Sexual Pain in Women: History, Assessment and Management

Susan Kellogg Spadt PhD,CRNP,IF, FCST
Director: Female Sexual Medicine
Academic Urology Center for Pelvic Medicine
Bryn Mawr, Pa
Professor: OBGYN
Drexel University College of Medicine
Professor: Human Sexuality
Widener University
E-mail: doctorkellogg@yahoo.com

Disclosures

- Dr. Kellogg is a consultant/speaker with Shionogi, Sprout, Neocutis, Novonordisk and Semprae

OBJECTIVES:

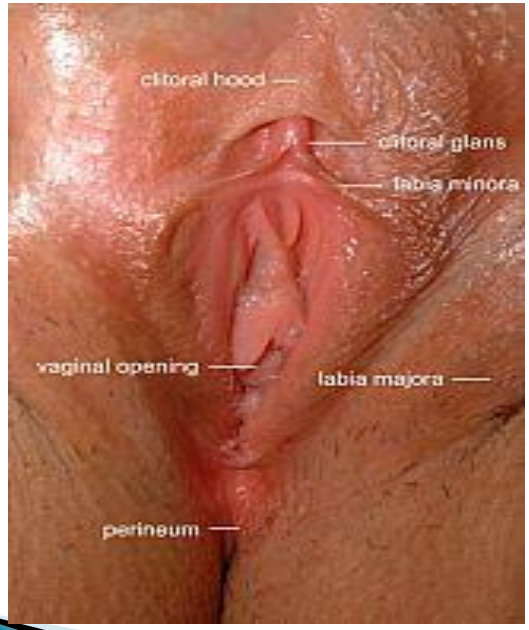
- At the completion of the presentation, participants should be able to:

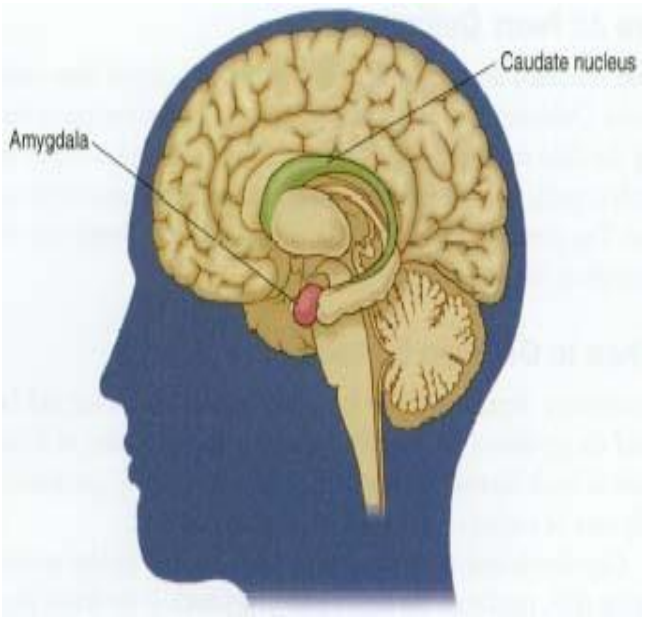
1-Identify 3 possible contributing factors to the onset of sexual pain in women.

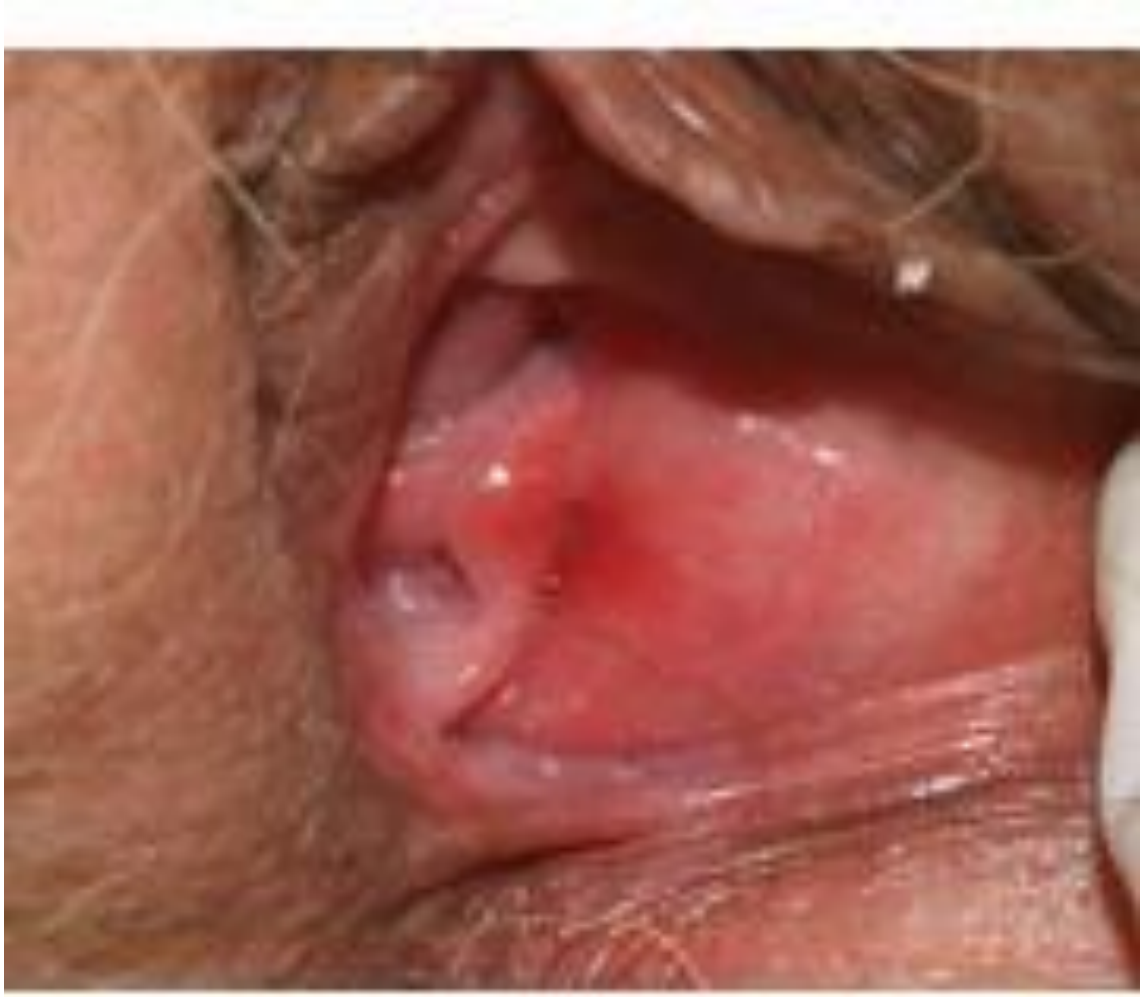
2-Explain the “touch test” technique as it relates to the physical assessment for provoked vestibulodynia .

3-Describe the interdisciplinary management of the woman with sexual pain.

27 yo women with 6 year hx dyspareunia. Seen by 5 gynecologists /1 urologist= all exams "WNL" (suggested psychopathology)







Every evaluation must begin with a thorough history.

1. Develop a timeline of the dyspareunia.
- Has intercourse always been painful?
- Has tampon use always been painful?
- Did the pain start acutely or gradually?
- Is the pain only during intercourse or is there pain without provocation?
- Since the pain began, have there been episodes of <u>completely</u> pain free sex?

Every evaluation must begin with a thorough history.

Determine the location of the pain

- Is the pain upon penetration?
- Is the pain inside the vagina?
- Is there pain with deep thrusting?
- Are there any positions that are more/less painful?
- Is there pain with clitoral stimulation?
- Is there post-coital pain?

Every evaluation must begin with a thorough history.

