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Case Report

A case report of successful treatment approach for Vaginismus

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ABSTRACT

Vaginismus is a condition that can be defined as an uncontrolled contraction of the vaginal muscles, which can lead to difficulty in coital activity.1,2 The term vaginismus was coiled in 19th century. However, vaginismus has been actualized as a inconsistent but well recognized and well managed female sexual dysfunction. In 1859 gynecologist pen down from his personal experience "I can confidently assert that I know of no disease capable of producing so much unhappiness to both parties of the marriage contract, and I am happy to state that I know of no serious trouble that can be cured so easily, so safely and so certainly"1,3. This actualization was extended by Masters and Johnson. Who clocked in a treatment and outcome success rate of 100%. 1,4. Beck stated vaginismus as "an interesting illustration of scientific neglect"1,5.

There is paucity in the evidences of epidemiological studies examining the population prevalence of vaginismus as it requires gynecological assessment and the effected will avoid it due the pain anticipation due to which there have been numerous estimation with concerns to the prevalence vaginismus1. Masters and Johnson state that it is comparatively sparse conditio1,4,6 And there are others who advocate that it is the most found female psychosexual dysfunction.7-10. The prevalence of vaginismus remains unspecific however the prevalence rate in clinical setting have been outlined to fall between 5-17%11.

It was found that Ghana reported 68.1% cases with signs and symptoms of vaginismus.12. An Italian women reported 9% of enquires for vaginismus over a phone call helpline.

1. Introduction

Vaginismus is a condition that can be defined as an uncontrolled contraction of the vaginal muscles, which can lead to difficulty in coital activity.[1,2] The term vaginismus was coiled in 19^{th} century. However, vaginismus has been actualized as a inconsistent but well recognized and well managed female sexual dysfunction. In 1859 gynecologist pen down from his personal experience "I can confidently assert that I know of no disease capable of producing so much unhappiness to both parties of the marriage contract, and I am happy to state that I know of no serious trouble that can be cured so easily, so safely and so certainly".[1–3] This actualization was extended by Masters and Johnson. Who clocked in a treatment and outcome success rate of 100%.[1,4] Beck stated vaginismus as "an interesting illustration of scientific neglect"[1,5]

There is paucity in the evidences of epidemiological studies examining the population prevalence of vaginismus as it requires gynecological assessment and the effected will avoid it due the pain anticipation due to which there have been numerous estimation with concerns to the prevalence vaginismus.[1] Masters and Johnson state that it is comparatively sparse condition[1,4,6] And there are others who advocate that it is the most found female psychosexual dysfunction.[7–10] The prevalence of vaginismus remains

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unspecific however the prevalence rate in clinical setting have been outlined to fall between 5-17%.[11]

It was found that Ghana reported 68.1% cases with signs and symptoms of vaginismus.[12] An Italian women reported 9% of enquires for vaginismus over a phone call helpline for sexual problems.[13] Women in Iran who attended a family planning clinic reported 12% of women suffered from vaginismus at least 50% of the time with 4% suffering vaginismus.[14] A study in Turkey where 54 women attended the psychiatric OPD found 75.9% reported vaginismus out of which 6 turned up with a lifelong problem[15]

2. Need of The Study

Vaginismus (Dyspareunia) being very commonly seen in women but rarely spoken about making it difficult to target the population. The need of the study is to create awareness about vaginismus and possible physiotherapy management for the same.

