MEDICAL PRACTICE

Gynaecology in General Practice

Dyspareunia

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Dyspareunia means sexual intercourse which is painful or difficult and includes vaginismus, a condition where the lower vagina is constricted by involuntary muscle spasm.

The Complaint

Though many women attend for consultation with a clear history of dyspareunia, for a variety of reasons some will be deterred from seeking medical advice or will change the complaint. For example, a woman may meet a friend in the waiting room, be perturbed by the murmur of conversation from the doctor's office, or be put off by finding a less well-known, or younger, doctor consulting; she may then produce a quite misleading but more acceptable and less embarrassing complaint, such as dysmenorrhoea or menorrhagia. Indeed, she may be quite decided from the outset that nothing would induce her to refer to her true complaint and still be hopeful that her doctor will elicit the symptom. Close questioning and leading questions are therefore necessary.

At the other end of the scale is the woman who finds the sexual attentions of her husband distasteful and who takes refuge in the complaint of pain. Though some degree of pain or discomfort may be quite real, there is the implication that this is not the normal discomfort of a woman not lubricated by sexual arousal but some more precise pathological condition. Her husband, too, may have driven her to the doctor out of concern or frustration.

Others may complain at length about dyspareunia and only when the consultation is nearly over let it slip out that the real problem is fertility and that they wish sterilization.

Yet other patients may present as infertile, and only pelvic examination will show that the problem is apareunia due to vaginismus. This is particularly likely when the woman has been married for a long time and is ashamed to confess to non-consummation. These are just a few of the diverse ways in which dyspareunia is encountered.

History

The real complaint therefore may emerge only on taking a comprehensive gynaecological case history. In addition the patient must then be questioned about her social and personal background. What is her sexual knowledge and that of her husband? Is he clumsy? Does she require and achieve other forms of sexual release? Does penetration occur, and if so is the pain superficial or deep; does it occur always and if not when? What is her social and religious background? Do the family have special problems, either financial or social (such as living in a room in a parent's house), which can inhibit their sexual relationship? Do they work long hours and in the evenings? Is contraceptive knowledge and technique satisfactory? What is the marital relationship? In all these matters it is impossible to overemphasize the ignorance often encountered in these patients.

Details of past disease and operations will, of course, be taken. Many patients will relate the complaint to some specific events, and these may include childbirth, an episiotomy, or a repair operation. Though in general this explanation must be taken at its face value, the woman whose complaint is entirely social will often relate it to some coincidental event.

The interview should be conducted in reasonable privacy. Treatment for dyspareunia tends to be perfunctory and unsatisfactory, because too much emphasis is placed on finding a mechanical or pathological explanation and also because any treatment is very time-consuming for the doctor. If sufficient

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time is not available it is probably better not to embark on investigation at all, unless a definite lesion is noted or suspected.

Investigation

An attempt at pelvic examination may be the first indication that the complaint is vaginismus, either primary or secondary to dyspareunia. The patient may retreat to the end of the couch with thighs firmly adducted and flexed, and only patient persuasion will permit examination. To persist despite obvious distress can only do harm. To tell the genuine patient not to be foolish will merely convince her that her problem is not understood at all. In patients with less severe vaginismus who permit examination the lower part of the vagina is found to be constricted by muscle spasm. This gentle examination has great therapeutic value.

CLINICAL EXAMINATION

Patients with no vaginismus should have a general examination of the pelvis carried out, any lesion noted, and any discharge taken for laboratory examination. The cervix is exposed by speculum. With digital examination it may be possible to reproduce the pain by moving the cervix or by pressure through the fornices on pelvic masses, areas of endometriosis, or scars.

