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Impact of Mode of Delivery on Female Postpartum Sexual Functioning: Spontaneous Vaginal Delivery and Operative Vaginal Delivery vs Cesarean Section

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ABSTRACT

Introduction: Several studies have explored the association between modes of delivery and postpartum female sexual functioning, although with inconsistent findings.

Aim: To investigate the impact of mode of delivery on female postpartum sexual functioning by comparing spontaneous vaginal delivery, operative vaginal delivery, and cesarean section.

Methods: One hundred thirty-two primiparous women who had a spontaneous vaginal delivery, 45 who had an operative vaginal delivery, and 92 who underwent a cesarean section were included in the study (N = 269). Postpartum sexual functioning was evaluated 6 months after childbirth using the Female Sexual Function Index. Time to resumption of sexual intercourse, postpartum depression, and current breastfeeding also were assessed 6 months after delivery.

Main Outcome Measures: Female Sexual Function Index total and domain scores and time to resumption of sexual intercourse at 6 months after childbirth.

Results: Women who underwent an operative vaginal delivery had poorer scores on arousal, lubrication, orgasm, and global sexual functioning compared with the cesarean section group and lower orgasm scores compared with the spontaneous vaginal delivery group ($P < .05$). The mode of delivery did not significantly affect time to resumption of sexual intercourse. Women who were currently breastfeeding had lower lubrication, more pain at intercourse, and longer time to resumption of sexual activity.

Conclusion: Operative vaginal delivery might be associated with poorer sexual functioning, but no conclusions can be drawn from this study regarding the impact of pelvic floor trauma (perineal laceration or episiotomy) on sexual functioning because of the high rate of episiotomies. Overall, obstetric algorithms currently in use should be refined to decrease further the risk of operative vaginal delivery.

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Key Words: Postpartum Female Sexual Function; Mode of Delivery; Pregnancy; Vaginal Delivery; Cesarean Section

INTRODUCTION

Several studies have demonstrated that female postpartum sexual functioning should be considered a complex phenomenon that can considerably affect female sexuality and the quality of intimate relationships.[1,2] According to the World Health Organization, "all women should be asked about resumption of sexual intercourses and possible dyspareunia, as a part of an assessment of overall well-being two to six weeks after delivery."[3]

Women's postpartum sexual functioning can be influenced by hormonal variations and by the physical changes in female genitalia caused by childbirth. Research has shown that women in postpartum can have problems in the resumption of sexual

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intercourse, loss of desire, dyspareunia, lack of lubrication, pain, and decreased orgasmic capacity.[1,2,4–7] Loss of desire and dyspareunia should be considered the predominant sexual problems, with a prevalence ranging from 22% to 86%.[1,4]

Postpartum hormonal status and breastfeeding can be associated with low desire, arousal and lubrication problems, and difficulties in achieving orgasm.[8,9] Postpartum sexual activities also can be influenced by psychological factors, such as depression, anxiety, parenting stress and fatigue, and body dissatisfaction.[2,8–10] Moreover, experiencing pain during intercourse can inhibit the sexual response cycle, with negative effects on multiple dimensions of female sexuality.

Recent studies have shown increasing interest in exploring the association between women's postpartum sexual function and mode of delivery, although with inconsistent findings.[7,11–31] Overall, elective cesarean section (CS) and vaginal delivery with an intact perineum seem to play a protective role for postpartum female sexuality.[7] The available evidence suggests that cesarean delivery could prevent the development of pelvic floor relaxation and pudendal neuropathy, whereas vaginal delivery, especially when operative, could have detrimental effects on desire, arousal, time to resumption of sexual intercourse, pain, and sexual satisfaction.[13,20,28–34] According to the findings of a recent British survey, a large proportion of female obstetricians would choose an elective CS for themselves to avoid the risk of pelvic floor injuries and future sexual dysfunctions involved by vaginal delivery.[35,36] The increase in elective CSs in Europe and other countries, such as in Latin America, might be due in part to this belief.[37–39]

Other studies have shown inconsistent findings regarding elective vs emergency CS or eutocic vs operative vaginal delivery (OVD).[1,4,10–27] Therefore, no firm conclusion can be drawn about the association between mode of delivery and postpartum sexual functioning.

These discrepancies might be due to differences in the methodology adopted, populations examined (eg, nulliparous vs multiparous women), type of sexual questionnaires administered, sexual outcomes chosen, follow-up duration, and indications for mode of delivery. Indeed, some studies have focused only on short-term sexual outcomes[11,25] and others have used nonvalidated questionnaires.[1,4,10–12,14,16]

AIMS

In the present study, we compared the impact of two types of vaginal delivery (spontaneous vaginal delivery [SVD] and OVD) with CS on female postpartum sexual functioning. Our main hypothesis was that vaginal delivery (spontaneous or operative) would be associated with worse sexual outcomes and longer time to resumption of sexual activity compared with CS. These worse outcomes for the two vaginal delivery groups were expected because several studies have demonstrated that vaginal delivery itself can have a detrimental effect on the pelvic floor and can cause pudendal neuropathy; these types of damage might be associated with impaired postpartum sexual functioning.[13,20,28–34] The worst outcomes are expected for OVD—which in Italy involves the use of vacuum extractor—because it can cause more severe injuries to pelvic floor muscles, nerves, and connective tissue.[7,28] Moreover, this study aimed at evaluating the impact of two potential confounders: diagnosis and treatment for postpartum depression and current breastfeeding.

METHODS

Participants and Procedures

The present study is part of a larger research on the mode of delivery and pelvic floor dysfunction. The investigation was conducted during 2013 at the Department of Women's and Children's Health, Fondazione IRCCS Ca' Granda, Ospedale Maggiore Policlinico, Milan, Italy. Institutional review board approval for the study was obtained. Women were consecutively recruited during the first 3 days after delivery before discharge from the hospital. At recruitment, trained researchers provided complete information about the aims and methods of the study and clarified all aspects of the research protocol. Written informed consent was obtained from all women who agreed to participate in the study.

Women were eligible if they were Caucasian primiparous women 18 to 45 years old, could understand and speak Italian, had a body mass index lower than 30 kg/m^2, and delivered at 37 weeks of gestation or later. Patients in the CS group were eligible only if they had an elective CS (owing to breech presentation, maternal request, medical maternal, or fetal indications) or a CS during labor but performed at a cervical dilatation less than 3 cm to avoid the potential confounding effect of labor. Therefore, women who underwent emergency CSs at a more advanced stage of cervical dilatation (ie, >3 cm, because of failure of induction of labor or non-reassuring fetal heart rate patterns) were excluded. Other exclusion criteria were multifetal gestation, history of chronic maternal illness (eg, diabetes mellitus and cardiovascular, neurologic, and renal diseases), and gestational complications such as preeclampsia, deep vein thrombosis, placenta previa, or antepartum or postpartum hemorrhages.

At recruitment we collected sociodemographic (age, level of education, current occupation, and smoking habits during pregnancy) and anthropometric (height and weight) data; information on female sexual functioning before delivery (ie, in the third trimester of pregnancy) also was gathered retrospectively. Six months after delivery, we assessed postpartum sexual functioning, time to resumption of sexual intercourse, diagnosis and treatment of postpartum depression, and current breastfeeding. The characteristics of the vaginal deliveries (type of episiotomy, degree of perineal laceration, use of vacuum extractor, and duration of the second stage of labor), indications for cesarean deliveries, and neonatal weight were retrieved from the hospital medical records.

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