Elicit symptoms

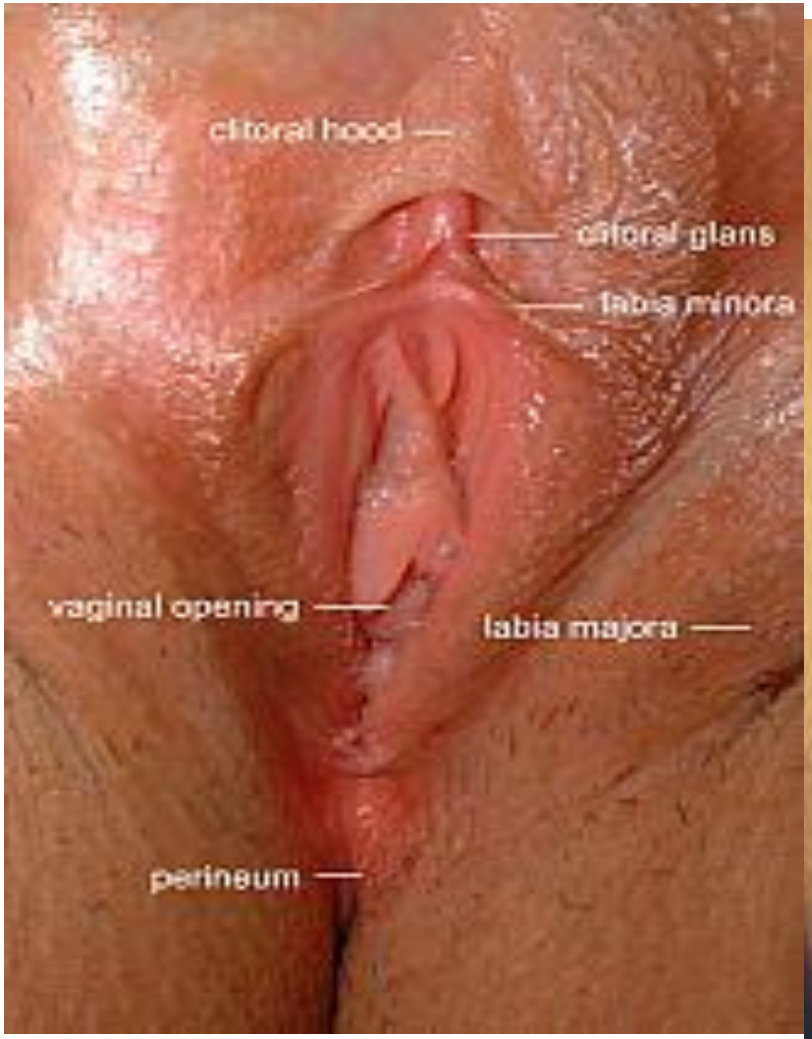
- Burning, rawness, cutting, tearing, searing, aching, dull, throbbing, tearing, dryness, pruritus ?
- Is there urinary hesitancy, urgency, frequency, incomplete emptying?
- Is there constipation, rectal fissure?

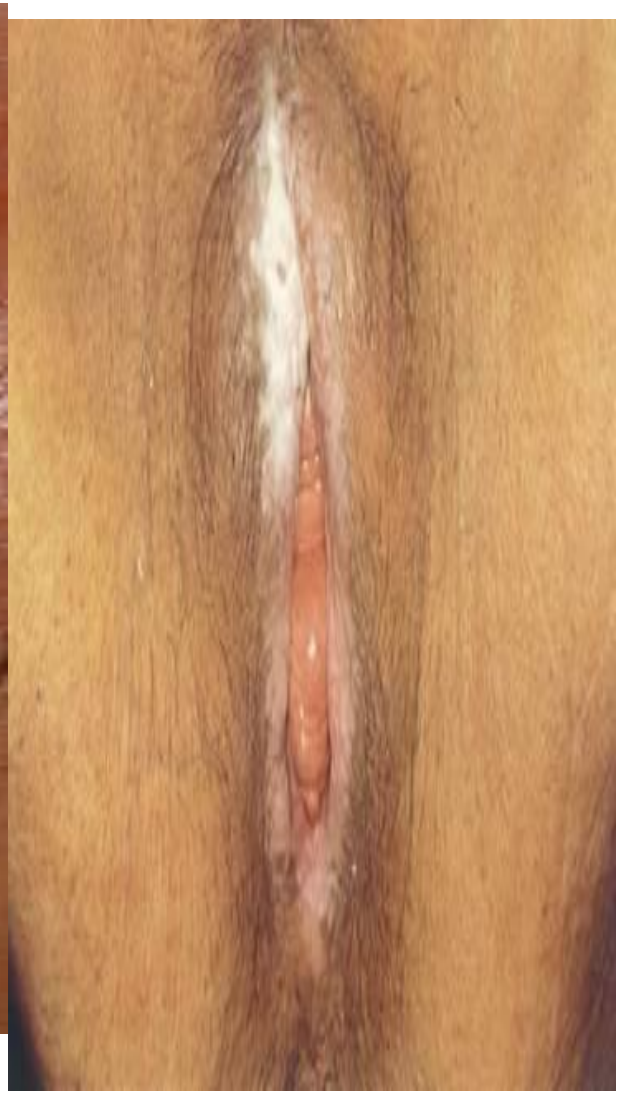
Every evaluation must begin with a thorough history.

- Did the pain start while on hormonal contraception?
- Allergic reaction to creams, spermicides?
- Positive cultures?
- Previous vulvar biopsy?
- Is there bleeding tearing during/after sex?
- Are there oral lesions?

