CASE REPORT

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Medical Science

Treatment of a woman with seconder infertility and vaginismus

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Introduction: **Vaginismus has traditionally referred to involuntary contraction of the muscles of the pelvic floor surrounding the vaginal orifice. Vaginismus is a disorder that is easy to diagnose but also has a psychiatric component that is difficult to assess and treat at the same time. We intend to write this article to show how the problem is recognized, approached, and treated in a county state hospital in the East of Turkey.** ***Case Report:*** **A patient with vaginismus who applied to our clinic with second child's wish was treated with different size of molds (dilators) for pelvic relaxation. The treatment efficacy was then tested with different validated tests.** ***Results:*** **After the patient's treatment has been completed and the sexual relationship has been established, the pre-treatment questionnaires were repeated, and significant improvements were observed in the questionnaire results.** ***Conclusion:*** **Vaginismus is a sexual dysfunction that is easy to diagnose but difficult to treat. The two most important factors that facilitate treatment are the understanding and patience demonstrated by the practitioner and the belief that those who experience this problem will be able to resolve this situation In our case, treatment has been successful and reflected in our surveys. If these conditions provided, vaginismus treatment can be performed with success, even in a region in eastern Turkey.**

INTRODUCTION

Vaginismus is listed as a genito-pelvic pain/penetration disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), [1]. Vaginismus is both an emotional and pain disorder [2]. The actual incidence of vaginismus is unknown because women generally do not discuss their symptoms [2]. Observational studies of women evaluated in sexual health clinics all over the world have reported a prevalence of 5 to 42 percent [3,4,5]. Vaginismus has traditionally referred to involuntary contraction of the muscles of the pelvic floor surrounding the vaginal orifice. The patient is averse to vaginal penetration (sexual and nonsexual, such as gynecological examination, tampon, dilators) due to actual or anticipated pain [6].

AIM

In recent times, clinics in the western part of our country have continued to increase in significance in this regard, still in the east as a mystery. Vaginismus is a disorder that is easy to diagnose but also has a psychiatric component that is difficult to assess and treat at the same time. We intend to write this article to show how the problem is recognized, approached, and treated in a county state hospital in the East of Turkey.

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CASE

A 24-year-old, G1P1, delivered by cesarean section, applied to our clinic with second child's wish. In her medical history, a patient who had no traits other than hepatitis B carriers were found to have no real sexual coexistence with his wife in his anamnesis. The patient stated that she was congested with the intercourse only by friction and became pregnant in this way. When deeply inquired, it was learned that she married loving her husband, that her husband was conscious of the problem against her, and that no one from family or conversation knew this problem. In the past, there was a story of sexual harassment by a distant relative from the village and an older brother living in the same house. The patient had a fear of spider and darkness accompanying this sexual dysfunction. Before marrying, she told by her close relatives that she was informed about the first night and was very afraid. When she got pregnant after two years of marriage, the patient explained how she was going to give birth, and she was terrified. She explained that she could not have a vaginal examination to the doctor when the birth pangs started and that she was delivered with cesarean section. She expressed that the most fearful thing during the relationship was that the hymen was supposed to be bleeding very much. The patient stated that she could not enter into the relationship with the pain of his life and the fear of bleeding and that she was intimidating herself and was quite uncomfortable. She stated that she had sexual intercourse with vaginal wetness and that she wanted to get in touch with her husband. She stated that at the time of union she suddenly unintentionally tightened the perineal muscles and could not enter into the relationship. The patient expressed her husband's desire for anal sex and oral sex because she could not have vaginal sex, but stated that he did not force herself and did not do it when she did not want it. The patient stated that she did not have any doctoral applications for this problem. Then the patient's

