

**Jean Hailes**  
FOR WOMEN'S HEALTH  
Healthcare Education Research

**Managing sexual pain: a multidisciplinary approach**  
*A webcast for health professionals*

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**Jean Hailes**  
FOR WOMEN'S HEALTH

**Sexual Function**

**Dr Elizabeth Farrell AM**  
MBBS, Hon LLD, FRCOG, FRACOG  
Gynaecologist & Medical Director  
Jean Hailes for Women's Health

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**Sexual function is an essential component of life**



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## Sexual dysfunction

- negative impact on the wellbeing of women and men of any age
- disturbance in the processes
  - that characterise the sexual response cycle or
  - by pain associated with sexual intercourse




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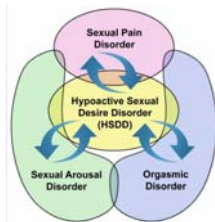


Figure 1.  
The four female sexual dysfunctions, hypoactive sexual desire disorder (HSDD), sexual arousal disorder, orgasmic disorder, and sexual pain disorder, flow into each other and outward as a continuum from HSDD. Successful resolution of HSDD frequently resolves or significantly augments resolution of the others. Resolution of any one of the others, when they are the primary complaint, also helps to resolve HSDD. This model is based on DSM-IV, which was replaced by DSM-V after May 2013.  
Adapted from Buster (1).

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## Sexual pain disorders

- Vaginismus
  - Repeated or long-lasting unintentional contractions of pelvic floor muscles in the lower third of vaginal canal.
- Dyspareunia
  - Strong and permanent genital pain during penile-vaginal penetration




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## Common sites of pain

- Vestibular area of the vulva
  - burning pain most frequently perceived at 5 and 7 o'clock
- Mid vagina/lower third
  - at the insertion of the levator ani bilaterally on the ischial spine
  - Pressure on the sore muscle may elicit localized pain, either unilaterally or bilaterally (tender points),
  - and/or an acute non-metameric pain (trigger points), radiate to the pelvis and/or to the external genitalia
- Deep pain
  - Upper vagina, the Pouch of Douglas, and the uterosacral ligaments:
  - differential diagnosis are deep endometriosis, followed by pelvic inflammatory disease and CPP.




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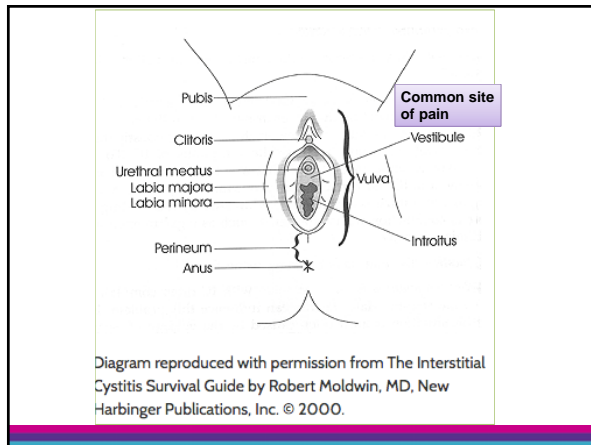
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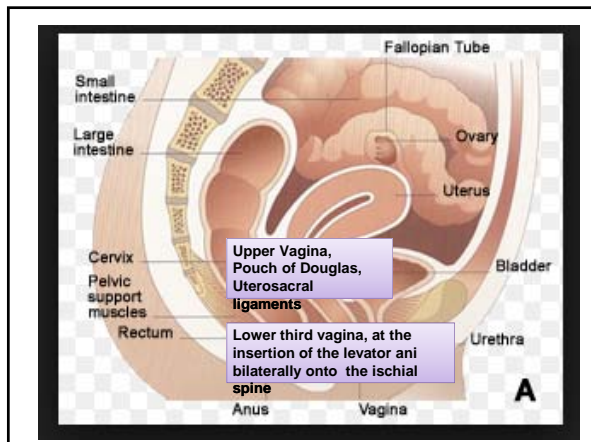
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### Factors affecting sexual function of women

- Medical surgical conditions
  - Urinary tract problems, endometriosis, fibroids,
- Obstetrics & gynaecology
  - Childbirth, breastfeeding, menopause
- Psychological
  - Depression, anxiety, other mental health problems
- Lifestyle
  - Physical activity, smoking, drug use
- Demographics
  - Age, education, culture
- Other factors
  - sexual orientation, sexual practice, sexual abuse, body image

