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Dyspareunia and vaginismus: what the gynaecologist should not miss

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Background

Sexual pain disorders – dyspareunia and vaginismus – are very sensitive issues, as pain involves emotionally charged behaviours: sexual intimacy and vaginal intercourse.
Sexual pain has been included into Female Sexual Dysfunction (FSD), classification established in 1998 during the 1st Consensus Conference and then revised during 2nd Consensus Conference, in 2004.
Before 1998, sexual pain was considered from the psychological point of view (ICD-10 and DSM-IV).
Opposite to that view, pain is almost never "psychogenic", except for pain from grieving. Physical pain has a prominent biological basis, nociceptive or neuropathic.

Aim of the presentation

To increase the gynecologist's competence in diagnosing and first line treating sexual pain disorders.

Method

Literature review plus Author's clinical experience.

Results

Key questions in the history taking and details of the genital examination critical for the diagnosis of sexual pain disorders will be presented with a structured diagnostic flowchart.
Special attention should be given to leading etiologies of **introital dyspareunia** (vulvodynia, vulvar vestibulitis, lichen sclerosus, genital mutilation, hyperactivity of the pelvic floor; iatrogenic: episiotomy-rraphy; colporraphy) and **deep dyspareunia** (endometriosis, pelvic inflammatory disease, iatrogenic vaginal shortening).
The **differential diagnosis with vaginismus** will be discussed.

Conclusions

Gynaecologists are the only physicians who can diagnose all the biological etiologies of dyspareunia and vaginismus.
If they omit the biological diagnosis, and refer to the psychologist, women will be exposed to endless, useless, expensive and distressing "doctor shopping".
Sexual medicine should become part of the basic training in Obstetrics and Gynecology.