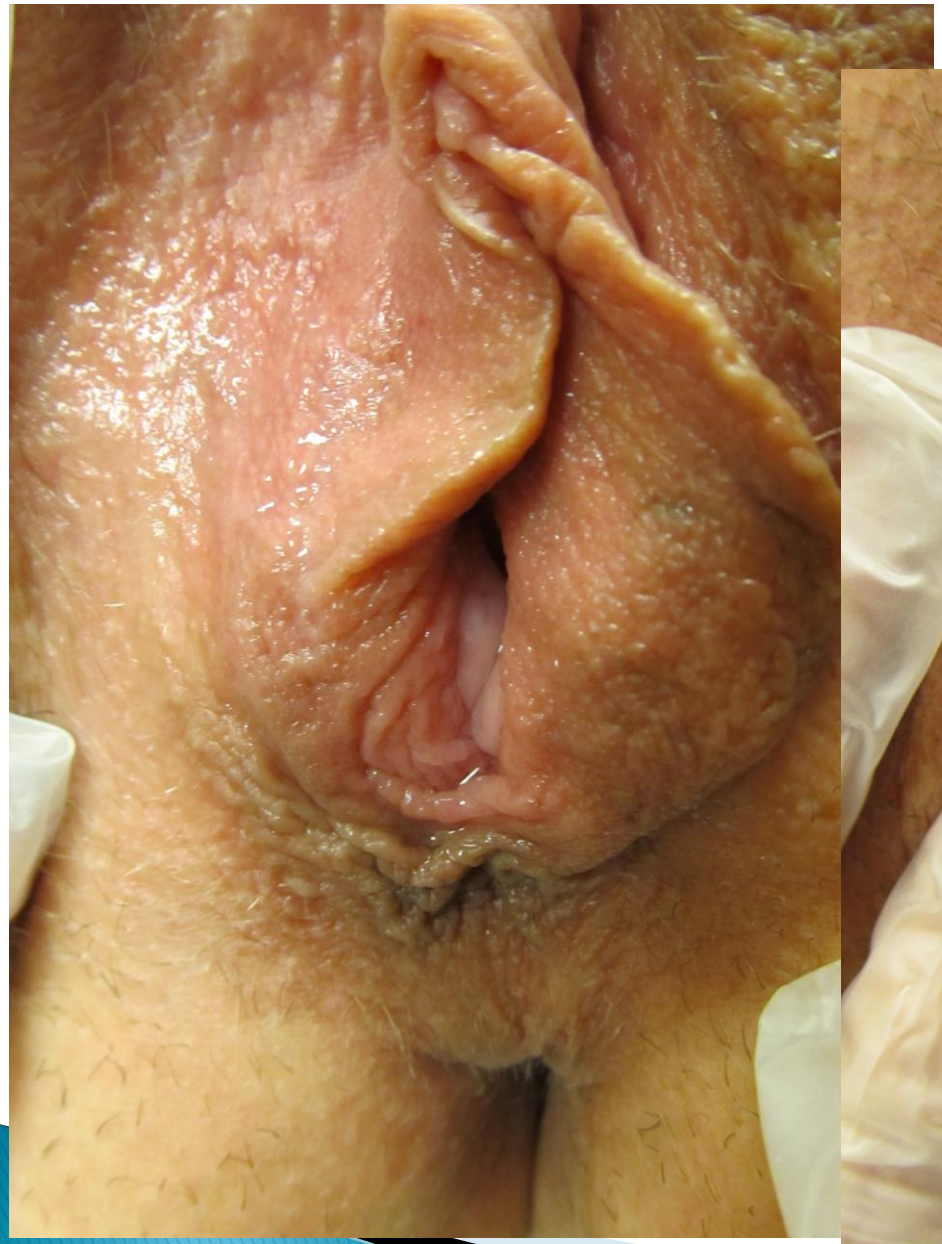
Physical exam

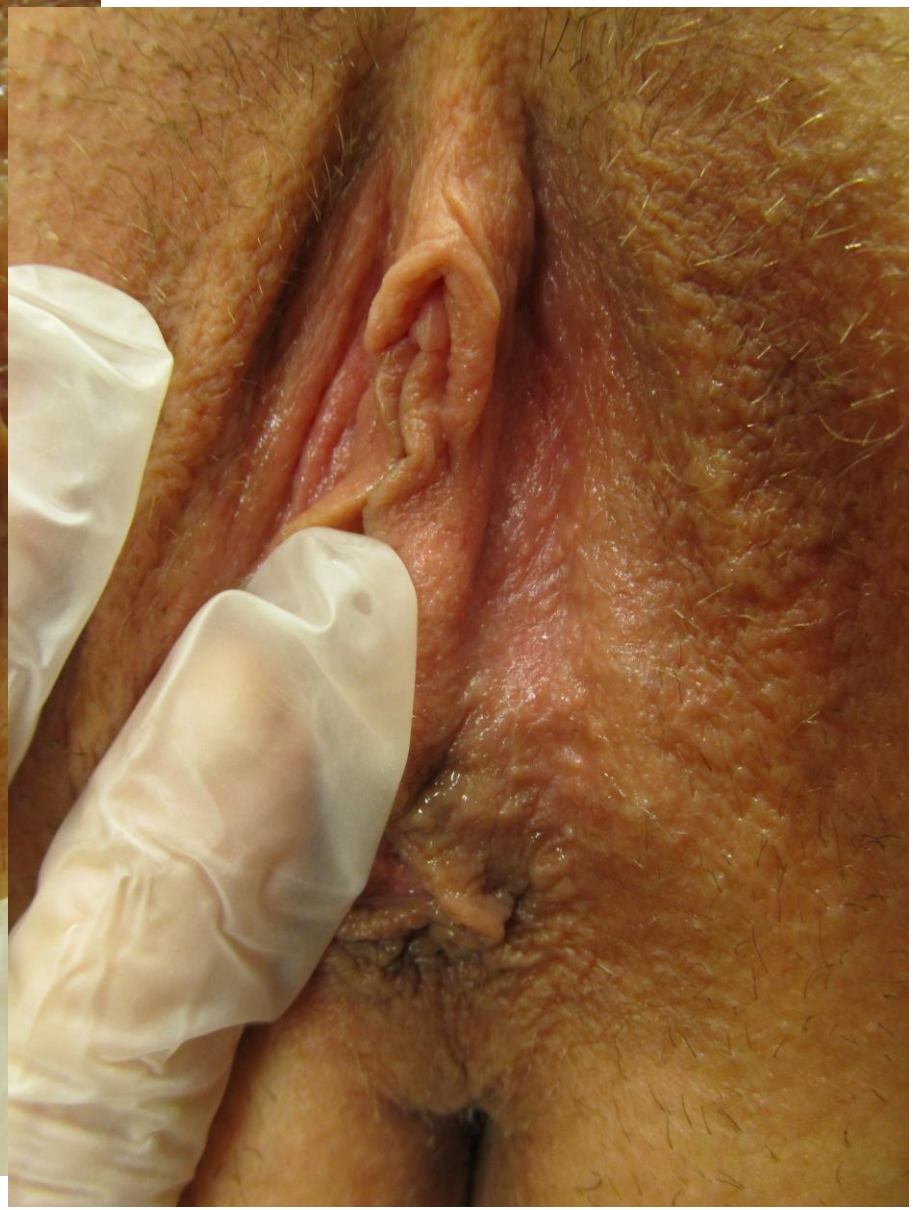
- -Visual inspection, cotton swab test
- -Vulvoscopic eval
- - Bx if indicated
- -Vaginal exam with pederson speculum- insert w/o pressure on vestibule
- -Examination of pelvic floor muscles
  -Palpation of the urethra and bladder



