



Dyspareunia

Common Causes & Treatments

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Introduction

- Program in Vulvar Health at OHSU
- Multidisciplinary treatment team care model.
- I may use the term “women” in this talk, but all of the concepts apply to patients who identify as trans men, non-binary or queer



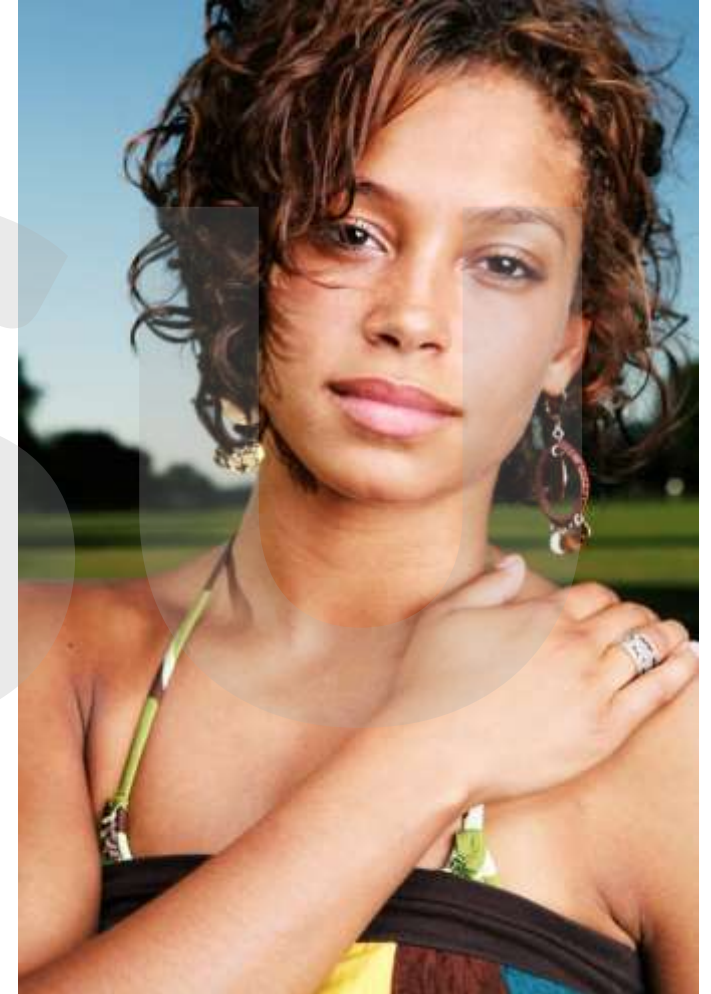
Objectives

- Define, diagnose and manage 3 common causes of dyspareunia
 1. Genital Syndrome of Menopause (aka “atrophic vaginitis”)
 2. Provoked Localized Vulvodynia or Vestibulodynia (aka “vulvar vestibulitis”)
 3. Levator Myalgia or Vaginismus
- Appreciate the impact on sexual expression

No Disclosures

Dyspareunia

- Definition: Recurrent or persistent genital pain associated with vaginal penetration causing personal distress
 - Introital: “Does it hurt just with penetration?” or “Does it hurt at the time of insertion of a finger, speculum, tampon or penis?”
 - Deep: “Does it hurt deep inside the pelvis, like with thrusting?” or “Does it feel like a pain, ache, stab more inside the vagina as opposed to just at the opening?”
- 8-22% of the general population
 - Women >> men
 - Risk factors: PID, sexual abuse, low estrogen state, depression-anxiety



Evaluation



Office Evaluation: History

- Quality: onset, frequency, location, severity, circumstances, description of pain, associated symptoms like bleeding or vaginal discharge
- Co-morbidities: fibromyalgia, Interstitial cystitis, IBS, mental illness, Chronic Pelvic Pain (CPP)
- Exposure to contact irritants/allergens: spermicide, lubricants, intra-vaginal products (enhancing gels, toys), cleaning habits of toys
- Hormonal status : Estrogen replete vs depleted (postpartum, menopause, anti-estrogen breast cancer treatment)
- Skin changes: symptoms of itching, ulceration, fissures or skin breakdown
- OTC or other treatments tried: anti-fungal, antibiotics, steroids, lidocaine, hormones

