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Original Research Article

A study of vaginismus in patients presenting with infertility

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ABSTRACT

Background: Vaginismus is an uncommonly reported entity, most of the patients present to the gynaecologist with complaint of inability to conceive. Female sexual dysfunctions are a common entity but difficult to diagnose and treat, Vaginismus is one of the categories of female sexual dysfunction.
Methods: Total 25 patients out of 900 patients attending the outdoor of Shivanjali Women's Hospital for infertility from the year 2008 to 2016 were found to be having vaginismus. With couple's consent females were treated for vaginismus. This is a retrospective study of 25 patients identified having vaginismus.
Results: Maximum 11 patients were in age group of 20 to 25 years. Forty percent 10 patients improved with counselling and education, lubricant gel and analgesic gel. Total 84% (21) patients conceived with different modes of treatment.
Conclusions: Vaginismus is uncommonly reported. With proper history and counselling of the couple vaginismus can be revealed, managed and conception can be achieved.

Keywords: Counselling and education, Muscle spasm, Vaginismus

INTRODUCTION

Infertility means inability to conceive. The incidence of infertility is on rise in India and worldwide. The reason behind this involuntary childlessness may be female factor, male factor or both. Female factors can be ovarian factors, tubal factors, uterine factors, immunological factors and others. Many patients face different problems related to consummation of marriage but some of them do not recognise it and many of them do not report it.

Sexual dysfunction is defined as a disturbance in or pain during the sexual response.[1] This problem is difficult to diagnose and treat in female counterpart than male because of the intricacy of the female sexual response. The female sexual dysfunction is divided in four categories. Sexual pain disorders being one of the category, include dyspareunia (genital pain associated with sexual intercourse); vaginismus (involuntary spasm of the vaginal musculature that causes interference with vaginal penetration), and noncoital sexual pain disorder (genital pain induced by noncoital sexual stimulation).[2]

Vaginismus is a condition that leads to difficulty in penetration of vagina, may be at the time of intercourse, vaginal examination, insertion of a menstrual cup or a tampon. Vaginismus is mainly as a result of vaginal muscle spasm which is involuntary leading to vaginal penetration almost impossible, where spasm of musculature of the outer third of the vagina interferes with intercourse.

There are two types of Vaginismus: total vaginismus, where intercourse is impossible, and the more seldom described partial vaginismus, in which intercourse is possible but painful.

Huguier first introduced the term "vaginismus" in 1834, as the title of his M.D. thesis. However, it was probably Trotula of Salerno, in her 1547 treatise on "The diseases of women", who provided the first description of what we now call vaginismus: "a tightening of the vulva so that even a woman who has been seduced may appear a virgin".[3]

Vaginismus may be triggered by physical events having inadequate foreplay or non-physical emotions as simple as general anxiety. Reacting to the anticipation of pain, the body automatically tightens the vaginal muscles, to protect itself from harm. Sex becomes painful, and entry may be more difficult or impossible depending upon the severity.[4]

Frequently, there are underlying negative feelings of anxiety associated with vaginal penetration. The belief that sex is wrong or shameful (often the case with patients who had a strict religious upbringing); and traumatic early childhood experiences (not necessarily sexual in nature).[5] Or strict conservative moral education, which also can elicit negative emotions.[6] Emotional triggers that result in vaginismus symptoms are unique. It is important that effective treatment processes include addressing any emotional triggers, so a pain-free and pleasurable sexual relationship can be enjoyed upon resolution.

According to the severity of the condition Vaginismus has been classified by Lamont in four degrees. In first degree vaginismus, the patient has spasm of the pelvic floor that can be relieved with counselling and reassurance. In second degree, the spasm is present but maintained throughout the pelvis even with reassurance. In third degree, the patient elevates the buttocks to avoid being examined. In fourth degree vaginismus (also known as grade 4 vaginismus), the most severe form of vaginismus, the patient elevates the buttocks, retreats and tightly closes the thighs to avoid examination.[5] Pacik expanded the Lamont classification to include a fifth degree in which the patient experiences a visceral reaction such as sweating, hyperventilation, palpitations, trembling, shaking, nausea, vomiting, losing consciousness, wanting to jump off the table, or attacking the doctor.[7]

Vaginismus is an uncommonly reported entity, most of the patients present to the gynaecologist with complaint of inability to conceive. A detailed history and examination along with counselling of the couple reveals the history of unconsummated marriage leading to the unmasking of the problem.

METHODS

Women attending the Outpatient Department of Shivanjali Women's Hospital with the complaint of inability to conceive are subjected to detailed history taking and physical examination routinely. During examination and counselling, patients identified as having vaginismus, were counselled about treatment and with the couple's consent, treatment started for vaginismus. All women under treatment for vaginismus were subjected first to counselling and education session. This session dealt with detailed sexual education with understanding of local anatomy. Discussion on the condition that it is not unique and can be overcome with continuous efforts. A common belief of many patients with vaginismus that their vagina is not of adequate size was also included in counselling session.