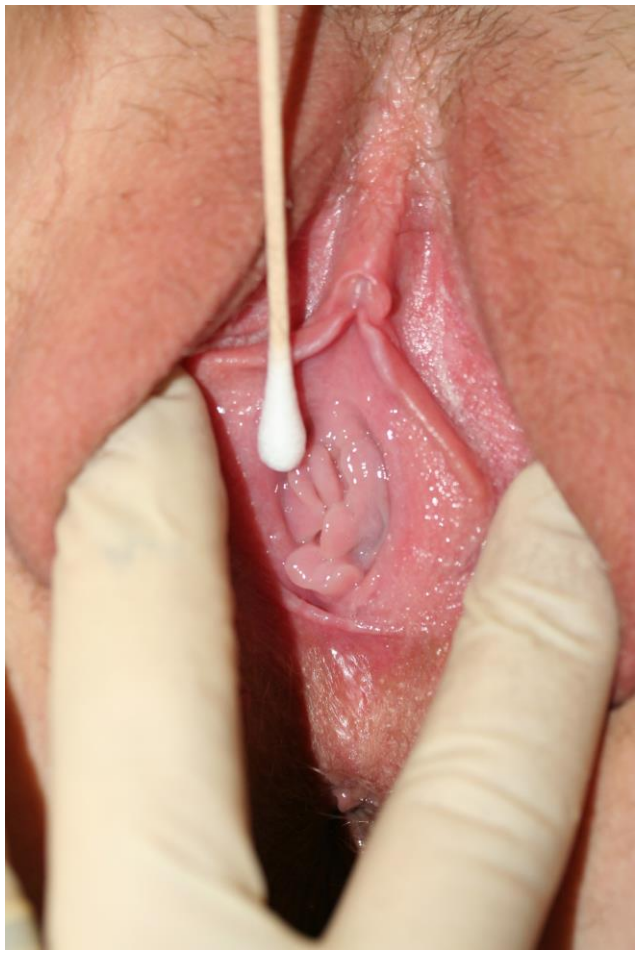


Visually inspect the vulva

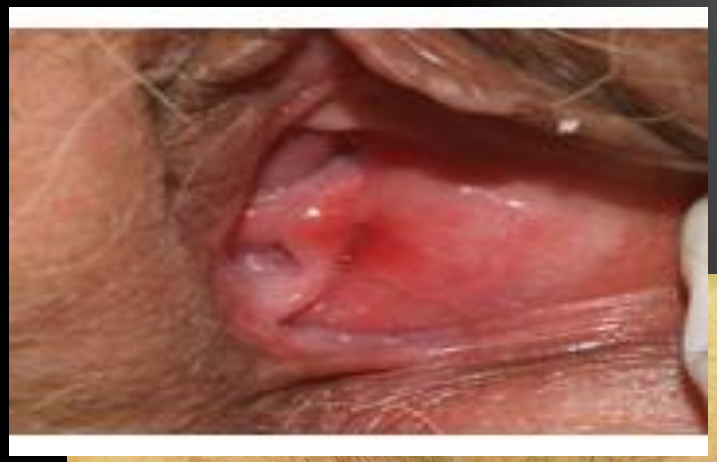


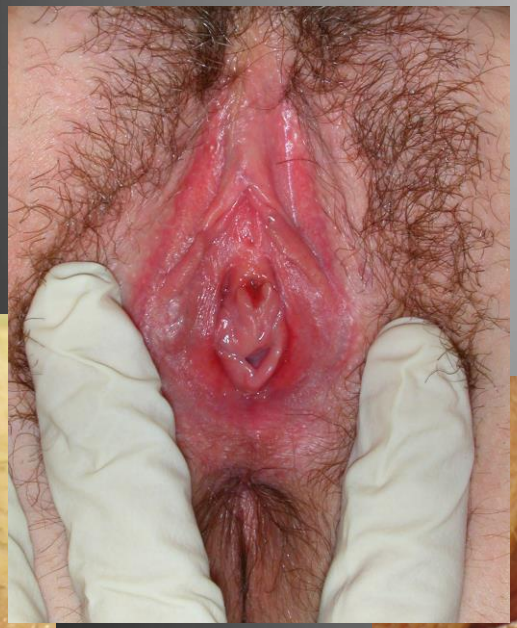


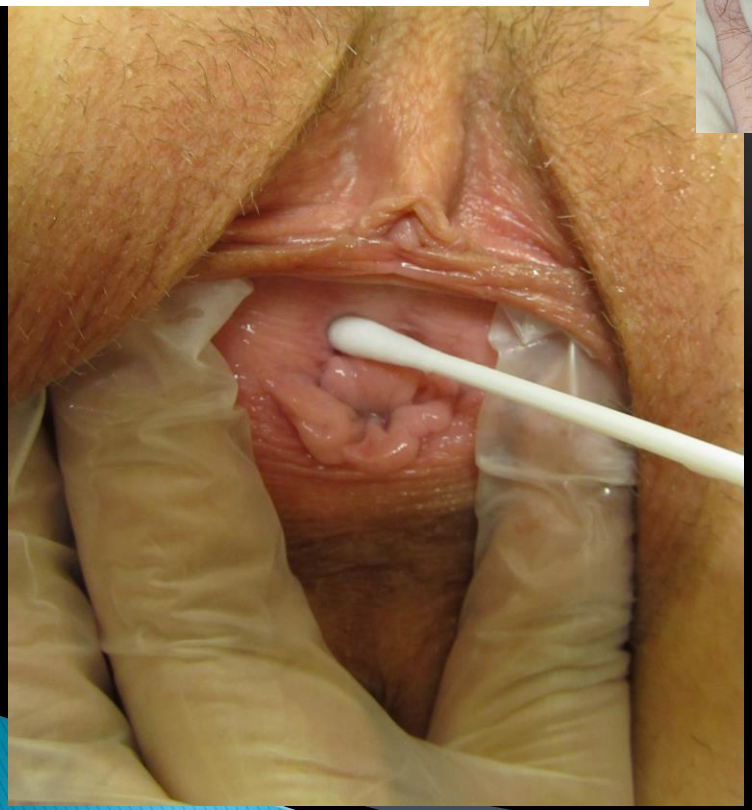
Cotton swab (Q-tip) test

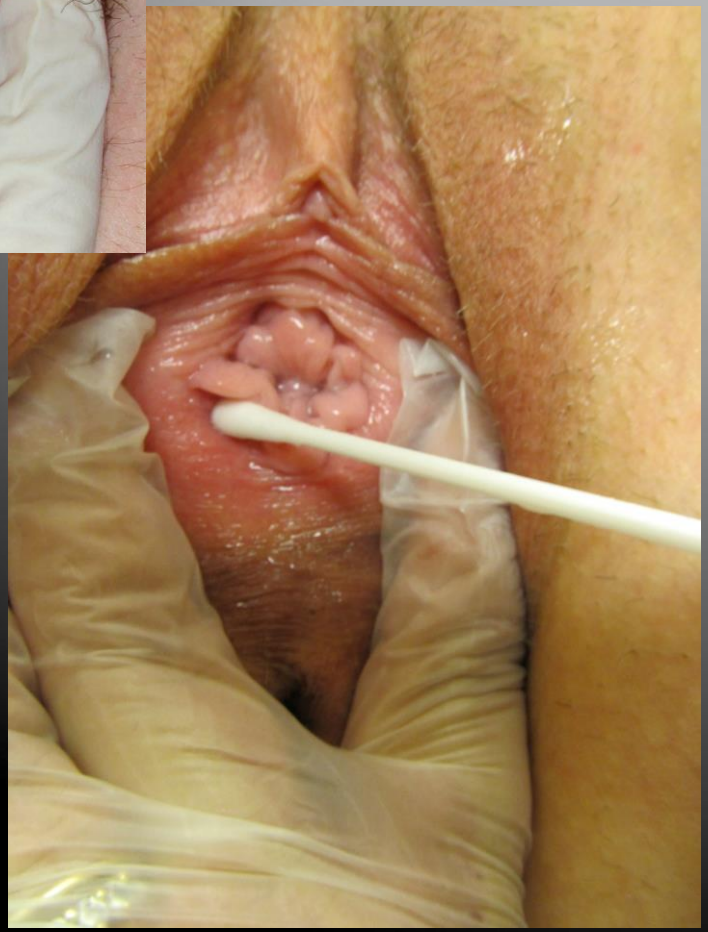


- Begin by touching the labia majora, interlabial sulci and minora
- Touch lateral and medial to Hart's line
- Touch the vestibule at Skenes and Bartholins ostia
- Can use a 1-5 or 1-10 scoring system for pain
- May use algesiometry for research purposes