Office Evaluation: Objective Data

- Physical Exam
 - Visual inspection of vulva , perineum, anus & vagina (speculum)
- Microscopy
 - pH immediately (normal=3.5-4.5)
 - NaCl and KOH: fresh prep or suspend in saline
 - APTIMA or BD AFFIRM vaginal swab (POC): appropriate if suspect vaginitis
- Vaginal Culture
 - Fungal culture helpful for identification and speciation of yeast
 - General bacterial culture not helpful
- Vulvar Biopsy
 - Reserved only for SKIN CHANGES, Random biopsy not helpful
 - **Careful not fooled by the blush of erythema in the vestibule (vestibulodynia)
- Pelvic Ultrasound
 - Appropriate when pelvic mass suspected or deep pain elicited on pelvic exam

Causes of Dyspareunia

- Provoked Localized Vulvodynia or Vestibulodynia
- **Genital Syndrome of Menopause or “atrophic vaginitis”**
- Levator myalgia or Vaginismus
- Poor arousal
- Vulvar dermatologic disorders (Lichen sclerosus, etc)
- Chronic Vaginitis (Yeast)
- Chronic Pelvic Pain
- Endometriosis
- Fibroid Uterus
- Interstitial Cystitis
- Ovarian cysts
- IBD/IBS

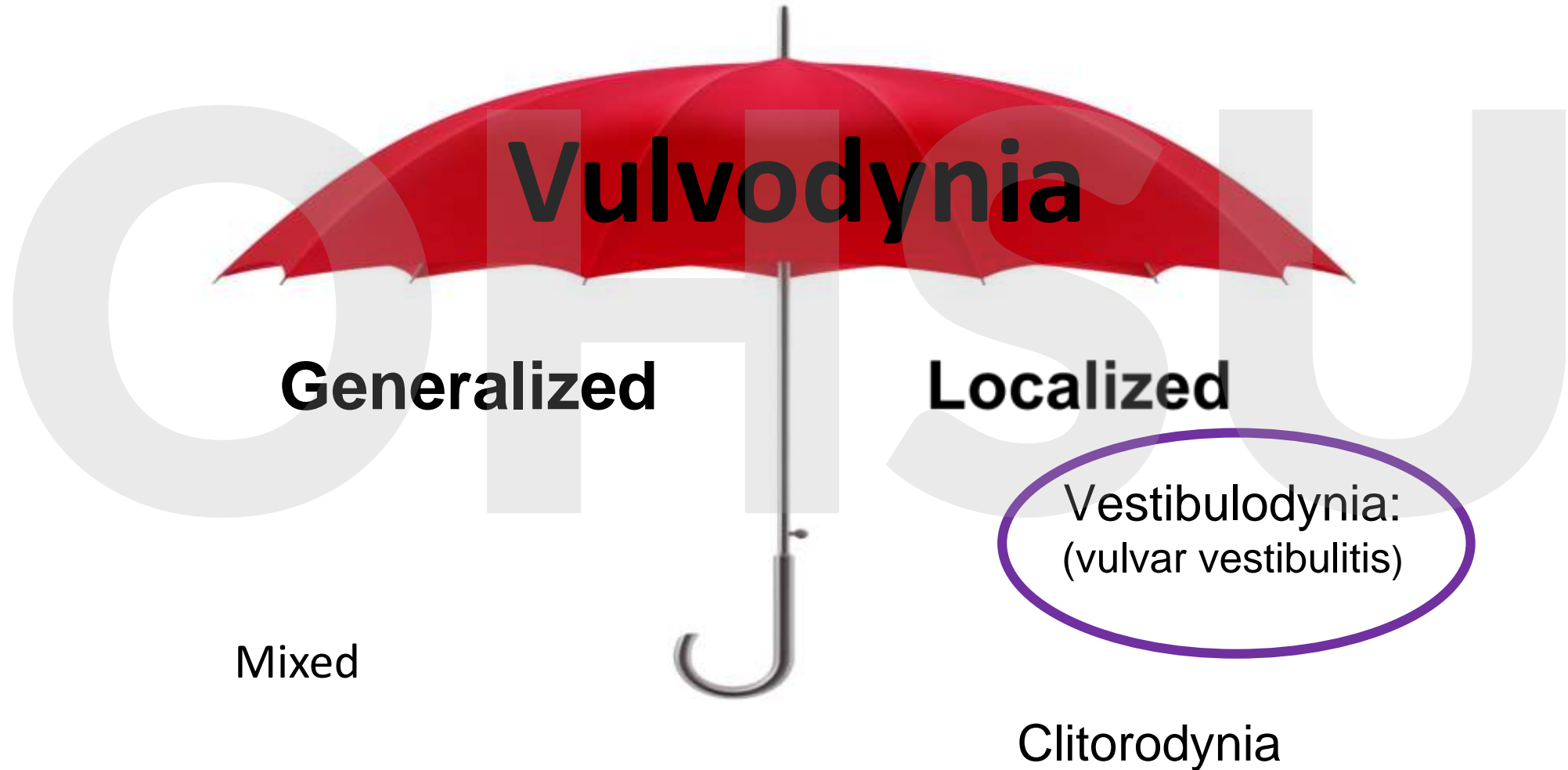


Case Presentation: Vestibulodynia

28yo G0 on OCPs who presents with dyspareunia. She complains of a raw and burning sensation with penetration



Vulvodynia



Vestibulodynia

SYMPTOMS

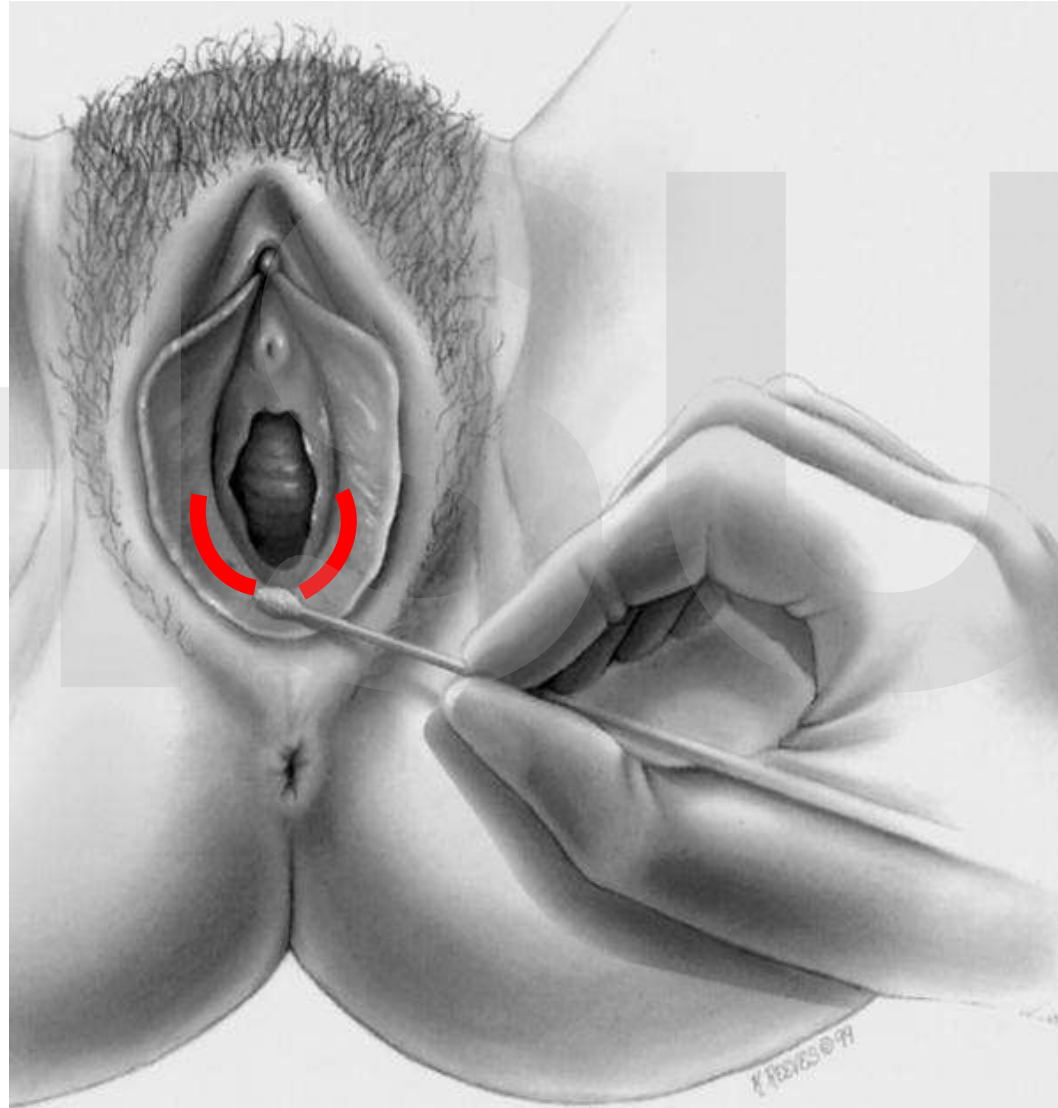
Entry dyspareunia
("at the bottom of the opening")
Difficult tampon use
Painful speculum exam
Pain usually only with touch