LAPAROSCOPY

Examination under a general anaesthetic may be required because of tenderness or, more commonly, lack of relaxation. When there is doubt about the findings laparoscopy can clear up the diagnosis. This technique is of particular help when a woman is perfectly clear about her complaint of deep dyspareunia, and no abnormality is felt at vaginal and rectal examination, but when it seems unlikely that the problem is social. A surprising variety of lesions (such as endometriosis or pelvic sepsis) can be discovered in the absence of physical signs on pelvic examination. Laparoscopy, too, is an easy, acceptable investigation where laparotomy would be contraindicated. The latter is strongly contraindicated when the problem is social and when it is doubtful whether there is any pelvic disease. These women may have an insoluble social problem but even a negative, though painful, laparotomy will give further credence to the view that the problem is at least partly due to some physical abnormality.

Prevention

Iatrogenic dyspareunia most commonly follows pelvic floor repair or episiotomy suture. It should not be assumed that a patient is not sexually active unless she says so, and the repair should be modified to suit her needs. The patient should be assessed when conscious. It is better to leave redundant mucosa than to risk removing too much and thereby cause insuperable dyspareunia. The perineum should be left rounded, without a useless shelf of skin which may be painful and by its presence cause the urethra to be traumatized at penetration. The patient should be aware of any change in anatomy which may require a different technique. Pelvic examination with a lubricant before discharge from hospital will prevent dyspareunia due to adhesions forming between the anterior and posterior vaginal incisions.

After any surgical procedure or the use of radium the patient should be clearly told when intercourse can be resumed. Fear of damage and infection or the expectation of total loss of sexuality may lead to long spells of abstinence, and when attempts at last are made they may be accompanied by pain because of advanced involutional changes.

Treatment

LOCAL CONDITIONS

In the treatment of simple local conditions, such as infections and senile vaginitis, for example, the patient should be followed up if her initial complaint was dyspareunia, because these women may be diffident about seeking another interview if the complaint continues. Senile vaginitis may be treated with oral or vaginal oestrogens. The latter are messy and sometimes not well absorbed. Oestriol, in the form of Ovestin, can be given in doses of 0·25 mg three or four times a day without causing uterine bleeding, and it is effective in building up vaginal epithelium.

Pelvic sepsis, cervicitis, and endometriosis all respond to current standard treatment, though in a few resistant cases a more radical, surgical approach may be required.

RETROVERTED UTERUS

There are many cases where some abnormality is found, but which should not be immediately or energetically treated, since it may be coincidental.

A retroverted uterus will rarely cause dyspareunia, though dyspareunia and retroversion are both common. Surgical intervention will, however, be effective in carefully selected cases, but even then a high failure rate must be accepted. Patients can be selected by reproducing the pain on pressing the uterine fundus and by finding the story consistent. Pain may be absent in the mobile retroversion when a coital position is adopted—for example, male inferior—to ensure that the uterus is not lying fully retroverted. But in no case should there be ready recourse to surgery. Laparoscopy may show adhesions between the uterus and the rectum and an excess of free fluid in the pouch of Douglas. Though surgical intervention should eventually be undertaken in these cases, the fixity of the tissues round the vault of the vagina may continue to cause pain during excitation and orgasm, even after treatment. Tender, prolapsed ovaries may cause deep dyspareunia and a similar approach is indicated here, with no ready recourse to surgery.

Scarring in the parametrium may result from childbirth or cervical dilatation. These tender scars can be excised satisfactorily, using the vaginal route. But again it is advisable to be diffident about early surgery, except in the most obvious cases with a good related history of onset.

VAGINAL ABNORMALITIES

Vaginal abnormalities with bands and septa respond readily to surgery, but, since the wounds heal by scarring, the vagina must be kept expanded, except in the slighter defects, by wearing an obturator. In all but the most rigid hymens incision is not required, and the problem is psychological and social rather than mechanical.

UNKNOWN CAUSE

Finally, there is a group in which no abnormality can be detected. Some of these cases will have vaginismus as a primary complaint, with attempts at penetration causing pain. Others may have primary dyspareunia with secondary vaginismus of mild degree because pain is expected. In either group incision of the perineum or a Fenton's operation will rarely do more than add a sore incision to the pain of dyspareunia. Unfortunately, the patient will often very readily accept the information that she is small and that the problem is mechanical. Follow-up, too, is often rudimentary and, as in all methods of treating the complaint, the patient in the busy

surgery or outpatient department tends to exaggerate her improvement.