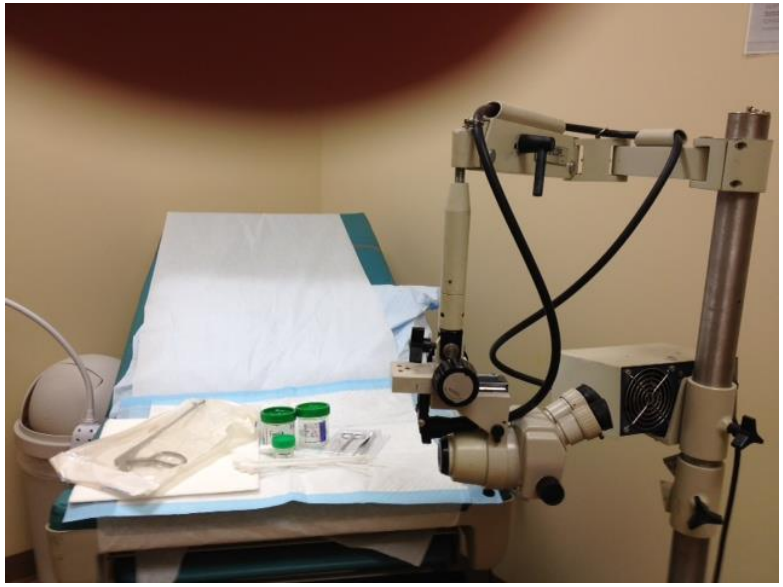


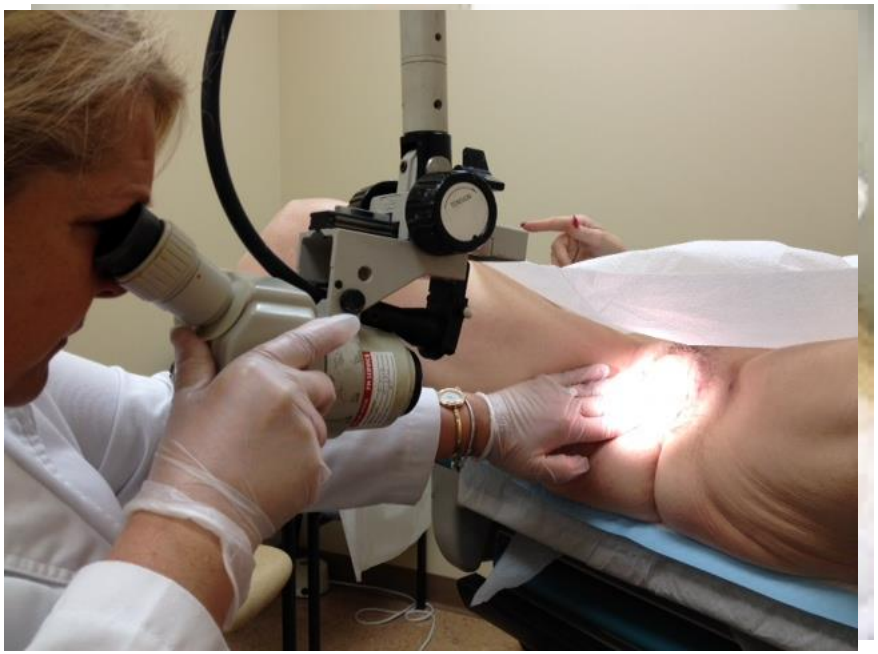




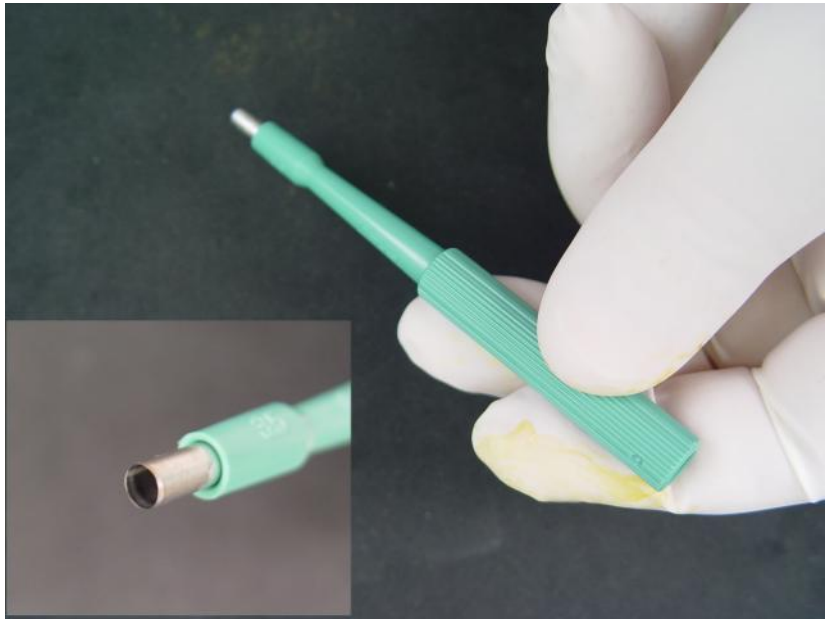
Vulvoscopy

- Erythema
- Lichenification
- Fissures, erosions, ulcerations
- Scarring & architectural changes
- Atrophy
- Hypo/hyperpigmentation
- Evidence of VIN

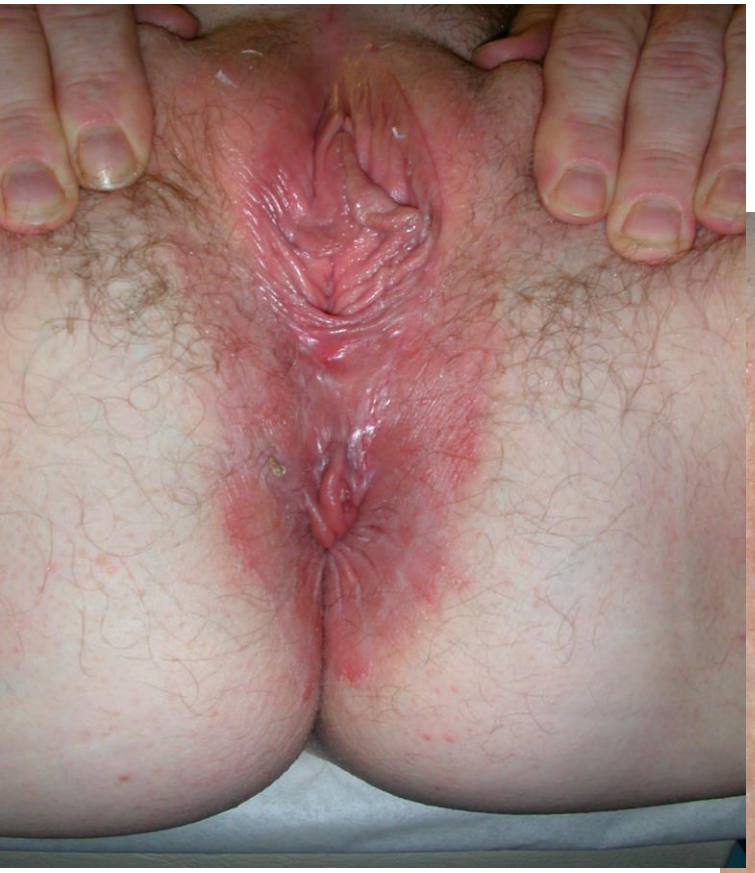


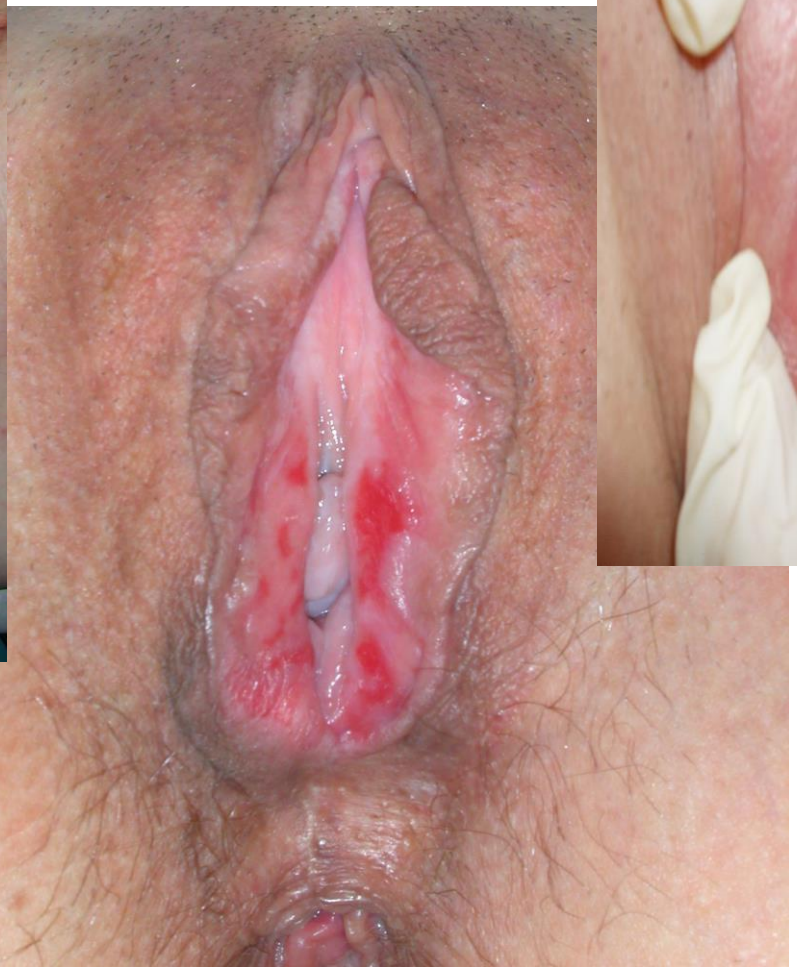


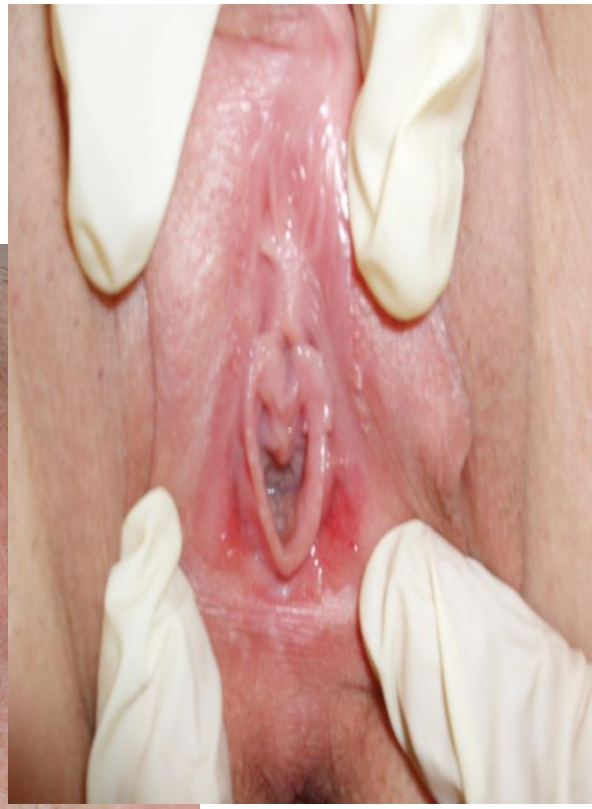
Vulvar biopsy- Only if there skin changes- send to a dermatopathologist with a differential diagnosis.



