Effective management of vaginismus
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Vaginismus - definition
• Persistent or recurrent difficulty in allowing vaginal entry of a penis, finger and/or any object, despite a woman’s expressed wish to do so. ¹

• A syndrome with overlapping elements of
  – Anxiety/fear/panic – sometimes to the point of phobic avoidance
  – Hypertonic pelvic floor muscles (PFM) –> vaginal tightness and difficulty and pain with penetration


A new conceptualization of vaginismus is proposed.

Vaginismus is a misnomer
• Term introduced in 1861 by Dr J. Marion Sims
• There is nothing wrong with the vagina!
• Vagina is compressed by tight pelvic floor muscles
• ‘Pelvic floor myalgia’

Vaginismus: tight pelvic floor muscles
• Tight pelvic floor muscles cause pain on stretching and prevent or restrict penetration of the vagina by some or all of
  – Tampon – often first sign of a problem
  – Finger (the woman’s, her partner’s or a PV)
  – Penis
  – Speculum
  – Transvaginal ultrasound probe
• Commonest cause of unconsummated marriage

Variable presentations
• Primary – where vaginal penetration including tampons and intercourse has never been successful
• Secondary – where pain-free penetration was possible in the past but is no longer possible - no age limit
• Total - nothing can be comfortably inserted into the vagina
• Situational - penetration is possible but limited
  – One partner but not another
  – Penis is OK but not tampons or medical examinations
  – Apareunia

Variable causations
• Psychological causation – usually due to fear of pain or trauma
• Mixed causation – an underlying physical problem + the subsequent fear of pain
• Vaginismus can occur in lesbians where the main symptoms are difficulty inserting tampons, fingers, vibrators or dildos and problems with vaginal examinations
Vaginismus is common in sexology practice

- Vaginismus is thought to affect 5-17% of females in clinical settings.
- True prevalence is unknown because many affected women do not present – often a hidden problem.
- Cross-cultural problem but primary vaginismus with a psychological basis is more commonly seen in sexually repressive cultures particularly where premarital sex is taboo and virginity at marriage is essential.

Vaginismus is a paradox

- Involuntary contraction of voluntary muscles.
- Involves the muscles just below the skin of the vulva (perineal muscles) and the deeper pelvic floor muscles particularly the pubococcygeus and puborectalis.
- On examination chronically shortened, tense and tender pelvic floor muscles are usually found – when penetration is attempted these muscles may “grab” or be constantly tense.

Involuntary PFM contraction - reflex

- Protective mechanism like the corneal reflex/hand withdrawal.
- Anticipation of genital pain causes bracing of the body with contraction of surrounding muscles such as abdomen, buttocks, hips and adductors often squeezing the legs together – all triggers of pelvic floor tension.
- Other common anxiety-related triggers of pelvic floor tension:
  - Holding her breath
  - Clenching her jaw
  - Making a fist
  - Tensing the body and moving up and away from the penis in bed.

Explaining vaginismus to patients

Muscles of the female pelvic floor from above
Pelvic floor muscles are like a hammock between two trees supporting pelvic organs.

Puborectalis muscle is a U shaped muscle when relaxed.

Puborectalis muscle – from a relaxed U to a W

Bulbospinousus – also U to W shape – drags perineal body body up with it

Vaginismus

Quality of discomfort/pain

- Often burning or stinging
- Tightness or tearing sensation
- Like the penis is “hitting a brick wall”
- Pain may persist for one or more days after attempts at penetration
Fear of harm or trauma
- Many women perceive the pain they experience as very harmful and a sign of great trauma (this is not the case)
- Can result in anxious reactions to attempts at penetration such as crying, hyperventilating, racing heart, sweating, feeling faint
- Fear of pain or harm perpetuates the cycle of muscle contraction → increased pain → increased muscle tension etc
- Even the thought of sex can trigger anxiety and pain

Causes of vaginismus
- Usually at the root of vaginismus are physical or non-physical triggers that cause the body to anticipate pain