M. Khajehei et al. 2015




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### Prevalence of sexual problems

*Prevalence of Female Sexual Problems Associated with Distress and Determinants of Treatment Seeking study*

- prevalence of any sexual problem was 44.2%

*National Health and Social Life Survey*


- more women(43%) than men (31%) reported sexual problems

**Of women who report any type of sexual difficulty:**

- difficulty with sexual desire is the most common (mean 64%)
- difficulty with orgasm (mean 35%)
- difficulty with arousal (mean 31%)
- and sexual pain (mean 26%)

- Many women are affected by more than one type of sexual difficulty
- Unreliable data due inconsistencies in female sexual dysfunction measurements

Erin Z et al 2013




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### How to initiate the conversation

**Only one third of women suffering with seriously distressing sexual problems seek professional assistance**

- Of this **one third**, the majority see primary care physicians and gynecologists about their concerns.
- The reluctance of health professionals to initiate discussion of sexual matters means the **remaining two thirds miss out on the appropriate care**

**Physician questioning increases patient reporting**


- In a study of Gynecology outpatients (n =887) women were screened for sexual concerns and dysfunction by the inclusion of two questions in the medical history.
  - Only 3% of the patients **spontaneously offered sexual complaints.**
  - **With direct inquiry, 19% of the patients acknowledged a complaint**

*Questions should be non-threatening & open-ended*

*eg: "Many people have concerns or questions about their sexuality. Do you have any questions or problems related to sex would you like to discuss?"*

*"Many women after menopause notice a change in their sexual desire. Have you noticed any changes?"*

Buster JE Managing female sexual dysfunction. Fertility & Sterility VOL. 100 NO. 4 / October 2013




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“Women want their sex lives back, no matter how old they are. They want to desire sex, they want lubrication, they want orgasm, and they want it pain-free.”

Erin Z et al 2013



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**Sexual Pain**  
A biopsychosocial approach

**Dr Anita Elias**  
MBBS, FASPM, FECSM  
Sexual Medicine & Therapy specialist

Head, Sexual Medicine and Therapy Clinic, Monash Health  
Sexual Counselling Clinic, Royal Women's Hospital

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**Definition of Vaginismus**

“the persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger or any object, despite the woman's expressed wish to do so”

Affected women often avoid intercourse; experience involuntary pelvic muscle contraction and anticipate, fear or experience pain

Basson R et al. J Sex Med 2004



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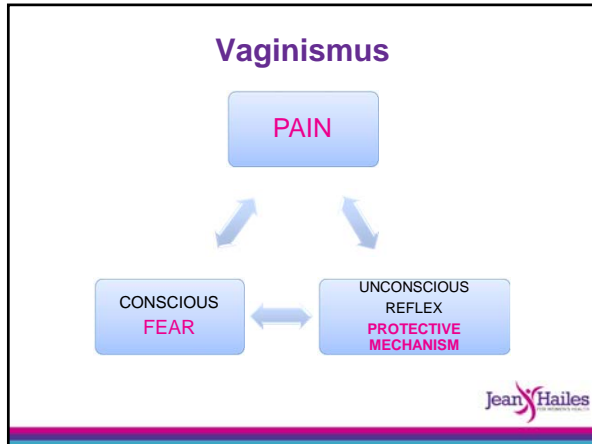
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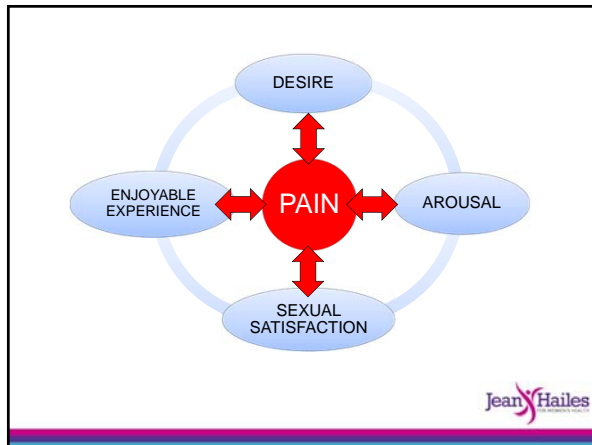
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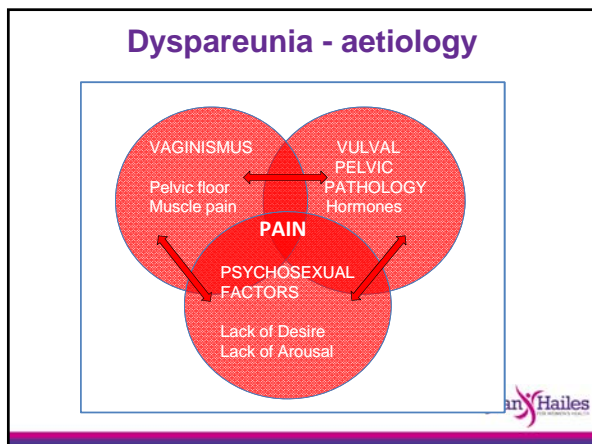
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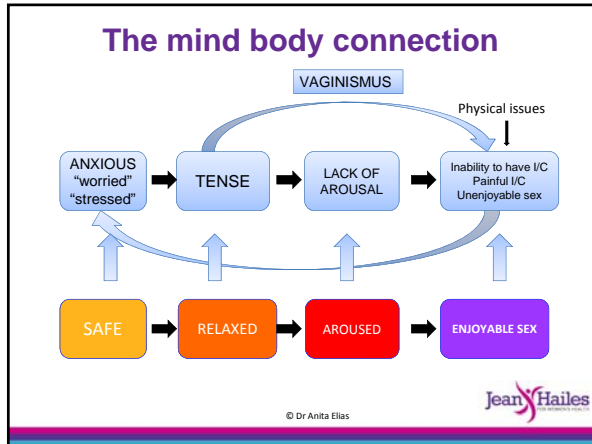
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### With dyspareunia:

**STOP TRYING INTERCOURSE!!**  
(Until assessment and management of whatever is causing pain.)

- Explain Pain / Anxiety cycle
- Explain possibility of exacerbating the problem

**KEY POINT**  
"Patients – and couples – should be required to abstain from vaginal intercourse and use other forms of sexual intimacy... until introital pain and burning have disappeared"



Ch 25 "Sexual pain disorders" Standard Practice in Sexual Medicine (Grazziotin p347)

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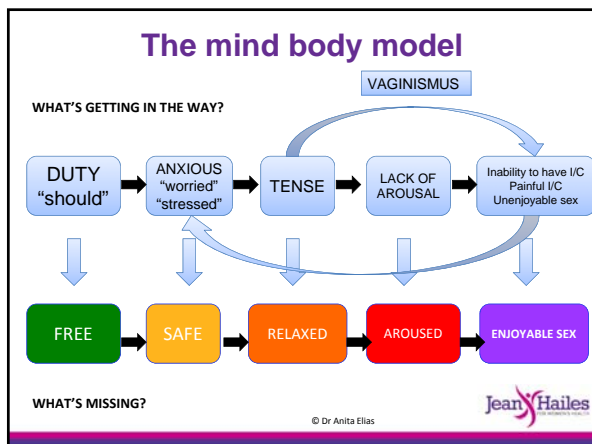
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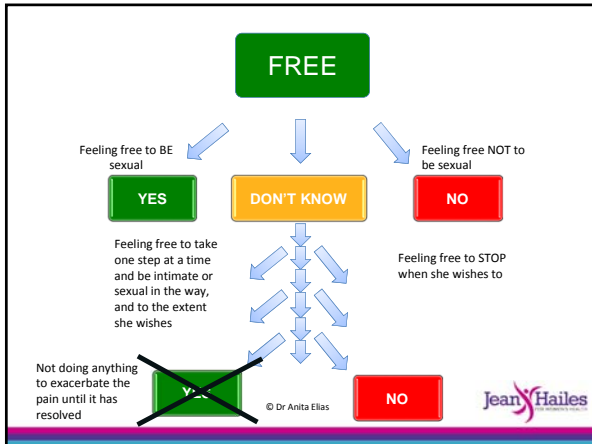
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*INTERCOURSE is only one part of*

*LOVEMAKING which is only one part of*

*INTIMACY (physical and emotional) which is only one part of a*

**FULFILLING RELATIONSHIP**

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FOR WOMEN'S HEALTH

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**Jean Hailes**  
FOR WOMEN'S HEALTH

