Dyspareunia: a difficult symptom in gynaecological practice

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Abstract

Dyspareunia is recurrent or persistent genital pain associated with sexual intercourse. It is a symptom that can have a significant impact on women's health, relationships and quality of life. There are multiple different causes for it, including both organic and psychosexual components. Despite the high prevalence of sexual pain, estimated to between 3 and 18% worldwide, few guidelines exist for its evaluation and management. Adequate assessment requires a comprehensive sexual history, a systematic and thorough examination of the lower genital tract to rule out anatomical causes and an exploration of potential psychosexual causes. Further investigations may include swabs and a pelvic ultrasound scan. In some cases a diagnostic laparoscopy may be required if there is evidence of endometriosis or utero-vaginal pathology that does not respond to conservative management. This article considers the diagnosis and investigation of women complaining of dyspareunia.

Keywords chronic pelvic pain; dyspareunia; endometriosis; pelvic inflammatory disease; vaginismus; vulvodynia

Introduction

Dyspareunia is defined as recurrent or persistent genital pain in association with sexual intercourse in either the man or the woman (although it is more common in females) which causes marked distress or interpersonal conflict. It can be superficial or deep, the latter sometimes associated with endometriosis or pelvic inflammatory disease. The combinations of biological, psychological and interpersonal factors are all important factors in the development of this often neglected symptom.

Patients can present with well-defined pain or a general dissatisfaction with sex due to discomfort. Obtaining a psychosexual history can provide key information about predisposing factors such as cultural influences on sexuality and possible relationship problems or a history of abuse. This article reviews the causes of dyspareunia and outlines assessment and investigation of it. The management of the variety diseases which cause dyspareunia are discussed in other articles.

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Epidemiology

Sexual problems can occur in heterosexual and homosexual relationships. They are reported by almost 43% of women. Between 16% and 75% of women have problems with desire, 16%–48% with orgasm, 12%–64% with arousal, 7%–58% with dyspareunia and 21% with genital lubrication. A recent study found two-thirds of over-60s in the United States were sexually inactive. From the remaining third, 12% who were married had difficulty with intercourse and about 13% experienced dyspareunia. Studies of middle-aged women estimated sexual dysfunction at 33% in the UK. A third of these had at least one defined sexual dysfunction but only 10% thought they had a sexual problem. If few women perceive sexual dysfunction to be a problem, it may explain in part, why not many seek medical attention for these conditions, making it difficult to determine the incidence. Known risk factors include generalized poor health, urinary tract disorders, low socioeconomic status, young age and a history of emotional difficulties.

Aetiology

Dyspareunia is a symptom of a variety of disease states which can have both organic and psychological dysfunction components. There are many ways of classifying dyspareunia; based on cause, onset, frequency or location.

Cause

Medical: for example; endometriosis.
Psychological: for example; following sexual abuse.
Mixed: for example; a history of endometriosis and therefore an association of pain with sexual intercourse, causing anxiety around it and exacerbating the problem.

Onset

Primary (onset with the first sexual experience):

- Congenital abnormalities
- Psychosocial causes
- Sexual abuse in childhood
- Fear of intercourse or painful first intercourse

Secondary (previously normal sexual function):

- Causes are usually physical but often investigations find no cause. Psychological support may be needed.

Frequency

Persistent: Symptoms occur with all partners in all situations.
Conditional: Symptoms occur with certain positions, type of stimulation or specific partner.

Possible causes for both include physical and psychological factors.