Psychological contributors to primary vaginismus
- Poor sex education – ignorance
- Sex negative conditioning and attitudes – family, religious and cultural
- Pressure to be a virgin at marriage
- “Horror” stories of deflowering – family, friends, media – fear of severe pain and copious bleeding
- Fear the penis may get stuck or damaged inside the vagina
- Childhood sexual/physical abuse or sexual assault

Psychological contributors to primary vaginismus
- Unrealistic vaginal fantasies
  - Hymen is a thick membrane that covers entire vaginal opening and must be “torn apart” – imperforate hymen – amenorrhoea
  - My vagina is fragile and easily damaged – in fact walls are similar to the hardy lining of the inside of the cheek
  - My vagina is too small for a tampon or a penis – compounded when doctors tell patients they are “small down there” – due to PFM tension
  - No vagina

Psychological contributors to primary vaginismus
- Mental health issues:
  - Anxiety
  - Depression
  - Fears e.g. of pregnancy and childbirth
  - Phobias
  - Relationship difficulties (cause or consequence?)

Psychological contributors to primary vaginismus
- Difficulty with initial tampon insertion and subsequent anxiety
- History of invasive childhood medical procedures - rectal examinations or enemas, throat or ear examinations, catheterisation
- No obvious explanation: no previous history but difficulty and pain with first attempts at penetration trigger the cycle of fear, muscle contraction and pain
Physical contributors to vaginismus

- Superficial or deep dyspareunia from any cause e.g. PID
- Endometriosis – often undiagnosed – associated with dysmenorrhoea, dyschezia and non-menstrual pelvic pain
- Chronic candidiasis – +/- irritation from topical treatments – oral Rx preferred
- Recurrent UTIs requiring antibiotics and subsequent candida
- Discomfort due to inadequate foreplay and sexual arousal

Physical contributors to vaginismus

- Vulval dermatological conditions – psoriasis, eczema, dermatitis, lichen sclerosus
- Nerve sensitivity at vaginal entrance – vestibulodynia, vulvodynia, pudendal neuralgia
- Childbirth trauma e.g. episiotomy or tear
- Pelvic trauma or surgery e.g. hysterectomy
- Musculoskeletal problems with spine or pelvis
- Irritable bowel syndrome
- Interstitial cystitis

Problems with vulval skin integrity due to hypo-oestrogenisation

- Thinning of skin, dryness, redness, splitting or irritation due to hypo-oestrogenisation
  - Perimenopause, menopause, early menopause or menopause after breast cancer treatment - vulvo-vaginal atrophy (GSM) – Rx Ovestin cream
  - Long term use of low dose OCP or irregular periods e.g. PCOS, amenorrhea – vestibular hypersensitivity Rx apply pea-sized amount Ovestin to introitus nocte

Help seeking behaviours

- Thoughts – stigma associated with vaginismus
  - Feeling of being flawed/ alone/ isolated: “What’s wrong with me? Everyone else out there is is having great sex except me.”
  - “How will I have a baby?”
  - “Will I be alone for the rest of my life?”
  - “It’s so embarrassing – who do I talk to about this?”
- Avoidance of seeking help is common however many patients have seen multiple HCPs before they find appropriate treatment

Doctors’ responses may increase anxiety

- Doctor may look and say “There is nothing to see” = it’s all in your head - unhelpful
- Prescribe anti-fungal medication
- Order a pelvic ultrasound – NAD
- Say
  - “Use a lubricant or local anaesthetic gel”
  - “Do Kegel exercises”
  - “Just relax” or “Have a glass of wine before sex”
  - “Try different positions”
- Prescribe dilators without proper instructions – refer to PF physio

Making the diagnosis

- Take a careful history
- Diagnosis can usually be made on history alone - diagnose underlying disorders
- Examine the patient – take your time - relax the patient - explain what you are doing – you will need a long consultation
- Take a good look at the vulva – she may have more than one condition - cotton bud test for vestibular hypersensitivity
- Exclude organic pathology e.g. vaginal septum, rigid hymen
- If necessary gentle superficial PV with 1 finger to feel pelvic floor tension – physios are good at this – do not insert speculum
Treatment