SIGNS

-/+Vestibular erythema
+ Qtip test
Response to lidocaine
Difficult speculum exam
(tender pelvic floor muscles)

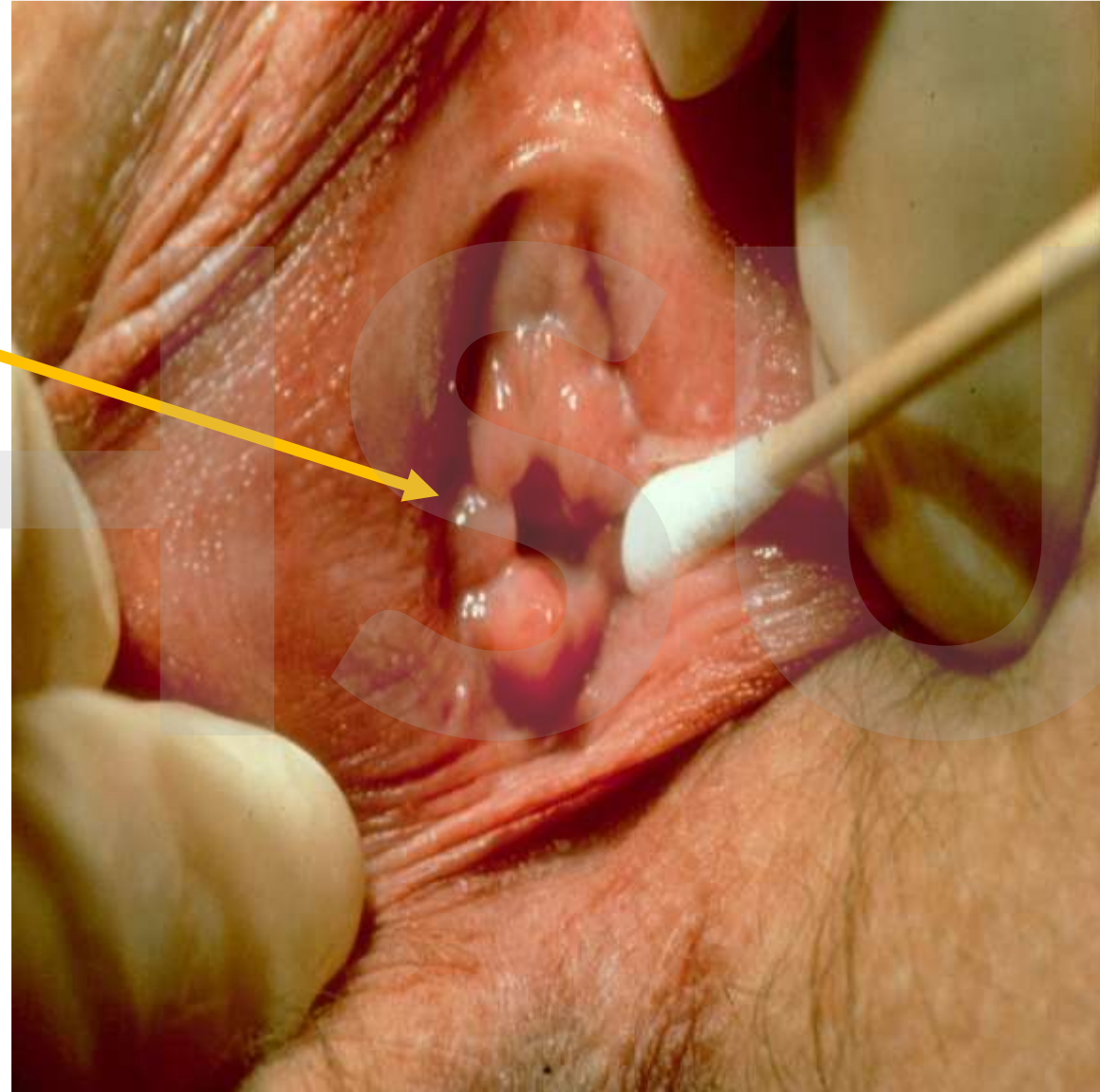
Diagnosis of Vestibulodynia: Friedrich's Triad