It seems true that only those cases where the abnormality follows an over-enthusiastic repair or incorrectly sutured episiotomy and a very few others where there is a distinct, anatomical defect, will be successfully treated by surgery. In all other cases, after interview and when abnormality has been excluded—if necessary under general anaesthesia—an interview should be sought with the husband. He may be unbelievably ignorant about sexual affairs, including anatomy. He may have premature ejaculation and this may be the cause of apareunia, and the wife, out of ignorance or loyalty or because she has been told the fault is hers, accepts this. Also, if he very clearly will not co-operate in treating the problem nothing can be done, apart from clarifying the situation to them. To involve the husband in the treatment will ensure that any advice given to the woman will be correctly related to her husband. A three-cornered discussion and reassurance about the commonness of the complaint and the excellence of prognosis may lessen anxiety and even be all that is required in the way of treatment.

VAGINISMUS

Dilators can be very successful in the treatment of vaginismus. After the problem has been fully explained the patient is given rectal or vaginal dilators. The former are preferable in severe cases where it may be difficult to insert the smallest vaginal dilators. The patient, or her husband under her direction, can use these until she can readily accept a large dilator. It should be explained that their function is to give confidence and not forcefully to dilate a small vagina; until a large dilator can be accepted there should be no attempt at penetration, and indeed it is better expressly forbidden.

Unfortunately, patients with vaginismus are often treated like those with dysmenorrhoea and menorrhagia. They are examined under anaesthesia; they may then be issued with dilators and asked to report to an outpatient clinic in a month or more. If the first attempt to use the dilators fails, the month has been lost and the patient confirmed in her view that the condition is incurable. A weekly attendance at the outpatient clinic is the longest acceptable interval consistent with most gynaecologists' weekly timetable.

FAILURE OF LUBRICATION

In other cases of dyspareunia where there is no physical abnormality the elementary point that pain or discomfort is normal when there is no lubrication from excitation may have to be explained. The husband and wife should be told that the woman should completely control the technique so that there is no pain and maximal arousal. The sexual habits of different groups and individuals must be taken into account in discussing this. A small group of people are extraordinarily ignorant about these matters and have failed to learn from experience, because of a failure to communicate with each other. Quite often there is also limited sexual drive in these marriages, though this may not be an entirely primary cause but may be induced by the dyspareunia.

Fear of pregnancy may cause failure of lubrication with increasing dyspareunia, and the remedy is clear. Coitus interruptus, or a mechanical method not acceptable to the woman, may result in frequent frustration with resultant dryness and pain. Sensitivity to rubber or creams and jellies will be apparent from the history.

OTHER FACTORS

Some patients will require specialized psychiatric help in dealing with the whole problem. Where the problem is a basic misalliance dyspareunia can be normal and expected, and an investigative or surgical approach will make no useful contribution. In addition, it cannot be assumed that the patient will have full insight into the cause of her complaint.

Clinical Problems

Management of Enuresis

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Summary

In 144 enuretic children at four Southwark school health service clinics a good measure of success was achieved by sympathetic handling alone. Most of the remaining patients responded to a buzzer; nevertheless, its use needs to be carefully presented and supervised. The use of drugs is questioned.

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Introduction

The treatment of nocturnal enuresis in children is by no means uniform. The methods used vary from leaving the child "to grow out of it" to drug therapy, with or without the use of conditioning apparatus. The following is an account of successful management without the use of drugs.

Patients

The children were treated at four special investigation school clinics of the London Borough of Southwark. The subjects discussed in this survey consisted of all enuretic children seen over the four-year period 1965-9 who were wet at least three times a week and who attended the clinics on two or more