

# Vaginismus- an inconspicuous disorder necessitating multimodal approach: a mini review.

## Mini review

Pain, fear and anxiety with penetration attempts in women describe vaginismus. It is described as penetration disorder by the Diagnostic and Statistical manual of Mental disorder 5<sup>th</sup> edition.<sup>1</sup> It is characterized by involuntary spasm of outer one third of vagina that leads to physiological disorder and is clearly different from vulvodinia and vestibulodynia.<sup>2,3</sup> The diagnosis is clearly history based and is characterised by strong opposition to any kind of sexual or non sexual vaginal penetration, even gynaecological examination.<sup>2,3</sup> Physical examination is then carried out to rule out any local pathology in the form of infection like herpes and dermatitis as the cause for pain during penetration attempts. The treatment is difficult and has to be individualised. Vaginismus is a rarely talked and taught topic, and so it is important that the problem and the various treatment modalities available are highlighted concisely.

## Penetration disorder

James Marison Sims first coined the term ‘VAGINISMUS’ in 1862 in Obstetric Society of London.<sup>4</sup> Spasm at the level of introitus defines vaginismus and can be of mild intensity or severe enough making treatment strenuous. Vaginismus is a rarely talked topic even among gynaecologist and also least taught during residency training. The incidence of vaginismus is 5-17% and is one of the more common female sexual disorders.<sup>5</sup> It can be further divided into primary vaginismus in which patient has never experienced non painful intercourse and secondary when patient had a non painful experience with sexual intercourse and is now having difficulty with the same.<sup>6</sup> Traumatic sexual event, sexual abuse, lack of sexual education and strict religious upbringing are some of the factors that may be causative, but not seen in all cases.<sup>7</sup> The patients usually presents with history suggestive of inability to use or remove tampons, inability to have intercourse and even a gynaecological examination. Vaginismus often leads to depression and marital disharmony in majority, thus warranting an effective treatment.

## Treatment- a multimodal approach

As the disorder states, the treatment should be a multimodal approach involving gynaecologists, psychologists, sex therapists and physical therapist to achieve a favourable and desirable outcome. Indefectible treatment must be based on an idea that there exist a complex relationship between biological, physiological and emotional aspects and also couple's relationship to each other. Appropriate counselling of the patient with her partner lays the foundation of the treatment, in which anatomy and physiology of the sex is discussed and also the probable factors responsible for the same. Psychotherapy and hypnotherapy are further treatment options available.<sup>8,9</sup> Systematic desensitization along with insertion of finger and graded dilators also known as Masters and Johnson's regime is one of the most effective treatment options available and results in deep muscle relaxation.<sup>10</sup> Physical therapy with or without pelvic floor biofeedback therapy comes next in line with almost 100% success rate.<sup>11,12</sup>

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Among pharmacological treatment, antidepressants, anticonvulsants, anxiolytics, lidocaine, a topical anaesthetic<sup>13</sup> and botulinum toxin, a temporary muscle paralytic have also been tried over the years for the treatment of vaginismus. Anxiolytic medications like diazepam are most commonly used, in patients with high anxiety level and are proven to be effective. However, no evidences are available from randomised controlled trial for other drug therapy. In a study, 241 patients were enrolled in the study with vaginismus. Pre-treatment questionnaire (FSFI-female sexual function index) was filled by each patient. This was followed by intravaginal injection of onabotulinum toxin A above, into and below the hymenal fragments on each side to include the full width of bulbospongiosus muscle and bupivacaine injection inserted along the length of right and left sub mucosal lateral vaginal walls and progressive dilation under conscious sedation. Pain free intercourse within a mean of 5.1 weeks was noted in 171 patients (71%), with a significant change in FSFI score as well.<sup>14</sup> Surgery is never an option in this case as was thought in early years. So, the treatment has high success rate when protocol of treatment is individualised as per patient severity of symptoms.

## Conclusion

Vaginismus as discussed above is a genito-pelvic pain/penetration disorder leading to fear, anxiety and stress in the sufferer. So, the treatment should target on all the sensitive issues in a multimodal approach. The treatment options available are pelvic floor physiotherapy, pharmacological treatment, sex and cognitive behavioural therapy and general psychotherapy. So, it is of utmost important to diagnose vaginismus and treat it appropriately to ensure a happy patient and a satisfied clinician.

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## Conflict of interest

The author declares there is no conflict of interest.

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