**Physiotherapy & sexual pain**

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Jean Hailes for Women's Health

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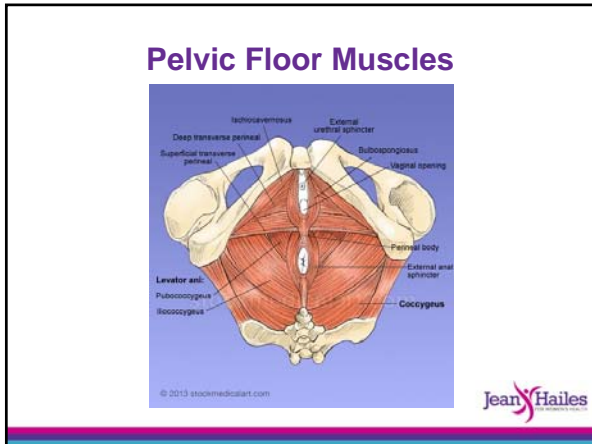
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### Always ask the question

- Common presentations associated with overactive pelvic floor muscles (PFMs):
  - urgency/frequency/bladder pain
  - Recurrent UTIs, voiding dysfunction
  - evacuation disorders/fissures/pain
  - pelvic organ prolapse (POP)
  - perineal pain
  - other musculoskeletal dysfunction

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### Physio Assessment of Sexual Pain

- Pain history-nature (may not describe as pain)
  - location
  - onset
  - triggers, every time?
  - worsening?
  - irritability
  - what helps?
  - numerical pain scale

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### Physical Assessment 1

- Posture
- Breathing
- Clear other M/S areas
- Importance of consent-check previous
- Position of "comfort"
- Resting pain



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### Physical Assessment 2

- Autonomic changes
  - Scar, fissures, haemorrhoids
  - Perineal position
  - Ability to contract and release PFM's
  - Pain on contraction/release
- If progressing past visual assessment:
- Q-tip test



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### Muscle Assessment

- Muscle palpation
- PFM contraction
- Pain
- Release
- Strength
- Endurance
- Coordination



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### Education

- Pain education
- Anatomy
- Causes of pain
- Prognosis
- Plan
- Expectations



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### Physiotherapy Treatment

- Breathing, relaxation
- Desensitisation to touch, general and specific
- Elasticity skin/scar tissue
- PFM downtraining (NB retrain function)
- Manual therapy
- Stretches



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### Adjunctive Therapy

- Heat, cold
- "Trainers"
- Surface EMG
- TENS
- Ultrasound
- General pain relief, fitness
- Treatment of other symptoms



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### Your Team

- GP
- Gynaecologist
- Psychologist
- Vulval dermatologist
- Musculoskeletal physiotherapist
- Urologist/Gastroenterologist/Colorectal
- Pain specialist
- Pelvic Pain Foundation of Australia




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### The patient perspective

#### Sarah's story




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### Case study 1: Sophie



- Sophie is a 19 year old student, born in Australia, in a non religious family.
- She's referred to a gynaecologist by her GP :
  - to discuss labioplasty (she is not happy with the appearance of her genitals).
  - She has also had sexual pain since she became sexually active with her first boyfriend 3 years ago.
- She attempted intercourse 3 weeks into the relationship, and it has been painful ever since the first time she tried. The pain has been getting worse.
- She has never been comfortable using tampons
- She has done a lot of Pilates




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### Sophie 1

- Careful history to determine her menstrual and sexual history.
- Determine:
  - her understanding of her own anatomy and what is normal
  - why she wishes a labioplasty
- Perform a careful and sensitive pelvic examination.




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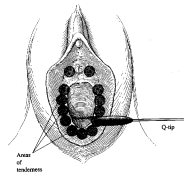
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### Sophie 2

#### Examination reveals:

- Normal labia
- Moderate tenderness to cotton bud touch at the introitus
- Tightness++ and pain with digital examination.



#### Diagnosis:

- Vulvodynia & Primary Vaginismus




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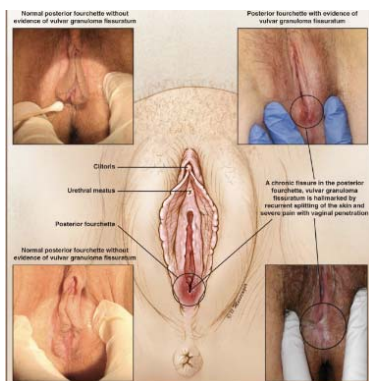
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## Vulvodynia

International Society for the Study of Vulvovaginal Diseases (ISSVD) definition.

