VAGINISMUS

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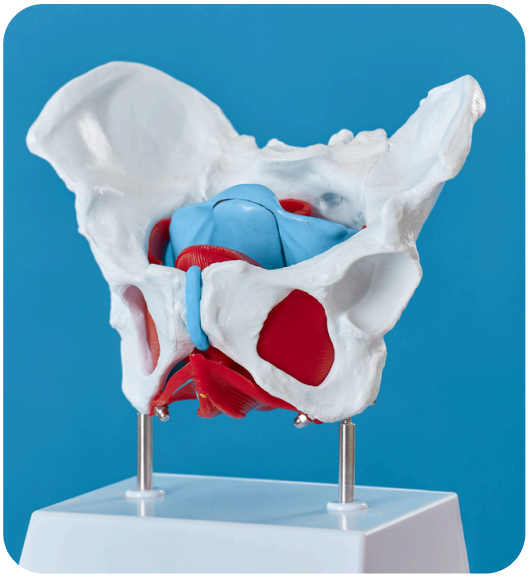

Vaginismus is one of many sexual pain/penetration disorders experienced by women and falls into the 'entry' disorders category. It is defined as 'recurrent or persistent spasm of the vaginal musculature that interferes with vaginal penetration' (1).

These patients may also have developed mental health issues, body image changes and relationship concerns as they are unable to have penetrative sex with their partner or it is very painful to do so. There are two sub-types:

- Primary – the patient has never been able to successfully have intercourse, insert a tampon or complete a PAP smear.
- Secondary – the patient has previously been able to enjoy pain free sex and/or insert a tampon but then gone on to develop vaginismus later in life.

It is thought that, in the clinical setting, between 5-17% of women experience vaginismus (7).

Causes

The definitive cause of vaginismus is unknown, however the following physical and psychological factors may be involved:

- recurrent thrush, urinary tract infections, endometriosis, and chronic pain syndromes
- trauma from childbirth
- previous painful or unpleasant sexual experience
- previous sexual assault or rape
- childhood experiences and subsequent beliefs
- previous painful pelvic exam
- fear of becoming pregnant
- poor muscle recruitment (pelvic floor, deep core, hips)
- fear of painful penetration
- anxiety, stress and/or fear
- no known cause

Pain or fear of pain then leads into the cycle of pain, fear and tension which subsequently leads to 'tight'/hypertonic pelvic floor muscles (7, 8).

Diagnostic Criteria

Within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), vaginismus falls into the *sexual disorders and dysfunctions* category. This describes persistent involuntary spasm of the pelvic floor that is causing marked distress and is unable to be better accounted for by another medical condition (3).

Statement

In the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) vaginismus and dyspareunia have been merged into a new category of Genito-Pelvic Pain Penetration Disorder (GPPPD) (2). However, vaginismus is still a currently recognised term in the IUGA/ICS joint report on terminology (1). For this newsletter we will use the term of vaginismus.

Assessment Tools

Golombok Rust Inventory of Sexual Satisfaction (GRISS) Vaginismus subscale

This was used prior to the merging of the terms Vaginismus and dyspareunia (9). The vaginismus subscale looks at 4 questions relating to any physical symptoms the patient is experiencing.

Binik Assessment of Genito-Pelvic Pain Penetration Disorder (GPPPD)

This new assessment has been put forward to correspond with the new diagnostic criteria relating to GPPPD (10). The assessment looks at five dimensions to be assessed including both physical and psychological factors.

Female Sexual Function Index

This is a generic sexual function questionnaire which looks at areas of desire, arousal, lubrication, orgasm, satisfaction, and pain. The larger the score the better the sexual function. This form is long so may be beneficial completing at home or one section of focus can be chosen by the practitioner.

Physiotherapy Treatment

In-depth history of symptoms: this allows the practitioner to develop rapport along with learning any beliefs the patient may have about the condition or any history of trauma. At this stage we may also suggest linking the patient in with other mental health services familiar with this area of work.

Education: prior to a physical exam an explanation of what is involved and why an assessment is appropriate for them is given. This will include the suspicion of vaginismus being a possible diagnosis and providing them with some easy-to-understand education on the condition and what physiotherapy can do to help. A reassurance is given that if they feel uncomfortable with this, we can apply other techniques until they do feel comfortable to work with the clinician.

Educational pelvic exam: the first couple of sessions may be fully clothed working through breathing and down training exercises for the pelvic floor and may progress on to a vaginal exam. This exam is a digital exam to determine sensation, any underlying dermatological conditions (such as lichen sclerosis/lichen planus), pelvic floor muscle tone and any responses or questions the patient may have to the examination and treatment process to help shape a management plan (4, 6).

Vaginal dilation: dependant on the individual we may progress toward the use of dilators which can be used in clinic and aim for the patient to also use at home. This progressive dilation is combined with breathing and muscle down-training techniques to provide a gradual stretch of the viscoelastic properties of the muscle fibres and osmotic pressure of the cells (5, 6).

Breathing and relaxation exercises: although with vaginismus it is mostly electrically silent on EMG (non-neurogenic hypertonicity) there may also be an active component (neurogenic hypertonicity) which can be influenced via breathing exercises, body awareness and specific relaxation techniques. This can assist with a vaginal self-exam and use of dilators. The use of surface EMG can be used to determine neurogenic and non-neurogenic hypertonicity being mindful that resting muscle tone may be higher in the luteal phase of the menstrual cycle (5, 6).

Sex education: patients with vaginismus are on a spectrum with how their symptoms effect them physically and emotionally. Clinicians also need to be aware of any history of sexual trauma that may be triggering for the patient and any suspicion of an abusive relationship. When progressing towards penetrative sex with their partner, the patient is asked to measure the circumference of their partner's penis/finger/sex toy and we gauge which dilator we need to work towards. Once the patient is achieving this size, we can then either work with a flat-topped dilator to mimic penetration from a penis or suggest the patient aim to progress to a slow introduction with the object of their goal. If there are additional concerns from the patient it is recommended that a review with a sex therapist with experience of vaginismus may be appropriate (7).

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