Those who could not improve with it were subjected to other modalities in a stepwise manner. That is addition of lubricants and analgesic gels, vaginal dilators, surgery etc. Women were called every 20 days. Every visit patients were analysed for improvement along with a detailed counselling and education session. Active patient participation in treatment was ensured in each visit along with certain home assignments. Minimum 3 months were given before stepping up to the next modality. This is a retrospective study of the patients who underwent routine treatment for vaginismus as well as infertility during the period of 2008 to 2016. Out of 900 infertile patients, 25 patients identified as having vaginismus and underwent treatment were analysed.

RESULTS

Out of 25 patients identified as having vaginismus, 11 (44%) patients were in 20-25 years age group. There were 10 (40%) patients in 26-30 years age group and 4 (16%) patients in 30-40 years age group.

Table 1: Age group of patients.

Age group	Number of patients (n=25)
20-25	11 (44%)
26-30	10 (40%)
30-40	4 (16%)

Fifty six percent (14) patients could seek medical help within first year of marriage, twenty eight percent (7) took one to three years before they seek help and sixteen percent (4) took more than three years.

Table 2: Seeking treatment after duration of marriage.

Seeking treatment after duration of marriage	No. of patients (n=25)
< 1 year	14(56%)
1year-3years	7(28%)
> 3 years	4(16%)

Three patients improved with counselling and education only. Lubricant gels and Analgesic gels added to counselling and education, 10 (40%) more patients showed improvement. Vaginal dilators helped 6 (24%)

patients. Two (8%) improved with surgery. Four (16%) patients could not improve.

Table 3: Improvement in vaginismus with different modalities.

Improvement with modality	No. of patients (n=25)
Counseling and education (C+E)	3 (12%)
C + E + lubricants and analgesic gels	10 (40%)
Vaginal dilators (educators)	6 (24%)
Surgery	2 (8%)
Not improved	4 (16%)

Within six months of commencing the treatment, 3 (12%) patients showed improvement, ten (40%) more patients improved in 6 months - 1-year period, eight (32%) patients took more than one year to show improvement.

Table 4: Duration for improvement.

Time duration for improvement with any modality	No. of patients (n=21)
Within 6 months	3 (12%)
6months-1 year	10 (40%)
> 1year	8 (32%)

Eight (32%) patient who improved with vaginismus treatment, conceived naturally.

Table 5: Conceived with different modality of treatment.

Conceived with different modality of treatment	No. of patients (n=25)
Natural conception	8 (32%)
Induction + follicular study by TVS	7 (28%)
Induction + follicular study by TVS + IUI	4 (16%)
IVF	2 (8%)
Not conceived	4 (16%)

Eight partners developed different dysfunctions.

Table 6: Male dysfunction.

Husband developed problems due to female sexual dysfunction	No. of patients
Premature ejaculation	6
Other dysfunction	2

DISCUSSION

Total 900 patients attended the outdoor at Shivanjali Women's Hospital with chief complaint of inability to conceive. Out of them with detailed history taking and examination with counseling as a routine for all infertile patients, 25 patients were detected having problem of vaginismus, underwent treatment.

Almost equal numbers of patients were found in 20-25 years and 26-30 years. Four patients were in 30-40 years age group. Out of 25 patients identified, 14 attended the outdoor in less than a year of marriage. Seven patients attended in 1-3 years of marriage and four patients seek help more than three years later which was quite a surprising factor. Delay in seeking medical help may be due to sexual ignorance, lack of knowledge in identifying the problem and personal hesitance.

Counseling and education helped 3 patients to improve, whereas when lubricant and analgesic gels were added as treatment to counseling and education, 10 more patients showed improvement, possibly due to local tissue desensitization. Treatment of vaginismus may involve the use Hegar dilators, (sometimes called vaginal trainers) progressively increasing the size of the dilator inserted into the vagina.[8] Six patients showed improvement with self-insertion of vaginal dilators and 2 with surgery. Four patients did not improve due to inadequate attempts, lack of support from spouse or irregular treatment. Twenty-one patients improved with different modalities got conceived. Many couples face male sexual dysfunctions also as a result of repeated failed attempts due to vaginismus. In the present study, 8 partners developed different dysfunctions. O' Sullivan's study, husbands were twice as likely (26%) to have a sexual dysfunction of their own if their wives had vaginismus rather than an orgasmic dysfunction.[9] However, an increased incidence of impotence and premature ejaculation in the husband of a vaginismic woman may be a result of the vaginismus. In response to repeated frustration, male sexual functioning may well be adversely affected.[10]

CONCLUSION

Vaginismus is a phobia with underlying negative emotions aggravating it. Ignorance of sexual attitudes may contribute to it. Infertility is a social problem in our country. So, gynaecologist may encounter the problem of vaginismus commonly. Gynaecologist as a consultant can provide therapy in an ideal manner. An empathetic and gentle manner as a therapist is most critical. Though improvement is slow but with repeated efforts of patients along with partner and consultant, it can be nullified. Present study has limited number of patients as it is limited to patients attending obstetrics and gynaecology outdoor for infertility, but results in the form of conception are encouraging.

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