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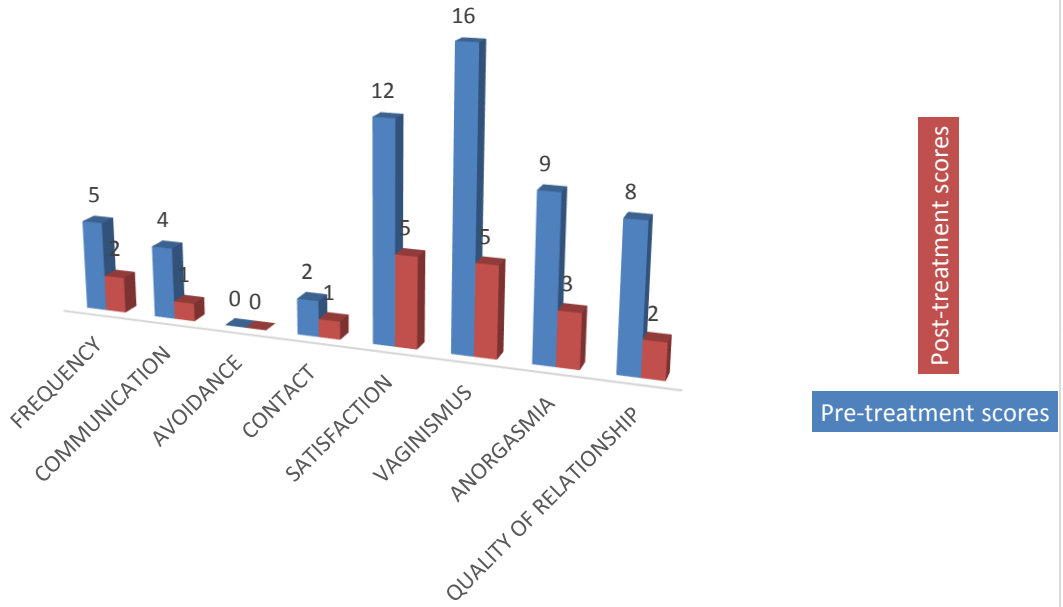
Table1 Pre and Post-treatment scores of Golombok-Rust Sexual Satisfaction Scale



husband was interviewed. The patient's husband stated that he was happy with the curing, was pleased to get into the relationship without pre-teasing and rubbing. He liked each other so much with his wife and stated that he did not understand why they could not enter into sexual relations. Her husband stated that he had been offering oral and anal sex to his wife, but his wife did not accept it.

After receiving detailed anamnesis from the patient and spouse, and after the diagnosis of vaginismus, the pre-treatment Beck Depression Scale, Golombok-Rust Sexual Satisfaction Scale, and Arizona Sexual Life Assessment forms were filled, and status assessments were made. Also, the patient was filled with the FSFI form (female sexual function index). Following the filling of the forms, the patient and her partner were told in the form of treatment, and their approval was taken.

The patient was treated with a total of 3 sessions of psychotherapy accompanied by molds (dilators) specially cylindrically shaped in specific sizes in glass factories (the sessions were performed weekly and for an average of 1 hour). The patient was given specific homework weekly during treatment, and the mold was given to her for use at home. It was especially emphasized that sexual intercourse should be avoided during treatment. In the last session of treatment, after working with specific mold sizes, the confidence of the patient increased weekly and reached the highest point, allowing her to enter into sexual relations with her husband and emphasized that they could give feedback by phone. After the treatment, the patient had telephone feedback and stated that she could easily enter sexual intercourse and expressed happiness born from this situation. At the end of a month when the patient and her partner had regular sexual intercourse, the pre-treatment questionnaires were repeated and significant improvements were observed in the questionnaire results.

GOLOMBOK-RUST SEXUAL SATISFACTION SCALE

The scores before and after treatment were reported on the following table (Table-1). If the score of first two components on the table are 4 or above, it indicates sexual dysfunction. If the score of the components after the first two components is 9 or above, it is indicative of sexual dysfunction. Post-treatment scores showed a significant improvement at the level.

FSFI (FEMALE SEXUAL FUNCTIONAL INDEX)

The scores before and after treatment were reported on the following table (Table-2). After treatment, FSFI scores showed improvement in all components except satisfactory component.

BECK DEPRESSION INVENTORY

The total score decreased significantly after treatment compared to pre-treatment, and it was observed that the mood improved according to the patient's score (Table-3).