Location (Table 1)

Superficial or insertional: defined as sharp, burning or stinging pain at or near the vaginal introitus on penetration. Commonly found in patients with vulvodynia and vaginismus. Superficial dyspareunia may be also associated with myofascial dysfunction of the perineal body. Other frequent causes include infections such as monilia, herpes, trichomonal vulvovaginitis or

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Causes according to location of dyspareunia

Superficial	Deep
Infection	**Infection**
Vulvovaginitis (monilial, herpes and trichomonal)	Pelvic inflammatory disease (pyosalpinx and salpingo-oophoritis)
	Chronic cervicitis
	Repeated cervical trauma
Vulval disease	**Pelvic disease**
Generalized vulvodynia	Endometriosis
Vestibulodynia	Fibroids
Bartholin's cyst	Ovarian cysts/tumours
Vulval dystrophies/dermatoses	Pelvic congestion
Lichen sclerosis	
Carcinoma of vulva	
Postmenopausal	
Atrophic changes	
Psychosexual	
Vaginismus	
Post surgery	**Post surgery**
Obstetric sequelae (narrowing of the introitus, episiotomy scar)	Related to childbirth
	Pelvic floor repair
	Vaginal mesh
Pelvic floor repair	Total hysterectomy
Perineorrhaphy	
Congenital	**Congenital**
Vaginal atresia	Incomplete vaginal septum
Vaginal septum	
Urological disorders	**Urological disorders**
Urethritis	Interstitial cystitis/painful bladder syndrome
Interstitial cystitis/Painful bladder syndrome	
Bowel disorders	**Bowel disorders**
Irritable bowel syndrome	Irritable bowel syndrome
Proctitis	Chronic constipation
	Diverticular disease
Neurologic disorders/muscular abnormalities	
Pudendal nerve lesions	
Pelvic floor hyper-hypotonicity	

Table 1

menopausal changes (vaginal atrophy). A Bartholin's abscess, previous surgery and childbirth can also be causes of superficial dyspareunia.

Deep: defined as pain felt within the pelvis associated with penetration deep within the vagina. Possible causes include endometriosis, previous surgery, pelvic tumours, pelvic inflammatory diseases and/or a retroverted uterus. Different sexual positions may be relevant in aetiology. Some patients felt pain when the penis made contact with the cervix, which can become sensitised by chronic cervicitis and repeated procedures (e.g. biopsies and/or conisation). Pain that comes with orgasm or lasts for several days may suggest obturator internus related myofascial dysfunction (Box 1).

Classification of vulval pain according to the International Society for the Study of Vulvovaginal Diseases (ISSVD)

Vulval disorders

- Vulvodynia
  - Generalized
    - Provoked (sexual, non sexual, or both)
    - Unprovoked
    - Mixed
  - Localized (vestibulodynia, clitorodynia)
    - Provoked (sexual, non sexual, or both)
    - Unprovoked
    - Mixed
- Vulval pain related to a specific disorder
  - Infections (Candidiasis, herpes)
  - Inflammatory (Lichen sclerosis, lichen planus)
  - Neoplastic (paget's disease, squamous cell carcinoma)
  - Neurological (herpes neuralgia, spinal nerve compression)

Box 1

History taking

Women rarely present with dyspareunia symptoms alone, it is often an accompanying symptom that has to be raised in closed or direct questioning. For some patients, the issue of dyspareunia may be harder to extract.

A patient's narrative of her illness and asking her what her concerns are, provides essential information. As well as pain, she may feel a wide range of emotions including, embarrassment, guilt, loss of self-esteem, frustration, depression and anxiety.

Creating an understanding, professional atmosphere during the consultation can improve doctor–patient relations and enhance openness and confidence. The patient must be made to feel that she has adequate time allocated for her and it is helpful to have no more people in the consultation room than is necessary.

Unless the patient raises the topic early on, it is generally advisable to ease into questioning about difficulties with sexual intercourse. Once it has been established that dyspareunia is a problem, then more systematic questioning can begin. Below is a list of useful questions. Be flexible and cover further areas as dictated by the nature of the consultation.

Specific questions

- How long has this been a problem?
- How would you describe the pain? Sharp, dull, burning, cutting, or throbbing?
- Is it getting better, worse or staying the same?
- Have you had pain ever since the first time you had intercourse or did it develop later on?
- Does it occur in every episode of intercourse?
- How often (approximately) do you have sex?
- Does the pain occur during superficial or deep penetration?

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