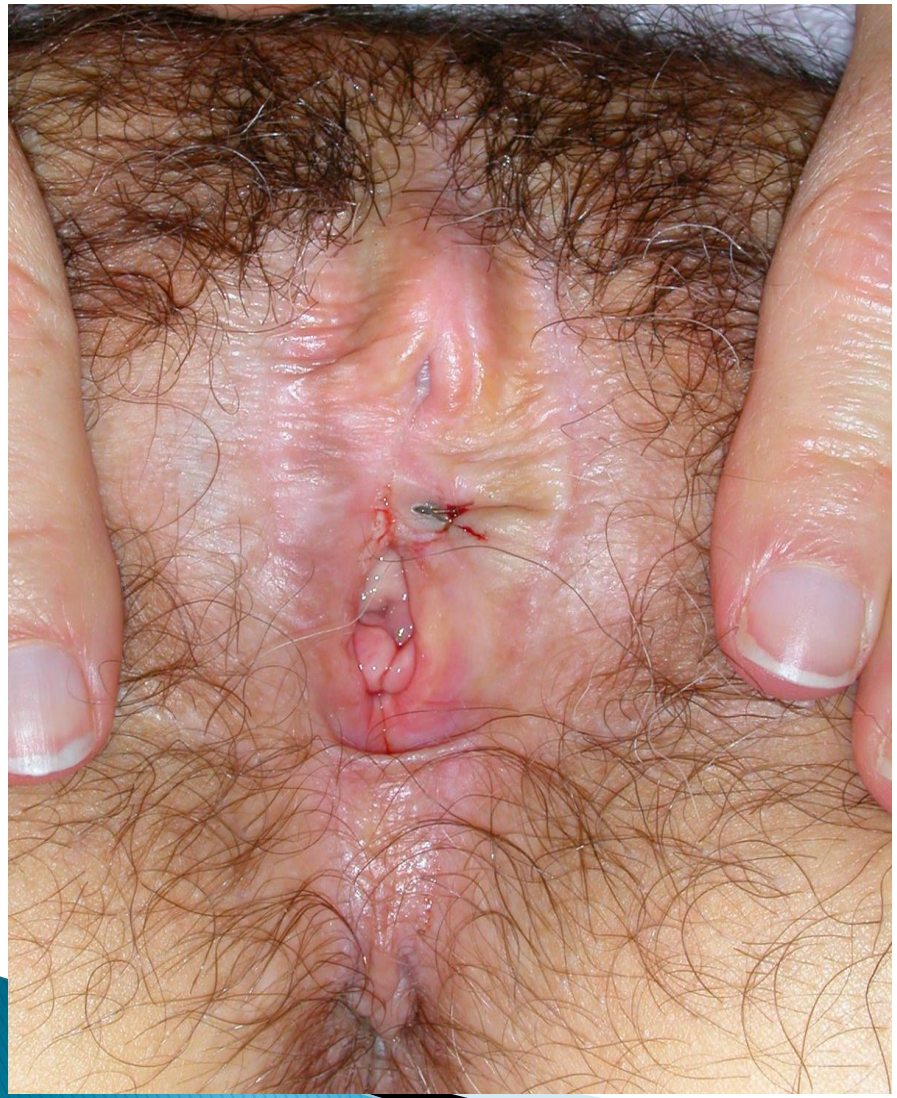
Erythema

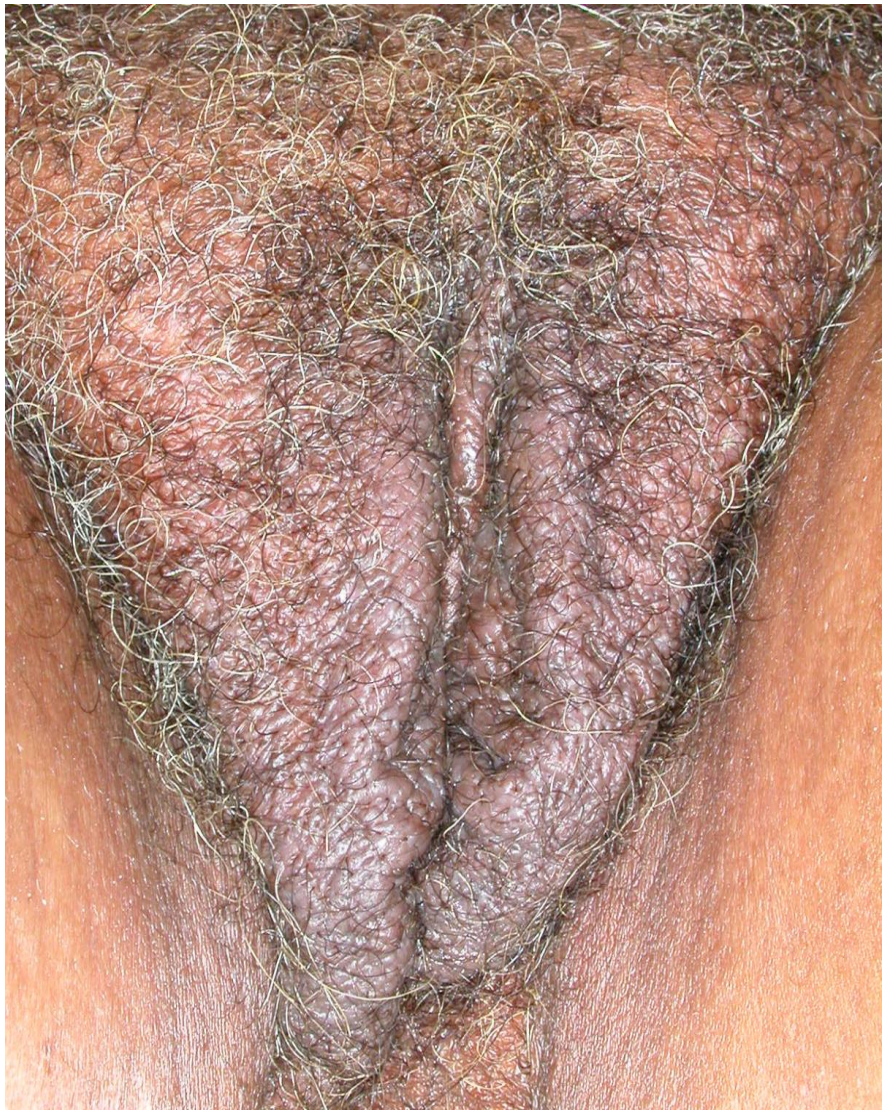




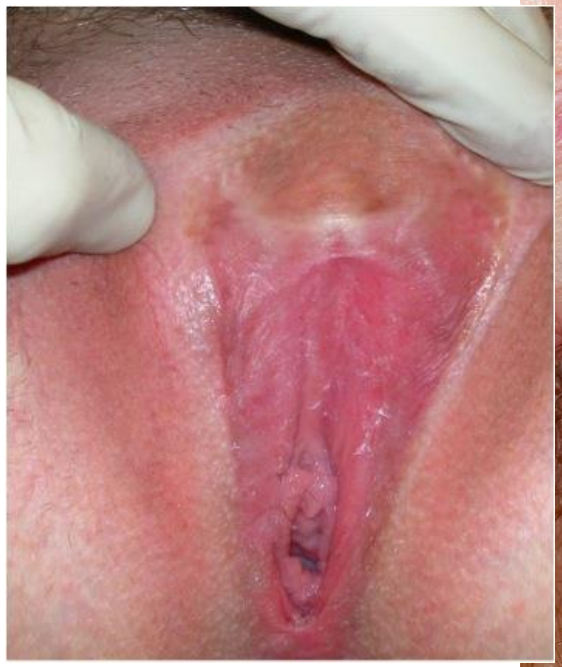


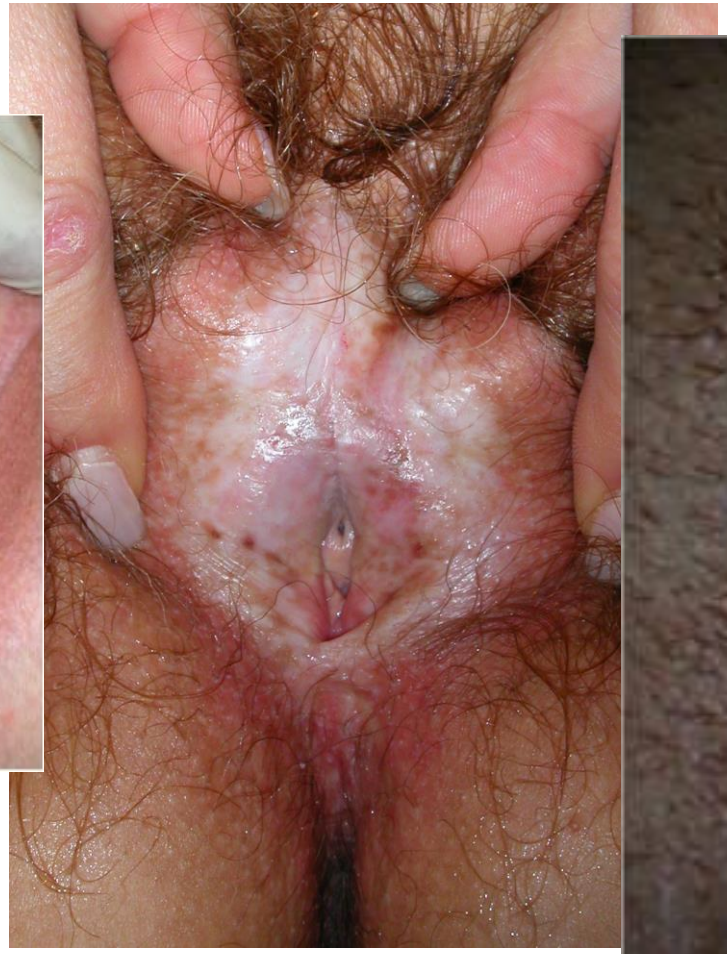
Lichenification





Phimosis / Plaques / Fissures

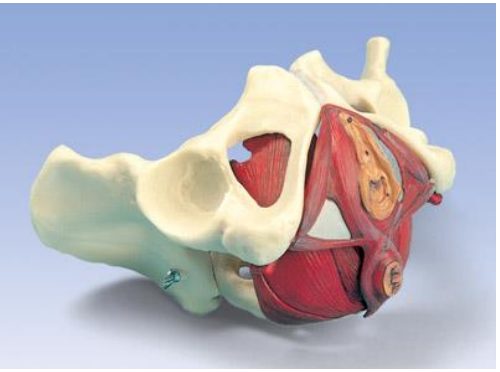


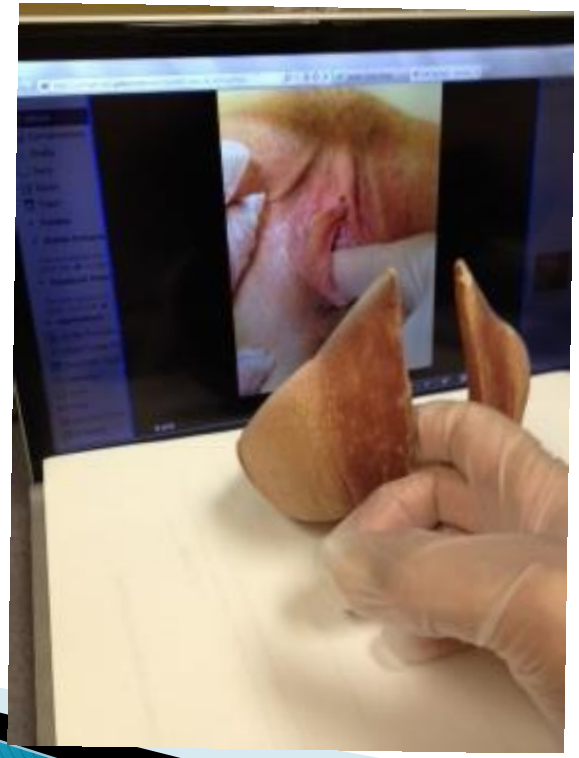