*Vulvar pain of at least 3 months duration, without a clear identifiable cause, which may have potential associated factors*



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## Vulvodynia

- Localised or generalised
- Provoked by sexual intercourse or other non-sexual factors (insertion of tampons, tight clothing etc), or
- Spontaneous, or Mixed (provoked and spontaneous).
- Its onset can be primary or secondary, and temporal pattern intermittent, persistent, constant, immediate or delayed.



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## Vulvodynia

- Treatment may be challenging
- Multidisciplinary approach
  - Medications
  - Physiotherapy
  - Psychological therapy
  - Pain management therapy
  - Behaviour modification
  - Surgery
- Significant improvement
  - with pelvic floor physiotherapy,
  - medication for neuropathic pain,
  - psychological support, and
  - attention to sexual function



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### Sophie 3

#### Management:

- Discuss the range of normal anatomy and suggest websites for Sophie to see for herself
  - [labialibrary.org.au](http://labialibrary.org.au)
- Education about Vulvodynia and Vaginismus
- Tell her to STOP doing anything that exacerbates the pain
- Refer for pelvic floor physiotherapy
- Refer for sexual therapy
- ?Commence medication for Vulvodynia



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### Pelvic floor physio assessment

- Common presentation to physio
- May present as frequency, voiding dysfunction
  - “Doctor says it's my muscles”
- Overactive PFM's a sign of persistent defensive action
- May also be “holding it all in” to appear slim
- Common inability to insert tampon
  - first experience of PFM spasm



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### Physio management

- Educate, anatomy, pain response
- Posture
- Respiration
- Visual examination
- Q-tip test
- Muscle assessment, may be unable to voluntarily contract
- Desensitisation
- PFM downtraining exercises
- Manual therapy
- Modify Pilates
- Trainers
- Resensitisation and progression back to comfortable intercourse



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### Sophie – further information

- Sophie initially had sex to be like her friends and also to attract and keep her boyfriend
- Sex education at school was about "not getting pregnant or catching something". She learned about sex from magazines and from watching porn with her friends. She doesn't like watching it, but Chris and his friends do. She doesn't look like the girls in porn.
- On questioning, she admits that she didn't like the things Chris did to her (that he sees in porn) but when she told him that, he said there was "something wrong with her" as all his other girlfriends enjoyed it. She used to pretend she enjoyed it (although she wasn't getting aroused) so he wouldn't get frustrated with her. He left her anyway, and she is devastated!
- She eventually went to her GP, who said there was nothing wrong, which made her feel even worse about the problem. She can't understand if the pain is "real" or "in her head".
- She also suffers from general anxiety



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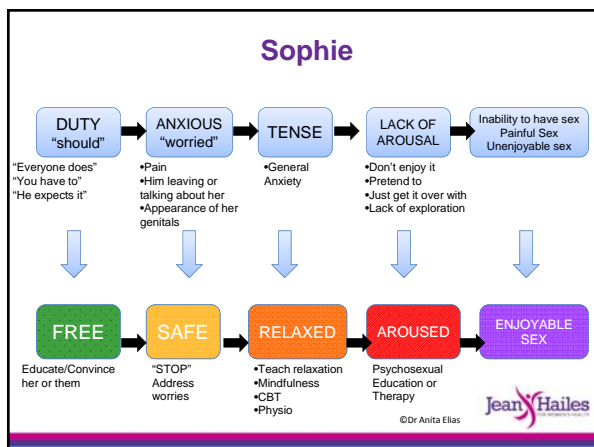
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### Case study 2: Paula

- 32 y old, mother of 2 boys, aged 3 and 9 months. She's breastfeeding.
- She had perineal trauma (a 3rd degree tear) with the birth of her first child.
- With second baby he had a normal vaginal delivery but suffered a small tear requiring suturing.
- She's had dyspareunia since birth of her first son, but it's been worse since second child.
- She has some urinary incontinence, and has done a lot of PFM exercises in the past to try and manage the problem
- She presents to pelvic floor physio for management of incontinence.