- Friedrich's Triad
 - Reported painful penetration
 - Qtip test (+) for tenderness
 - -/+ vestibular erythema



Qtip Test

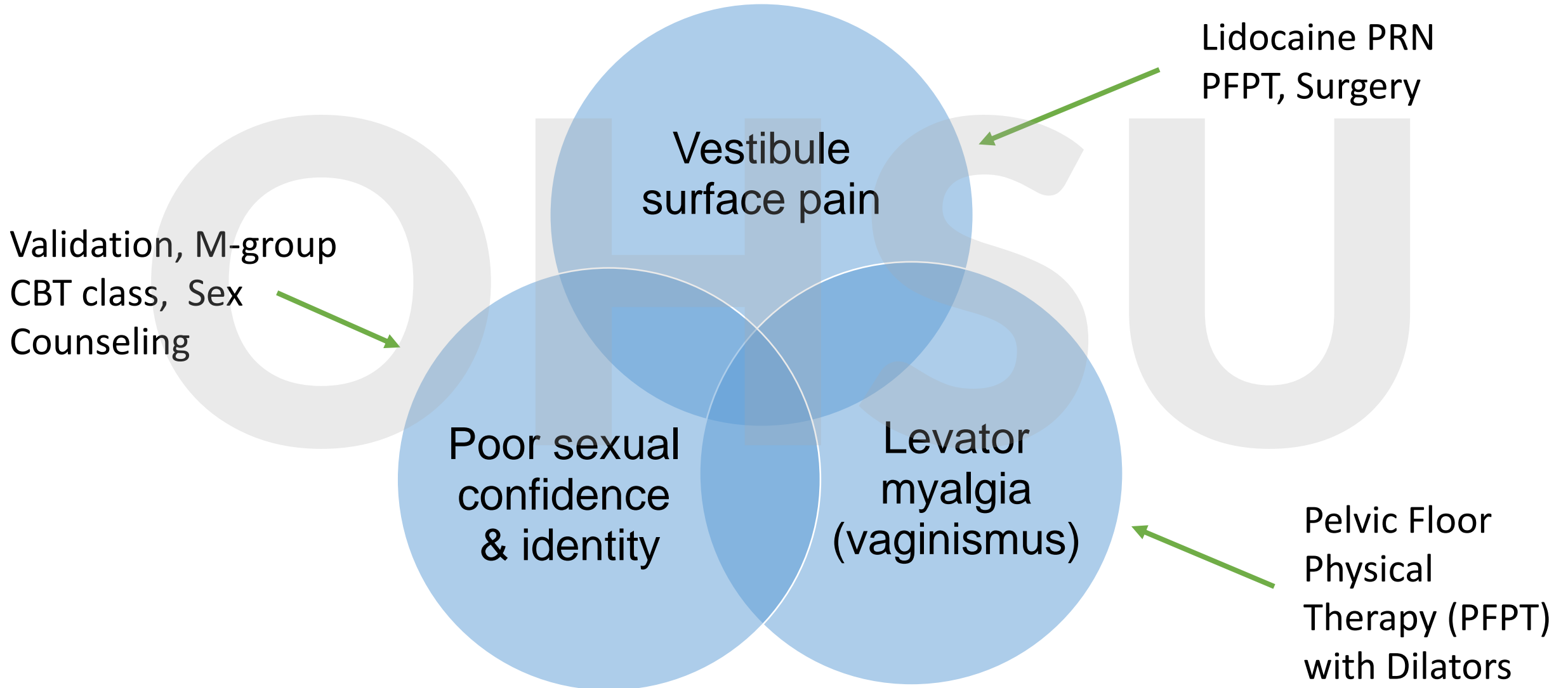
- First locate the vestibule (just under the hymen)
- Gently **ROLL** moist Qtip. . . . no pressing or poking Qtip
- Give time for patient to answer your verbal rating scale
- Start up at 2 o'clock
- Vestibule clock-face
 - 2, 4, 6, 8, 10 o'clock
 - Numeric verbal pain scale: 0-10
 - Record



Vestibulodynia is a clinical diagnosis



The Oregon Approach: Vestibulodynia



What can you do?