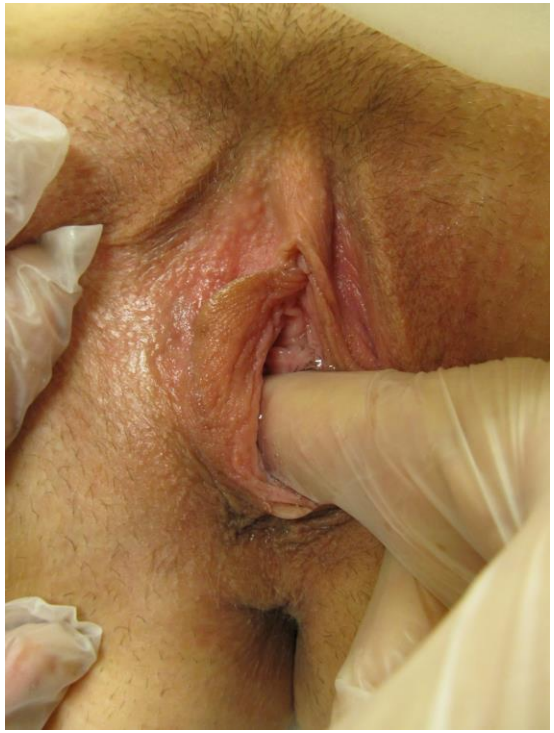
Additional lab tests

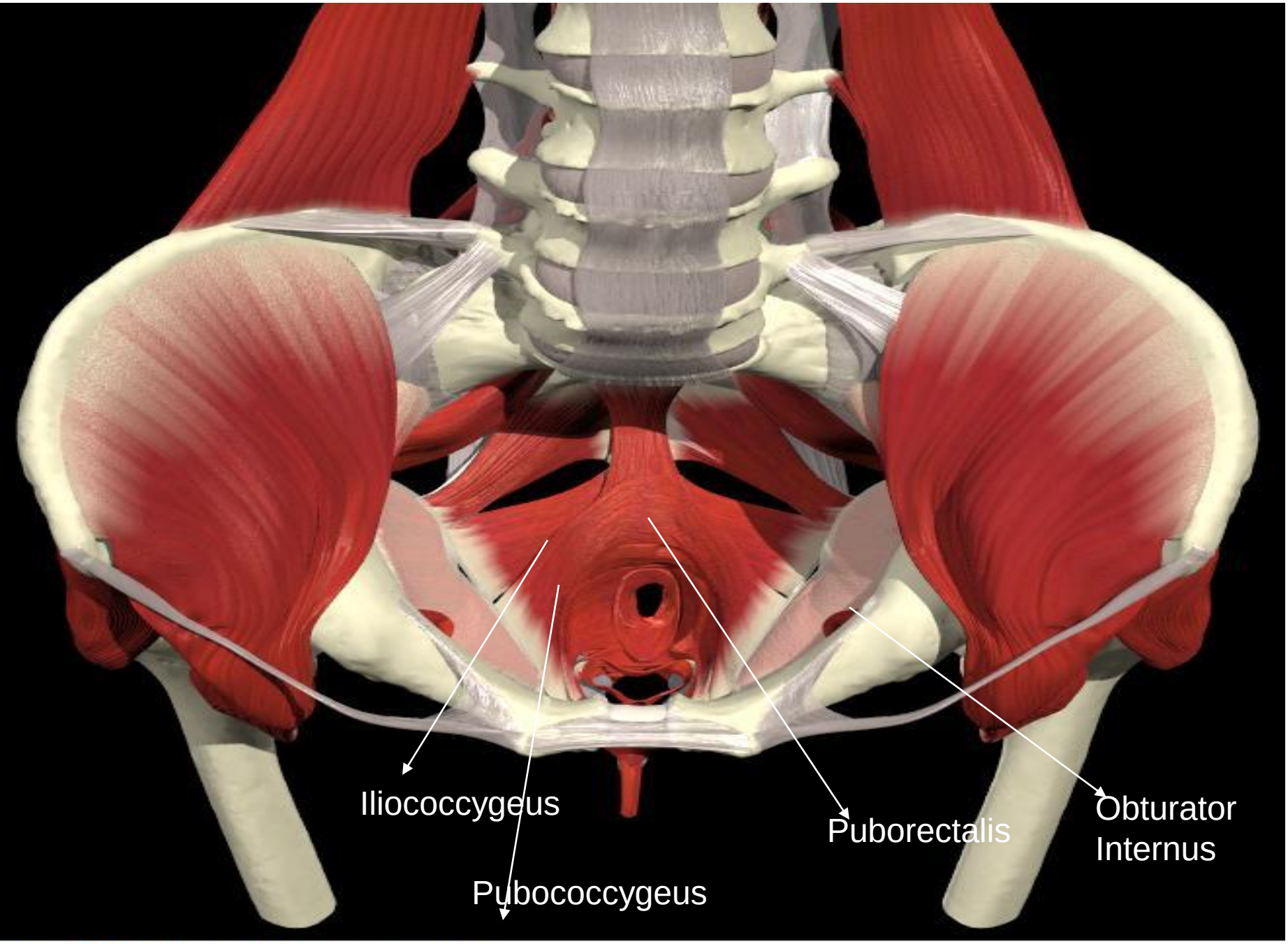
- Microscopy
- Cultures
- -speciation
- -sensitivity
- STI testing
- Perineometry
- Biothesiometry
- Bladder scan
- Cystoscopy-
- CT Urogram
- ** if bladder tender or unexplained microscopic hematuria