0-9 POINTS-NORMAL LEVEL
10-18 POINT-LIGHT LEVEL DEPRESSION SYMPTOM
19-29 POINT-MIDDLE LEVEL DEPRESSION SYMPTOM
30-63-REPRESENTING THE SEVERAL DEPRESSION SYMPTOM

Before the treatment, the patient was moderately depressed according to this inventory and returned to normal mood after the treatment.

THE ARIZONA SEXUAL EXPERIENCE SCALE-FEMALE FORM

A total score of 11 or higher in the Arizona Sexual Experience Scale form is considered to be a sexual dysfunction. In this patient, the total score before the treatment was 20, and after the treatment was reduced to 10, indicating that the existing sexual dysfunction was absent (Table-4). Questionnaires were also filled by the patient's husband and compared before and after the treatment. The Arizona Sexuality Scale male form score was 10 before and after treatment and no changes were observed and sexual dysfunction was not detected. The Beck Depression Inventory score was 2 before and after treatment and was found to be in normal mood. The male form of the Golombok-Rust Sexual Satisfaction

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Table 2 Pre and Post Treatment Scores of FSFI

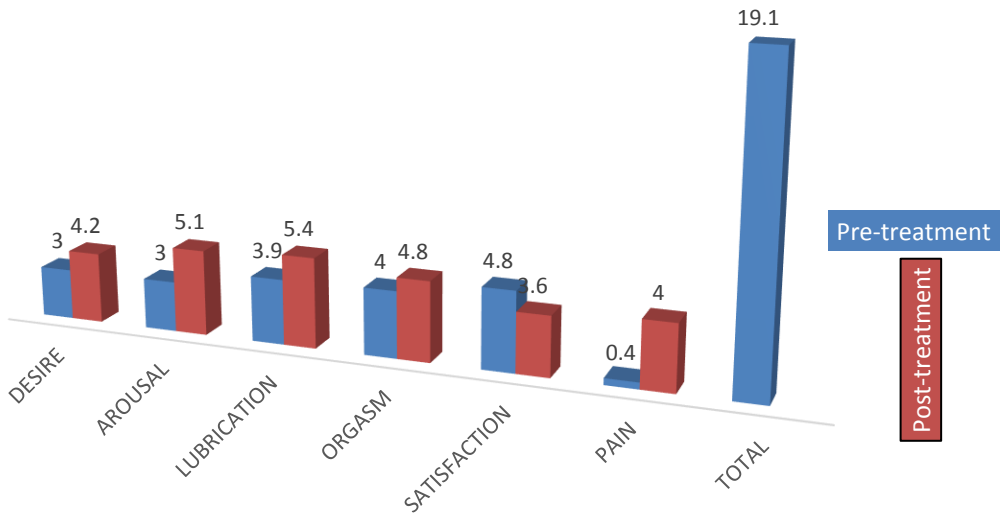

Table 3 Beck Depression Scores pre and post treatment

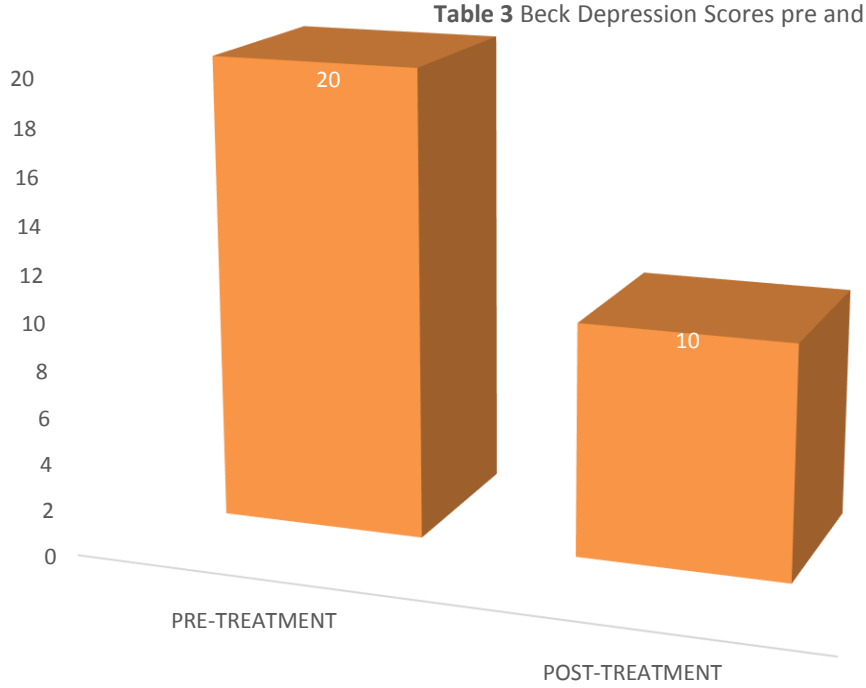

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Table 4 The Arizona Sexual Experience Scale-Female Form

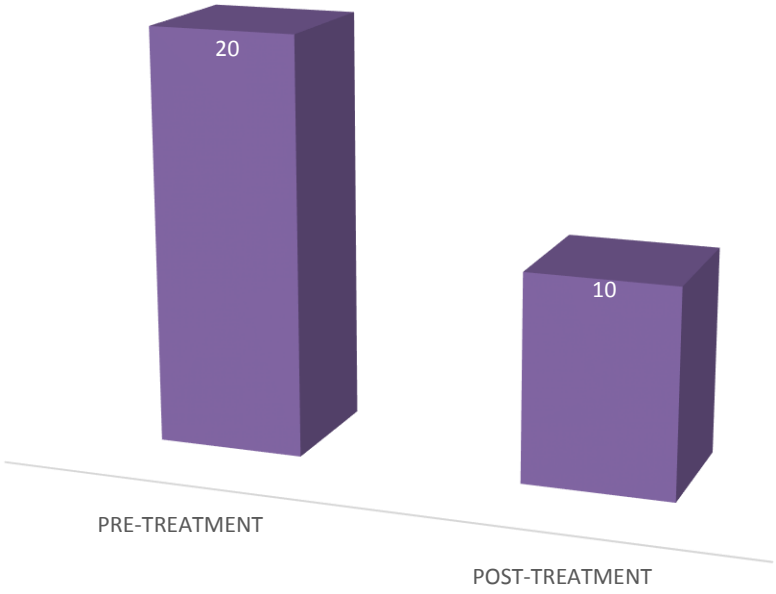
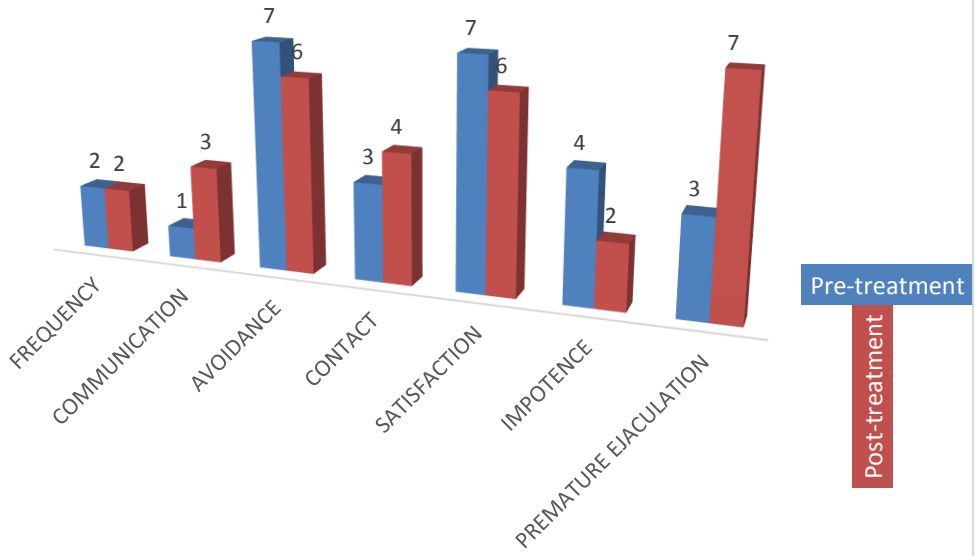


Table 5 Golombock-Rust Sexual Satisfaction Scale-Male form-pre and post treatment scores



Scale was filled before and after the treatment, and the results are given in the table below (Table-5). As in the case of the same female form, the first two components of the male form show a score of 4 and above, while the scores of the next components are 9 and above, indicating that the problem is in the field. Before and after treatment, all scores are below the limit scores that are problematic for men.The remarkable detail is that the premature ejaculation after treatment is more frequent, as the patient's wife has complained about the only complaint since the mating has occurred.

