CME

Managing Pregnancy and Delivery in Women with Sexual Pain Disorders

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ABSTRACT

Introduction. Vaginismus and dyspareunia most commonly affect women in their childbearing years, yet sexual function, and not childbirth, has been the focus of most research.
Aim. The aim of this study is to discuss pregnancy and birth outcomes in women with sexual pain disorders (SPDs) and address practical concerns of patients and practitioners regarding management during pregnancy, pelvic examination, labor, and delivery.
Methods. Review of the relevant literature and recommendations based on clinical expertise of the authors.
Results. A review of SPD, conception, and birth outcomes is provided as well as clinical recommendations for prenatal, labor, and delivery management of women with SPD.
Conclusions. Practitioners involved in obstetrical care should be knowledgeable about SPD and provide appropriate modifications and interventions. **Rosenbaum TY and Padoa A. Managing pregnancy and delivery in women with sexual pain disorders. J Sex Med 2012;9:1726–1735.**

Key Words. Vaginismus; Vulvodynia; Pregnancy; Sexual Pain; Penetration Anxiety; Labor and Delivery; Dyspareunia; Pelvic Floor

Introduction

Sexual pain disorders (SPDs), including vaginismus and dyspareunia, are prevalent in women in their childbearing years [1]. Preventing or facilitating pregnancy are major concerns for premenopausal sexually active women, yet, research on vaginismus and provoked vestibulodynia (PVD), the most common cause of dyspareunia in this age group, has focused mainly on sexual function. There is a paucity of literature related to pregnancy and birth concerns in this population.

The proposal to replace the two Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) sexual dysfunction categories of vaginismus and dyspareunia with "genito-pelvic pain/penetration disorder" [2,3] reflects a conceptual shift away from considering these conditions only within their sexual context and toward recognizing them as pain disorders with nonsexual sequelae as well [4]. This is of particular significance to practitioners who may be consulted regarding contraceptive advice, pelvic examination, the appropriateness of fertility intervention in couples without organic infertility, or a preferred mode of delivery.

The practical concerns of patients with SPD who wish to prevent pregnancy include determining the necessity for birth control when no penetrative sex occurs and the appropriate type of birth control to use when oral contraceptives are discouraged [5], when barrier methods are painful and when physicians are hesitant to insert an intrauterine device because of nulliparous status. The practical concerns of patients who desire a pregnancy are far more extensive. These concerns

include the facilitation of pregnancy without intercourse, the need for lubrication or topical anesthetics that may potentially harm sperm, the safety of conceiving while being managed with oral and topical agents including antidepressants, anxiolytics, myorelaxants, and gamma-aminobutyric acid (GABA) analogues as well as their safety throughout pregnancy. Additional concerns include the safety of physical therapy (PT) during pregnancy including the use of dilators, biofeedback, manual therapy, and other interventions. Women with SPD contemplating pregnancy or already pregnant may be particularly concerned about the need for pelvic examinations and internal ultrasounds. In the clinical setting, women express concern about the effect that pregnancy and birth will have on their pain symptoms, the preferred mode of delivery, pain management during labor and delivery (L&D), the need for internal examination prior to delivery and whether they are at higher risk for birth intervention. While physicians may anticipate that vaginal birth improves SPD symptoms due to the stretching effect on pelvic floor (PF), there is to date insufficient evidence to support this claim.

Alternately, as sexual history taking is not a standard component of prenatal, L&D or ultrasound technician's intakes and pregnant patients with SPD may be embarrassed about revealing that they have not undergone an exam or had intercourse, these women may be particularly vulnerable to a potentially traumatic experience. It is, therefore, important that practitioners screen women for this possibility and reveal knowledge, understanding, and cooperation with these situations.

The purposes of this Continuing Medical Education (CME) activity are to present a review of the literature related to pregnancy and birth outcomes in women with SPD, briefly address the aforementioned practical concerns of patients, discuss L&D techniques directed toward avoiding perineal trauma and introduce practitioners to a mindfulness-based approach to addressing pelvic exams, labor, and childbirth anxiety.

SPDs and Conception

Vaginismus and PVD are common conditions affecting about 5% and 12% of women, respectively [6,7]; nevertheless, little is known about their impact on fertility, pregnancy, and childbirth. Despite the focus on the patient's subjective experience of sexuality, failure to conceive may be a primary concern for women suffering from SPD.

There are little data regarding the incidence of couples presenting for fertility treatment who may not have organic infertility but who do not engage in sexual intercourse. In 1988, Drenth reported on four women who considered vaginismus to be primarily a fertility problem. Self-insemination with semen from their partner proved to be a simple and effective solution, resulting in three pregnancies [8]. In a larger series published 8 years later, the author reported that desire for a pregnancy might have been a significant motivating factor in successfully achieving intercourse in the 74% of 57 vaginismus patients who conceived naturally. Nine patients reported having conceived through self-insemination leading the authors to conclude that self-insemination is a good solution for SPD patients who seek fertility as a first priority [9].

In a study published in 2009, Jindal and Jindal reported that of 5,341 infertile couples seen over an 8-year period, 76 (1.4%) had primary vaginismus. Sixty-three patients were treated with the use of a simplified sensate focus technique. There was complete symptomatic resolution of vaginismus in 60 women, and 52% conceived spontaneously. Although the authors do not specify how long it took to achieve those pregnancies, the treatment protocol was completed in 6 weeks [10].

Conception Concerns

Women with SPD often require the use of lubricants and/or topical anesthetics in order to allow intercourse and may express concern that they impair sperm motility. Anderson et al. found baby oil to have no negative effect on sperm motility [11]. The extent to which other commonly used oils such as olive, almond, or wheat germ may impair sperm mobility is unknown, yet appear to be a better choice then chemical lubricants for patients wishing to conceive. Recently, a lubricant was designed and marketed which, according to a recent study by Agarwal et al., does not cause a decrease in sperm motility and chromatin integrity in comparison with other common lubricants [12]. No data were found regarding whether the use of lidocaine may impair sperm motility. Many women with SPD are treated with topical or intravaginal agents that include gabapentin, baclofen, diazepam, and amitriptyline. Patients wishing to conceive should avoid these agents.