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### Pelvic floor physio assessment

- Presents to physio for urinary incontinence - this is most common
- Questioning reveals faecal incontinence and dyspareunia
- PF physio will manage all of these but stay focused on patient's goals
- ?Also pelvic organ prolapse, voiding and evacuation dysfunction
- Reduction in self-esteem associated with all these issues
- "Lots of PFMT" without release
- Holding on to prevent incontinence
- May still be scar tissue pain- desensitize
- Downtrain PFM's , follow with strength, coordination, endurance, functional training
- Advice re general fitness




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### Gynaecological approach

- Once again a careful history should be taken.
- After having a third degree tear with the first baby the second stage of labour should have been well controlled to lessen the possibility of further tearing
- Check for ongoing problems with continence, perineal scar pain, pelvic floor sensation and body image.
- Careful examination of perineum, pelvic floor, vaginal dryness and bimanual examination to exclude any pelvic masses.
- Refer to pelvic floor physio and for couple counselling
- Prescribe vaginal oestrogen for vaginal atrophy




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### Paula – further information

- Sex was painful and Paula lost interest after her first son was born, but used to do it sometimes to keep her husband happy.
- Pain got worse when they were trying to conceive a second child, but she really wanted to fall pregnant, so kept trying. Now she can't bring herself to do it at all.
- Her husband is complaining. They are drifting further and further apart. Paula is worried that he'll look elsewhere for sex, or leave her.
- Paula has symptoms of depression, not being treated.
- Her father died a year ago. She was close to him.
- Her mother has a history of bipolar disorder and her in-laws live interstate, so she has no family support.




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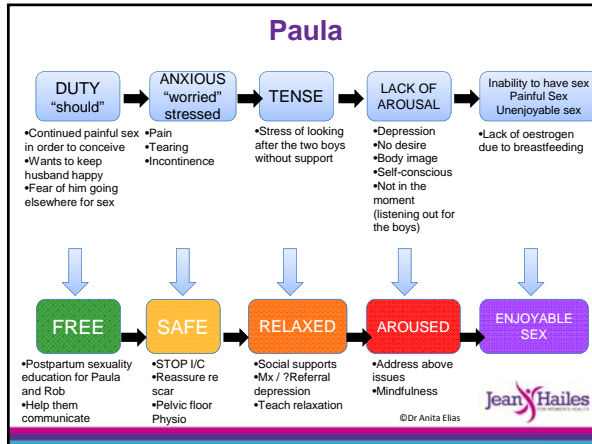
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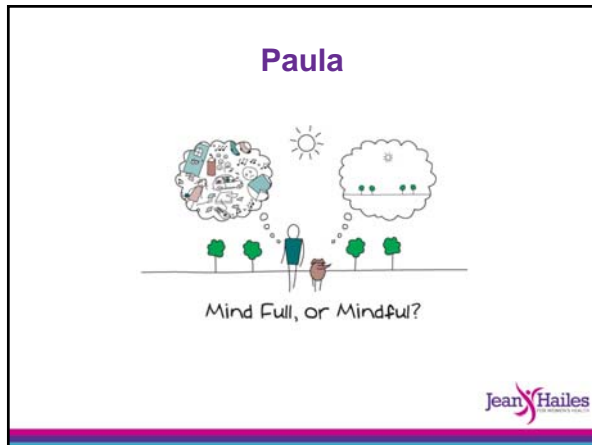
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### Case study 3: Maria

- Maria is a 56 y old woman presents to the gynaecologist for a routine PAP smear.
- She works in a fruit shop, she's married with 2 children in their 20s
- She has recently experienced recurrent UTIs that have been treated with antibiotics. This has led to thrush.
- Maria doesn't complain, but talks about dyspareunia when asked directly
- Generally sex was always good for her and Tony but after menopause (50 yrs), sex started to be painful. It improved after she started HRT. She was on HRT for 5 years, and was then told to stop by her GP.