- Validate her pain, give her a diagnosis, refer her to Vulvar Program
- RX Pelvic Floor Physical Therapy
- RX topical lidocaine
 - 4% Aqueous lidocaine
 - sig: apply with cotton ball to vestibule for 10 min prior to intercourse
 - 2% lidocaine gel
 - sig: apply amply at vaginal opening for 15 min prior to intercourse, wipe off and then apply lubricant

Case Presentation: Vaginismus or Levator Myalgia

32yo G0 with anxiety, chronic constipation, dysmenorrhea and aching deep pain with intercourse



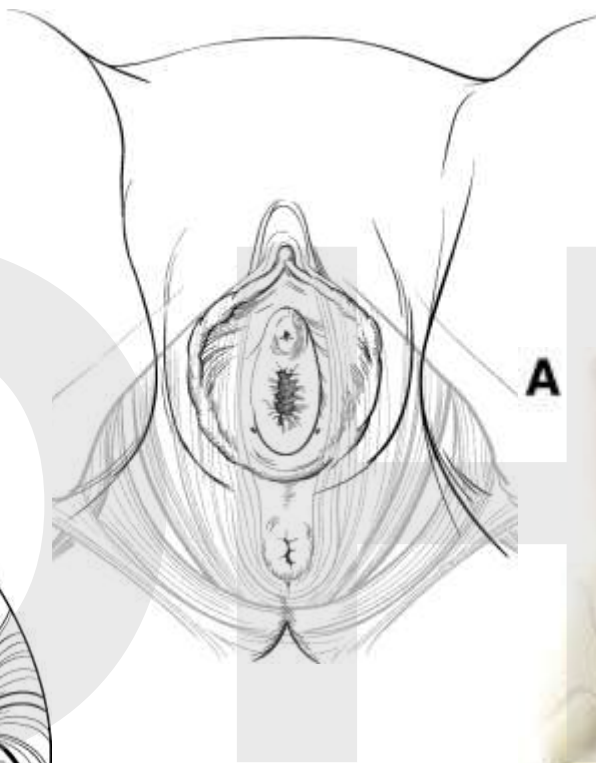
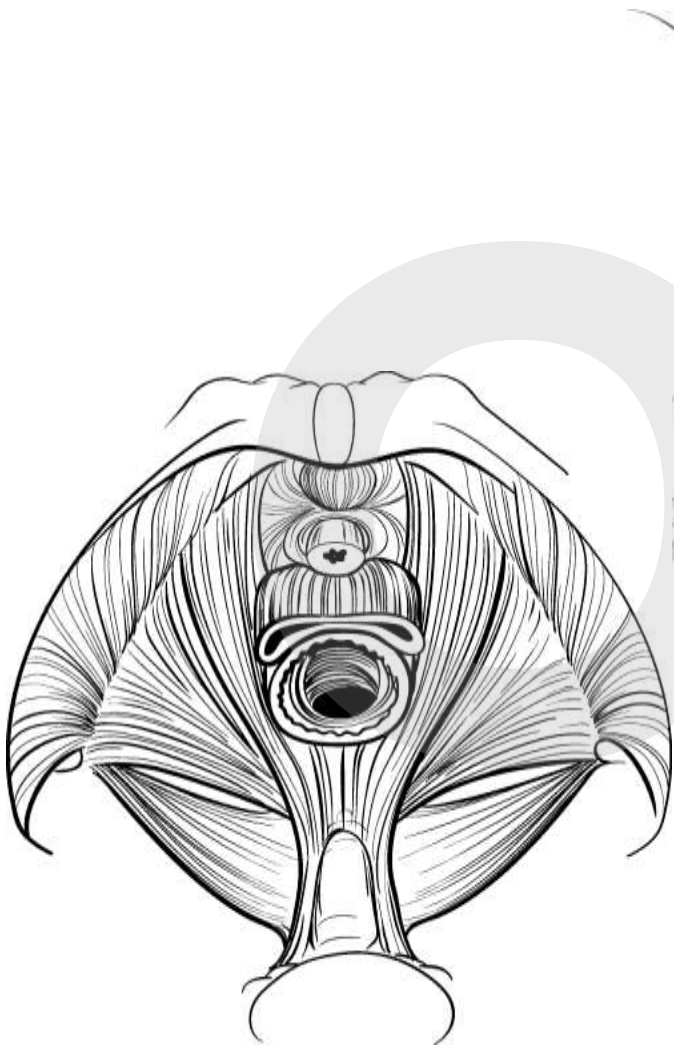
Definition Levator Myalgia or Vaginismus:

- Hypertonicity of the pelvic floor with pelvic floor motor dysfunction and tenderness (reduced ability to contract and relax the pelvic floor)

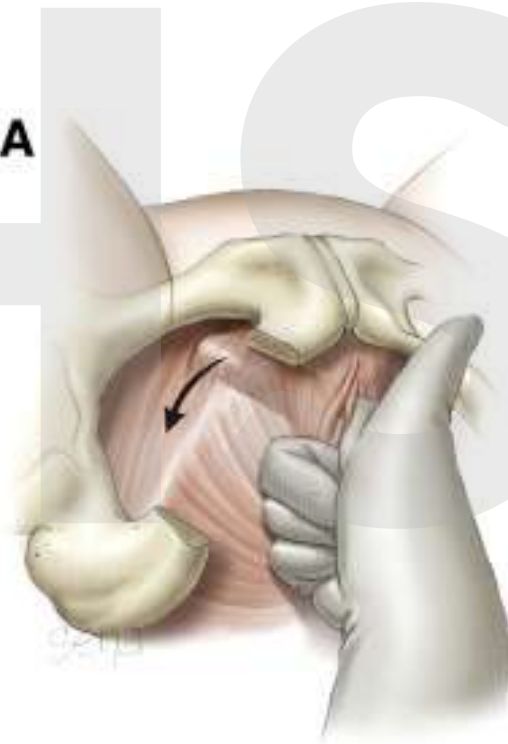


Physical Exam

Notice **no** hand on the abdomen
Notice different muscle bellies: levator vs obturator
Normal feels like pressure (rectum) but abnormal is tender

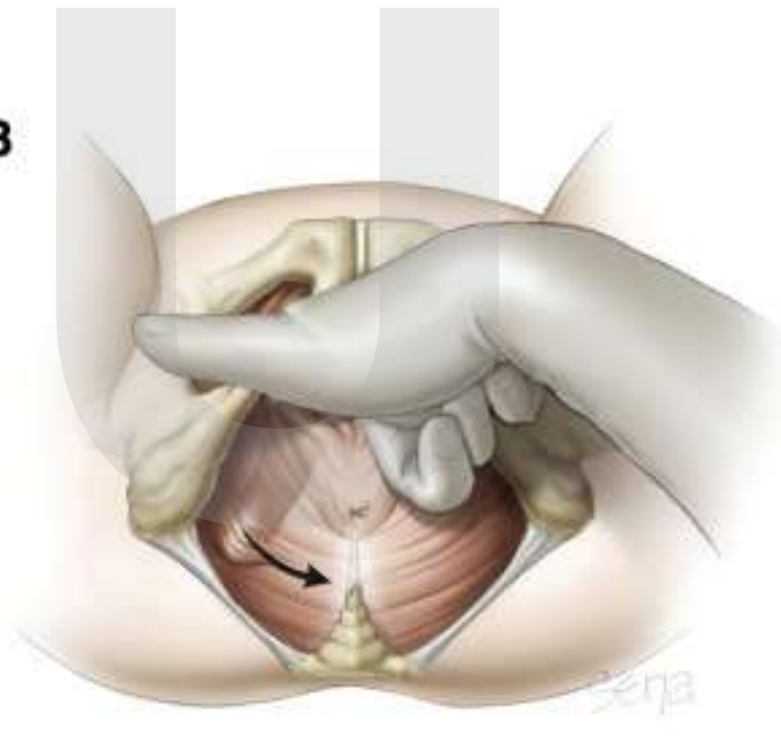


A



Obturator Internus

B



Levator Ani

Levator Myalgia- Vaginismus

- Pelvic Floor Physical Therapy (PFPM) + Dilator Work
 - Treats levator muscle spasm, hypertonicity and poor contraction/relaxation phase
 - Biofeedback with dilator therapy increases patient awareness (home program), accommodation (of increasingly larger stretch w/o triggering contraction) and control over muscles
 - Good evidence that PFPT improves pain and decreases dyspareunia
 - In VESTIBULODYNIA, evidence supports the PFPT in combination of surgery improves outcome and often leads to cure.
 - Role for dilators in transitional intercourse (managing the anxiety, voyeurism to pain)

