

Dyspareunia and vulvodynia

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Background

Female Sexual Dysfunctions (FSD) are highly prevalent: up to 42% of women report FSD in the lifespan. They are usually neglected in the clinical practice. The most urgent FSDs to be diagnosed and cured are Sexual Pain Disorders (SPD) – dyspareunia and vaginismus – which dramatically affect the intimate life of women's and couples, and the associated comorbidities.

Aim of the presentation

To offer a very practical approach to the diagnose of Sexual Pain Disorders and related pathologies, to empower the gynecologist's competence in diagnosing and treating coital pain in women.

Method

Literature review plus Author's clinical experience.

Results

Epidemiology. In the US, Laumann's data indicate that 21% of women aged 18 to 55 years, and 10,5% of those aged 40 to 80 report coital pain; Graziottin's survey of UK, German, France and Italy with validated questionnaires indicate that 14% of women aged 20-70 complain of dyspareunia. Pelvic comorbidities of dyspareunia include vulvar vestibulitis syndrome (VVS)/vulvodynia, diagnosed in more than 80% of women with introital dyspareunia; bladder symptoms, with urge, frequency and bladder pain symptoms, reported in 42 to 48% of women with introital dyspareunia; endometriosis, diagnosed in 30-50% of women with deep dyspareunia; pelvic inflammatory disease (PID) which increases the probability of deep dyspareunia with an OR=9.98; irritable bowel syndrome (IBS), associated with introital and/or deep dyspareunia in 30 to 50% of patients complaining of coital pain; obstructive constipation has been reported by 61% of patients with introital dyspareunia; hyperactivity of the elevator ani, with myalgia, has been proven with Electromyography (EMG) in 91.6% of patients with dyspareunia.

Pathophysiology. Dyspareunia has a solid biological aetiology, with the histologically proven triad typical of VVS: significant increase of mastcells, of degranulated mastcells and of mastcells closer to pain fibers; hyperactivity of the pelvic floor muscles; proliferation of vestibular pain fibers; associated systemic symptoms when the persistence and worsening of dyspareunia and comorbidities determines an increase of proinflammatory cytokines with higher vulnerability to depression, headache, chronic fatigue syndrome (CFS), and fibromyalgia which affects women's quality of life, affective and erotic intimacy and couple' relationship.

Diagnosis. A careful clinical history and genital examination are sufficient for the etiological diagnosis of dyspareunia in 90% of cases. Specific exams (pelvic echography, TAC, MR, electromyography, CA 125, etc.) can be required in specific cases to confirm the diagnosis.

Conclusions

A **clinical flow-chart** will be offered to screen the SPD to get the most rapid etiological diagnosis. Key therapeutic options will be considered. Gynaecologists should improve their skill in diagnosing and treating FSD, and specifically sexual pain disorders and associated comorbidities, to improve women's quality of life.