DISCUSSION

The definition of vaginismus as muscle spasm has been questioned. Evidence from electromyography (EMG) studies does not actively support a vaginal muscle spasm mechanism [6]. An operational definition of the term “muscle spasm” does not exist, and there has been a lack of consensus regarding which muscles are involved in vaginismus [7]. Studies identifying specific muscle groups as the source of spasm did not indicate the method used to arrive at these conclusions [8], and it is essential to recognize that the diagnosis of vaginismus has relied mainly on clinicians and researchers who do not do physical evaluations

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of their patients. On the other hand, some studies have shown that the pain of vaginismus is similar to the pain of provoked vulvodynia [9,10,11].

Many different organic factors can lead to vulvovaginal pain through a variety of pathways; congenital abnormality, acute or chronic inflammation, atrophy, loss of epithelial integrity, and central nervous system sensitization are a few examples. Often, these are undiagnosed vulvovaginal disorders. Organic factors often combine with other factors such as anxiety and phobia, disgust, lack of sexual knowledge, cultural and religious beliefs, genital and sexual trauma, and abuse [7,12]. Although unproven by randomized, controlled trials, these combinations may represent the explanation for vulvovaginal pain, dyspareunia, and pelvic floor dysfunction/vaginismus.

A physical exam is performed to rule out physical conditions, such as infection or inflammatory dermatitis, which may have triggered the pain. If a known cause is identified, both the cause and the pain of pelvic floor/vaginismus require treatment.

Subcategories of vaginismus to describe patient variations have been proposed, including:

-Primary vaginismus: lifelong pain with attempted vaginal penetration [13]

-Secondary vaginismus: progression to painful vaginal penetration after some pain-free period [13]

-Situational vaginismus: inability to tolerate certain forms of penetration such as intercourse, yet insertion of tampons or fingers is possible [14]

-Spasmodic vaginismus: spasm of the vagina [14]

-Complete vaginismus: inability to tolerate any vaginal penetration [14]

Primary and secondary vaginismus may be treated initially with the myofascial release of muscle tension in muscles of the pelvic floor, thighs, and abdomen, with or without biofeedback. Desensitization techniques are then applied to give the woman control over muscle tonicity/relaxation. Activities include Kegel exercises, the pelvic floor drop technique (reverse Kegel), and the use of dilators. Self-insertion of dilators of gradually increasing size in and out of the vagina teach the woman that control of introital musculature can be voluntary and painless. Desensitization is the goal of dilator therapy, not a physical enlargement of the vaginal opening. A small amount of topical anesthetic should always be used on any object inserted intravaginally since desensitization will not occur without painless insertion. We applied this method in our patient and observed that the treatment was successful. Other therapeutic approaches include sex therapy, progressive relaxation, sensate focus, electromyography, biofeedback, use of benzodiazepines, hypnotherapy, and Botulinum toxin type A injections [15,16,17]; none have been evaluated in well-designed studies [18,19].

CONCLUSION

In conclusion, vaginismus is a sexual dysfunction that is easy to diagnose but difficult to treat. The two most important factors that facilitate treatment are the understanding and patience demonstrated by the practitioner and the belief that those who experience this problem will be able to resolve this situation. The more the patient believes this situation will be resolved and the more understanding the partner is, the more successful the treatment will be. In our case, treatment has been successful and reflected in our surveys. If these conditions provided, vaginismus treatment can be performed with success, even in a region in eastern Turkey.

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Authors Contribution

Omer Demir: Opinion, Design, Consultancy, Data Collection, Analysis, Resource Science, Article Writing, Language

Cihan Comba: Resource Science, Language

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Vaginismus, treatment, infertility

Conflict of Interest

No author has any potential conflict of interest.

Informed Consent

Informed consent was obtained from the parents of the patient.

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