourse, feelings of guilt towards the partner, being afraid of pain before/during sexual intercourse and feelings of being a burden for the relationship also decreased significantly in patients with peritoneal endometriosis and deep infiltrating endometriosis. Interestingly, sexually related personal distress did not improve in women with peritoneal endometriosis/vaginal resection, but improved in cases of deep infiltrating endometriosis (DIE).
Conclusion: Radical laparoscopic excision of endometriosis offers an effective treatment option and offers a significant improvement in dyspareunia and quality of sex life.

Introduction

Endometriosis as one of the most common gynaecological diseases in women's reproductive years is defined as endometriotic tissue outside the uterine cavity. Tissue responds to the ovarian steroids and reacts in the same way as the endometrium during the menstrual cycle. Endometriotic lesions extending more than 5 mm underneath the peritoneal surface are defined as deep infiltrating endometriosis (DIE). Endometriosis has been shown to cause adhesions, local inflammatory reactions and pain symptoms such as dysmenorrhea, dyspareunia, chronic pelvic pain and/or a reduced level of fertility. In cases of bowel or bladder involvement, typical complaints are dyspareunia, dyschezia and dysuria [1]. This benign, but progressive and chronic disease affects approximately 2% of the general female population and about 50–70% of women with pelvic pain symptoms in their reproductive years [2]. Due to the proven diagnostic delay, patients experience disease-related symptoms between 3.3 years in China and 10.7 years in Austria and Germany before getting the correct diagnosis and treatment [3].

Literature shows the presence of endometriosis in 60–70% of women undergoing surgery for pelvic pain symptoms [4–6] and between 50% and 90% of those using hormonal therapies for

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chronic pelvic pain [7,8]. Dyspareunia, one of the most common symptoms, is classified into two types: superficial (pain in and around the vaginal introitus) and deep (pain with deep penetration) dyspareunia (SD, DD). In comparison with the general female population, women with endometriosis have a nine-fold increase in risk of dyspareunia [9]. DD is associated with deep infiltration of the cardinal and uterosacral ligaments, the pouch of Douglas (POD), the anterior rectal wall as well as the posterior vaginal fornix [10,11].

Dyspareunia not only causes pain, but also effects psychological and psychosocial wellbeing in symptomatic women. Within this, its presence is associated with a reduced number and/or interruption of sexual intercourses and a lower sexual function. Furthermore, feelings of fear before/during intercourse, emotions of guilt towards the partner and of being an insufficient woman are predominant. Not surprisingly, relationship and quality of sex life (QoSL) are affected distinctly by dyspareunia [12]. Consequently, endometriosis as a main causative factor for dyspareunia has been demonstrated to negatively effect psychosexual issues of couples with partners suffering from this disease [13]. The primary aim of endometriosis treatment is pain relief and improvement of quality of life. One possibility is hormonal treatment, but studies often show its limited efficacy regarding control of dyspareunia [6,14]. A further option is the radical resection of all visible endometriotic lesions, which requires a high level of technical competence in cases of extensive disease [15]. To date, there is a paucity of prospective studies evaluating the effect of radical resection of deep and peritoneal endometriosis and pain symptoms affecting sexual functioning.

The objective of the present analysis was to investigate the efficacy of surgical removal of endometriosis on dyspareunia, QoSL and predefined psychological parameters.

Patient and methods

Patient data

The present work was conducted in Austria and Germany in six participating certified tertiary referral centres for endometriosis. Between May 2011 and August 2012, consecutive symptomatic patients scheduled for surgical excision of endometriosis, were recruited prospectively. Patients with previous surgeries for endometriosis, pain symptoms of other origin (chronic disease other than endometriosis possibly causing pain symptoms) or a history of gynaecological malignancy/internal disease were excluded. Histological proof of disease was regarded mandatory.

Furthermore, only heterosexual women above 18 years of age and dyspareunia lasting for at least 6 months (and additional other pain symptoms related to endometriosis) and without any concomitant hormonal treatment (oral contraceptive pills, GnRH, etc.) within a period of 3 months onto the time of the surgical intervention until the point of postoperative symptom evaluation were invited to participate. Consecutive recruitment led to generation of data from 128 patients. Out of 128 women, one patient was homosexual and two patients did not provide informed consent and were excluded from the study in the first step (see Fig. 1). As stated, none of the included patients received hormonal treatment postoperatively. Patients gave written and

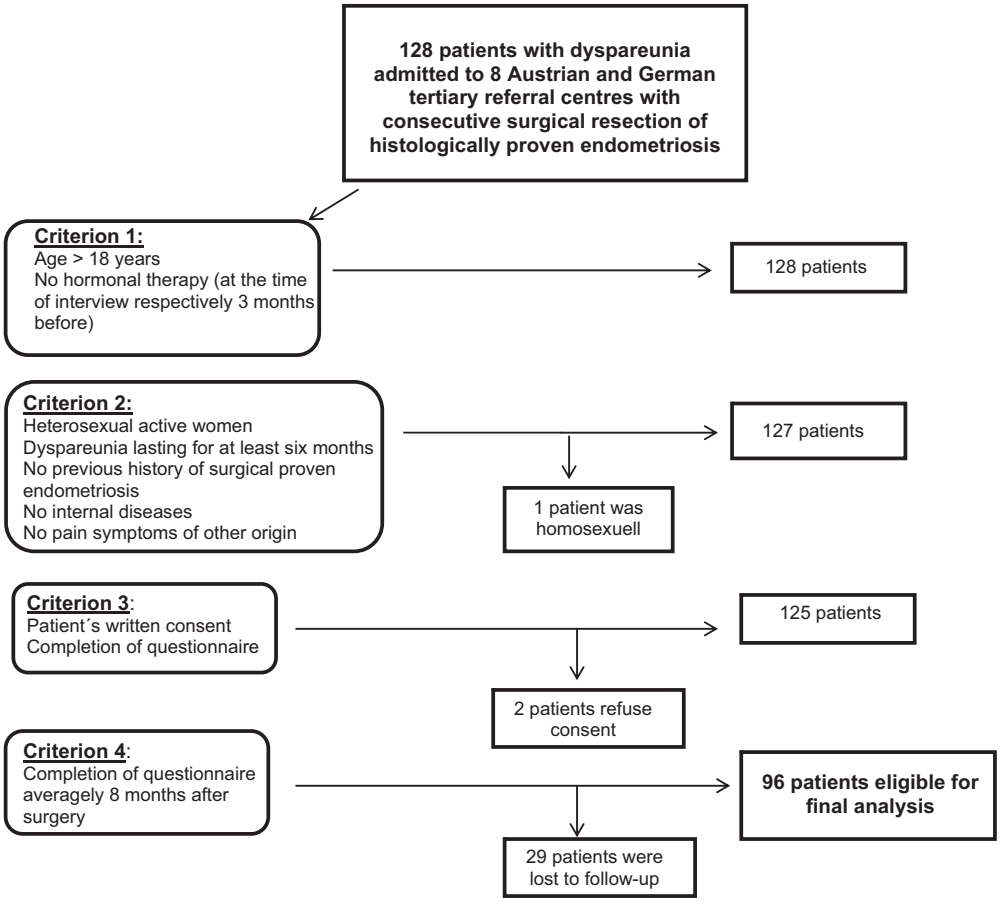

Fig. 1. Flow chart of study participants.