Levator Myalgia-Vaginismus

- Exists independently of vestibulodynia
- Any traumatic experience or condition of chronic pain (to the pelvis) can lead to levator myalgia/vaginismus
- Be suspicious in women with co-morbid chronic constipation, CPP, dysmenorrhea, IBS/IBD or h/o sexual assault WITH dyspareunia

What can you do?

- Validate her pain, give her a diagnosis, refer her to Pelvic Floor PT
- Be inquisitive about your referral
 - Managing incontinence (PFPT) is NOT the same as managing dyspareunia
 - Have your office support (MA, RN) inquire if your PFPT has worked with dyspareunia/vaginismus patients in the past

Case Presentation: GSM or “atrophic vaginitis”

54yo woman presents with increasing pain during intercourse. She reports dryness, poor lubrication and a sand paper sensation.



Genital Syndrome of Menopause



- Symptoms:
 - dryness & irritation
 - burning
 - fissures
 - poor arousal response
 - poor lubrication
 - Intercourse bleeding
 - dysuria
 - **dyspareunia**
 - urethral burning
 - Urinary frequency
 - Urinary urgency

Genital Syndrome of Menopause



- Physical Exam:

- thin, dry, pale vaginal mucosa
- loss of labial fat pads
- scant pubic hair
- reduced amount of discharge
- loss of vaginal rugae
- increased pH (>5.0)
- loss of lactobacillus +/- wbc on wet mount, scant cellularity

Genital Syndrome of Menopause

- Treatment:
 - Vaginal Moisturizers
 - Lubricants
 - Estrogen Locally



GSM Treatment: Moisturizer, Lubricants & Estrogen

1. Vaginal Moisturizers

Replens[®]: lubricating product containing mineral oil, glycerin, purified water and other fillers to produce a moisturizing effect.

- Not intended as sexual lubricant, many use as such
- To maintain effect, need to use 2-3x/week
- \$15 for ~2 oz tube, advertised as 14 count
- Does not affect vaginal epithelium

2. Lubricants

Water : Astroglide[®], Slippery Stuff[®], and Wet[®]

Silicone: EROS[®], PJUR[®]

Oil: natural oils like mineral or vegetable oil

GSM: Local Estrogen

- Cochrane Review of 4000 PMP women using local estrogen

All delivery methods essentially equal in relieving effects of atrophy whether ring, tablet or cream*

No opposing progestin needed *

Less studied in breast cancer patients but most Med Onc on board with use



Genital Syndrome of Menopause: Estrogen RX

| Preparation | Dosing | Regimen (by manufacturer) |
|-----------------|---------------------------|---|
| Estring® | 7.5mcg E2/day 90d ring | Ring inserted vaginally and replaced/removed in 90d |
| Vagifem® | 10mcg E2/tablet | 1 tab PV QHS x 14d then 2x/week |
| Premarin® cream | 0.625mg CEE/g | 1g PV QHS x 7-14d then 0.5g cream 2x/week |
| Estrace® cream | 100mcg E2/g | 1g PV QHS x 7-14d then 1g 1-2x/week |

What can you do?

- Discuss arousal phase, lubricants, positioning and potential use of moisturizers
- Realize that local estrogen is gold standard for GSM
- Choose estrogen vehicle (s)
 - Step 1: Consider intravaginal (ring or tablet) **AND** vestibular (introitus) application for local support of vulva
 - Topically: dime size QHS of estrogen crm at vestibule
 - Step 2: Allow adequate time for effect
 - No data on how long to wait
 - observation 4-6 wks
 - Step 3: Re-examine for effect
 - If related just to estrogen then pain should improve

Psychosexual Distress



- Individual or Couples-Sexual Counseling
- Sensate Focus
- Programs at OHSU
 - Counseling
 - Menopause & Sexual Medicine Clinic
 - Mindfulness-CBT Group



Thank You