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### On examination

- Vaginal atrophy, thin with petechiae
- Introital narrowing
- Tender tense pelvic floor
- Very dry vagina



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### Incidence of vulvovaginal atrophy (VVA) symptoms

- The incidence of VVA symptoms has been estimated at approximately 60%
- Symptoms increase with age
  - 50 % of women 50-60 years
  - 72% women 70+ years
- 2/3 women in WHI had physical evidence of VVA but only 10% declared symptoms
- Estimated that only 7% of women are treated Archer D et al Menopause 2015
- The incidence increases with time from perimenopause to menopause
  - 47% at 3 years Dennerstein et al 2000



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### Oestrogen maintains healthy tissues but oestrogen deficiency leads to profound changes



- Non oestrogen exposure**
- Vaginal tissues dry and thin
  - Alkaline and changes to the the vaginal ecology
  - Vulva loss of fatty tissue
  - Labia majora and the hood of the clitoris



- Oestrogen exposed**
- Vaginal walls thick and elastic.
  - Acidic to maintain resistance of the vagina and bladder to infection

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**TABLE 2. Genitourinary Syndrome of Menopause (GSM): symptoms and signs**

Symptoms	Signs
Genital dryness	Decreased moisture
Decreased lubrication with sexual activity	Decreased elasticity
Discomfort or pain with sexual activity	Labia minora resorption
Post-coital bleeding	Pallor/Erythema
Decreased arousal, orgasm, desire	Loss of vaginal rugae
Irritation/Burning/Itching of vulva or vagina	Tissue fragility/fissures/petechiae
Dysuria	Urethral eversion or prolapse
Urinary frequency/urgency	Loss of hymenal remnants
	Prominence of urethral meatus
	Introital retraction
	Recurrent urinary tract infections

Supportive findings: pH >5, increased parabasal cells on maturation index, and decreased superficial cells on wet mount or maturation index.

Portman D et al, *CLIMACTERIC* 2014;17:557–563

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## Symptoms

- Perception of touch altered making touch hypersensitive or sometimes numb to touch.
- Loss of clitoral stimulation
- Inflammation:
  - Pain on urination and urinary tract infection.
  - Persistent or recurrent malodorous discharge caused by increased vaginal alkalinity.
    - Mistaken for thrush.




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## Management

- Prescribe vaginal oestrogen, vaginally and perineal massage
- 1-2 litres of water per day.
- Referral
  - Pelvic floor physiotherapy
  - Sexual therapy




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### Pelvic floor physio assessment

- Pain a factor in PFM over activity
- Importance of vulval care
- Maria unlikely to be “an exerciser” as her day is so busy
- Less likely to be aware of specific PFM training
- Education +++
- Physio treatment v self-treatment




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### Maria – further information

- Her husband has been unable to work for 18 months due to a back injury. He’s becoming more demanding (generally and sexually). He does nothing to help Maria and needs/wants a lot of attention.
- Her mother had a stroke 9 months ago. Maria visits her in the nursing home every day after work to feed her.
- Her oldest son is unemployed and moved back home. He does nothing to help.
- She doesn’t complain!
- Sex has been gradually getting worse for the last 12 months, she is not getting aroused like she used to and it’s become painful.
- Maria doesn’t understand why sex is worse now, because her hot flushes have improved.




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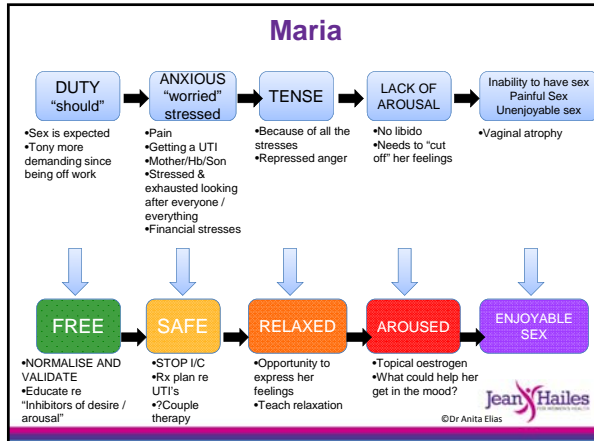
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### Maria




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Questions?

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### Links

- **Pelvic Pain Foundation Seminar**
  - Adelaide 15 -16 Oct 2016
  - <http://www.pelvicpain.org.au/pelvic-pain-seminar-october-15-16-adelaide-2016>
- **ANZVS meeting**  
The Cutting Edge of Vulvo-vaginal Disorders
  - Melbourne 11-13 Nov 2016
  - <http://anzvs.org/meetings/>
- **New research – Prof. Sue Davis**  
(Monash University, Melbourne)
  - A study recruiting women over 18 years, who are taking an aromatase inhibitor and experiencing symptoms of vaginal dryness, itch or pain with sexual activity
  - <http://www.med.monash.edu.au/sphpm/womenshealth/current-research/swab-study.html>
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