NEXT:
Evaluate the pelvic floor muscles









Pelvic Floor Muscle Principles

- *PFM are an integral support system : work with large postural groups to maintain skeletal position

  *PFM provide local "front, middle, rear" support

  *PFM enhance FSR
  (place pressure on deep dorsal clit. vein =preventing venous escape; facilitate sensation during intercourse)

  PFM can contribute to FSD if they are either HYPO- or HYPERTONIC

Travell JG & Simons DG. Myofascial Pain and Dysfunction. Chapt 6: Pelvic Floor Muscles.1992.Baltimore, Williams & Witkins/ Rosenbaum TY, Role of PT in FSD, Current Sexual Health Reports,2008
Graziottin A: [illegible] Sexual Dysfunction.: Evidence Based Physiology for the Pelvic Floor: Bridging Research and Clinical practice. Eds K Bo et al. Oxford, Elsevier2005.

Hypertonic Pelvic Floor Muscle Dysfunction

- Associated with: SI joint dysfunction, poor core strength, excessive strengthening, altered gait, piriformis syndrome, hip pain/labral tears.

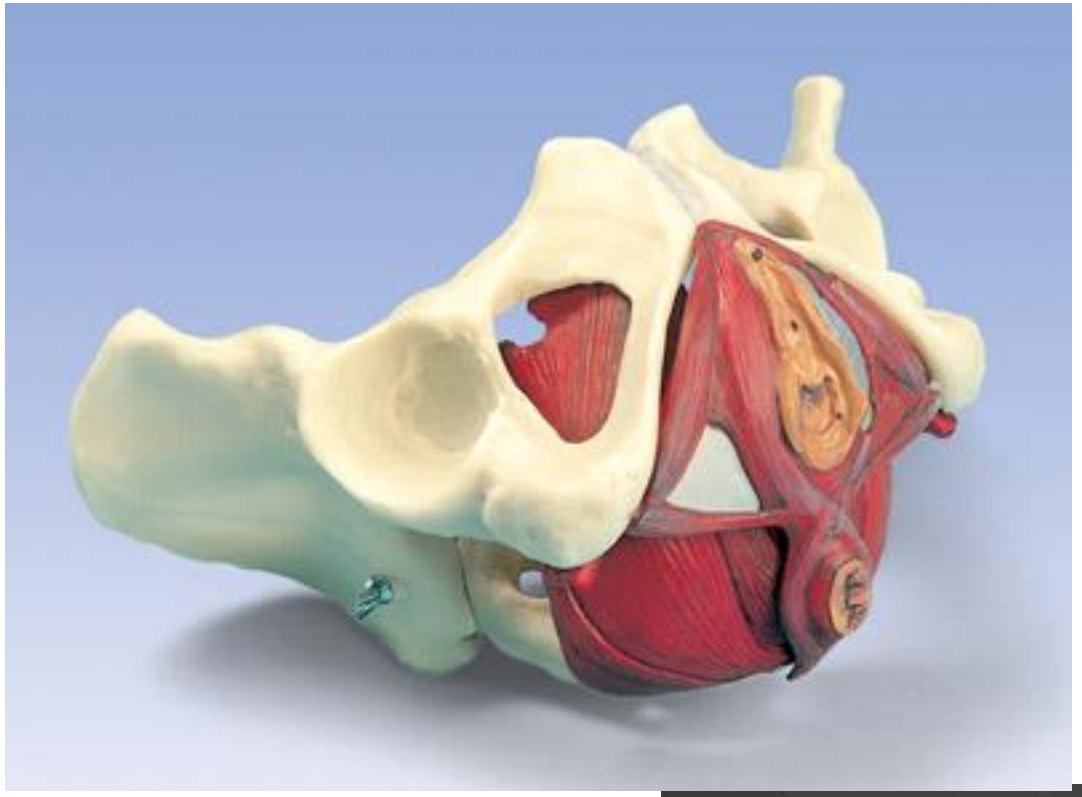
- Increased tone= decrease oxygenated blood flow = increased lactic acid in PFM

Hypertonic Pelvic Floor Muscle Dysfunction

- Symptoms:
- vulvar pain, burning, tenderness, introital dyspareunia, urinary symptoms, constipation, fissures

- "Vaginismus" =used in the past but term may be removed from DSM V.

Triage: pelvic floor physical therapy (www.womenshealthapta.org, **NVA.org).**

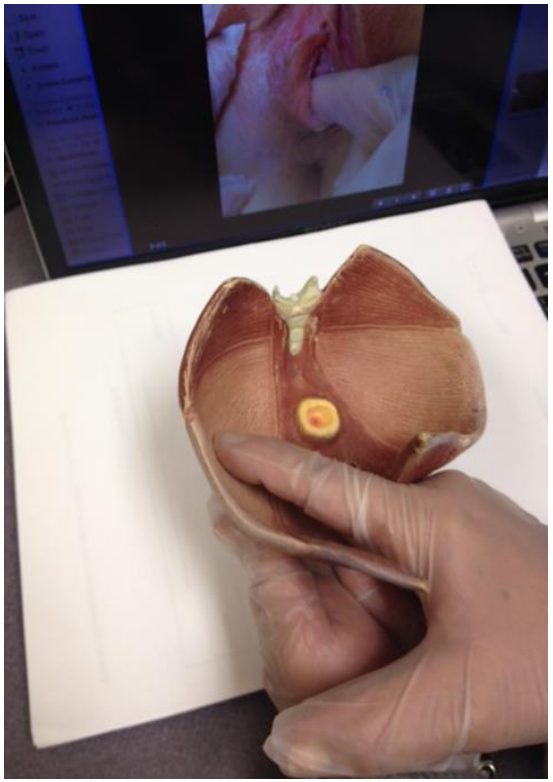


•PE=
poor contraction
and relaxation
MTRPs

Evaluation of the pelvic floor muscles

- Insert one finger through the hymenal ring then:

1. Palpate the superficial and deep PFM
2. For each muscle ask “is this pressure or pain?”
3. Have them squeeze-relax
4. Palpate the bladder-
   it should cause pressure
   but not burning or pain.



Use all the data you have collected from the history, physical, tests, and procedures and apply them to the differential diagnosis.