- Treatment depends on the cause – tailored to the patient
- Psychological intervention: progressive desensitisation - manage feelings of fear and anxiety around penetration – relaxation and mindfulness techniques can help
- Involve the partner if possible
- Treat underlying medical conditions
- Hymenectomy is rarely necessary and Fenton’s procedure is unhelpful

Treat vulval pathology

- Treat skin conditions e.g. psoriasis, eczema, dermatitis, lichen sclerosus etc
- Vulval hygiene measures
  - Don’t use soap – QV wash, Cetaphil, sorbolene, warm water
- Vestibular hypersensitivity elicited by cotton bud test – Rx topical amitriptyline 0.5% and oestriol 0.03% in organogel in pump pack – apply nocte or BD

Refer the patient?

- Refer the patient if necessary to
  - Gynaecologist
  - Vulval dermatologist
  - Sex therapist
  - Psychologist/counsellor
  - Psychiatrist
  - Pain specialist
  - Urologist

Management of vaginismus

- Education
  - Explain condition and its probable cause(s)
  - Explain genital and pelvic floor anatomy in detail – be sensitive
  - Genital self examination with mirror either with doctor or at home
  - Locate and identify pelvic floor muscles – contract, hold, relax
  - Vulval hygiene measures
  - Reassure patient this is a treatable condition
- Counselling before or with pelvic floor physiotherapy
  - Sex therapist, psychologist or counsellor for CBT, relationship counselling, treatment for trauma (EMDR), hypnosis or self hypnosis

Vaginal dilators or trainers

Physiotherapy

- Ban on intercourse during physiotherapy
- Encourage sensate focus and/or outercourse - aim is to reawaken desire and arousal by eliminating the fear of pain – ability to penetrate does not = pleasure
- Start with hamstring stretch to pain as a reference point for the brain to let go of the protection that drives the PFM to contract
Physiotherapy

- Practice contracting, holding and relaxing pelvic floor muscles (biofeedback can be useful)
- Stretching of external pelvic and hip muscles e.g. adductors, piriformis, gluts
- Trigger point releases via PFM massage can be very painful and can traumatis patients – not recommended

Physiotherapy

- Learn to “undo” all factors that tense the pelvic floor
  - Unclench teeth and fists
  - Relax abdomen, buttocks and thighs – bulge abdomen
  - Breathe – exhalation facilitates penetration
- For dilator work sitting position supported with pillows – upper body is at 45 degree angle to the bed and the abdomen is relaxed
- Alternatively stand with one leg raised on a chair or the bed

Physiotherapy

- Do dilator homework every day except day 1 and 2 of period
- Use lubricant – olive oil or coconut oil, Olive and Bee
- Always start with smaller dilator and progress to larger
- Contract, hold and relax pelvic floor and insert dilator on relaxation phase – leave for 5 to 10 mins = “static”
- Once comfortable with static try gentle stretch with dilator at 4, 6 and 8 o’clock – “stretch”

Physiotherapy

- When comfortable move to next larger dilator – do static then stretch – gradually progress to larger dilators
- Woman on top position can be helpful for attempting intercourse – woman controls the position, pace and penetration – contraceptive advice – use lubricant
- Contract hold and relax pelvic floor to insert graded dilators then penis
- Problems transferring to the penis: insert dilators in the upright kneeling position with knees wider apart than hips – step up from smallest to larger dilator before attempting intercourse

Botox – Botulinum Toxin Type A

- If women have tried all or some of the above approaches without success and still struggle with vaginismus Botox injections into the pelvic floor muscles under sedation provide a temporary window of opportunity (up to 6 months) to rehabilitate and stretch the tense pelvic floor muscles and also reduce the bulk of the muscles
- May not be suitable for all women e.g. pregnancy planned, BF
- Not on PBS – cost depends on dose required approx $380 per vial

In conclusion

- Vaginismus is a common sexual problem
- Treated by counselling, education, anxiety reduction, pelvic floor muscle relaxation exercises and retraining of pelvic floor muscles
- Treatment may take some months of physiotherapy sessions and practice at home but the success rate of therapy is very high when couples commit to treatment