3. Case Report

1. A 29 years old women nulliparous IT professional with no medical history was referred to us with a chief complaint of pain during coital activity and unable to complete the coital activity due to pain. When the comprehensive analysis was done her BMI wad 20.3kg/m2 she had an increased lumbar lordosis and her muscle strength according to manual muscle testing was as follows
2. Lower abdominal strength (Transverse abdominis : 3/5
3. Int and Ext Obliques: 3/5
4. Lower back strength (Multifidus: 3+/5)
5. DRAM: supraumbilical - 2 fingers
6. Umbilical - 2 fingers
7. Infraumbilical - 2 $\frac{1}{2}$ fingers

Transvaginal examination findings are in Box 1 with states the finding done on the day of consultation and on her 1^{st} review

Table 1:

Measurments	Day 1-01/12/20	1^{st} review -04/02/2021
Dynamic assessment	Accessory muscles use	No accessory muscles use
Response to cough	Inward Protrusion	Inward Protrusion
Palpation	Outer ring tighter than the inner ring (1finger penetration	Outer ring comparatively less tight (allowed 1 finger penetration), trigger point at 3,9,10 o'clock
PFm Relaxtion (HET's MMT)	-1	-2 on the 1^{st} 2 tries -3 from 3^{rd} tries
Endurance	5 Sec	8 Sec
Repetition	4	7
Fast twitch	4	6

Table 2:

Out come measures	Day 01-01/12/20	1^{st} review-04/02/2021
Dilater size	1 finger penetration was difficulty	Dilator size 4 dilator was introduced with a little difficulty but penetration was possible
Female sexual function index (FSFI)	6.6	24.6

4. Pelvic Floor Physiotherapy Intervention

4.1. Relaxation

Breathing relaxation was given to the women where the 1^{st} 10 mins of the intervention was invested in. she was asked to take a deep breath in from the nose and breathe out from the mouth once this concept was familiarized then she was asked to breath in from the nose and breath out from the mouth and at the same time try to open the virginal opening.

4.2. Perineal massage

For the the individual was asked to lie down on her back with knees folded then she was asked to rest her knees on the therapist. Gentle strokes were given at the vaginal opening and strokes from mons pubis to vaginal opening with gloved fingers and gel applied on the fingers. Gentle pressure with the tips of the fingers was applied at the vaginal opening.

4.3. Clock wise awareness of pelvic floor

Once she was comfortable with the relaxation and the perineal massage clockwise awareness was thought to her this would make it easy for her to understand her pelvic floor and understand where the tightness is.

4.4. Finger insertion

After the pelvic awareness, gently a finger is inserted into the vaginal opening this is done by keeping the gloved finger at the vaginal opening and asking her to contract and relax. This continuous contraction and relaxation will guide the finger into the vaginal canal without applying excessive forces and stimulating pain. Once this is done with less pain and minimal discomfort, it will help in gaining her confidence in you and will also help in reducing her anxiety regarding penetration. Once the finger in the vaginal canal very gently the clockwise assessment was done. The finding of the assessment on the 1^{st} day and the review is in box 1.

4.5. Trigger point release

After the clockwise assessment and the trigger points are determined they are gently released by applying pressure as tolerated by her and the pressure is maintained for 30 sec. this is repeated 3 to 4 times and then the other trigger point is targeted.

4.6. Dilator

After the trigger points are released and the finger penetration gets easier with lesser pain dilator was introduced. Use of dilator must be in functional positioning. Use of the dilator was started in lying down position, once this was achieved was progressed to side lying and then into all 4 position. The dilator was first applied to the applicator and with gel applied at the tip and girth of the dilator was gently placed at the virginal canal and with the same technique that was used for finger penetration the dilator was introduced into the vaginal canal. Once the dilator was introduced into the vaginal cavity gently the copulation activity was mimicked and was continued for 15-20 mins with rest period of 2 3 mins after every 4 mins.

5. Discussion

The invasive therapy used for managing the case shows a positive outcome to the therapy delivered. There is an improvement seen in the hypertonus muscle and a significant improvement in the quality of life. In a study done by Weiss JM it states that invasive pelvic myofascial release helps in reducing the hypertonus state of the pelvic floor muscle[16] similarly in the case study performed the invasive intervention given for the release of the trigger points in the pelvic has shown to reduce the hypertonicity and was maintained till the next session.

There was a study performed by Silva AP Et al. where perineal massage was done for individuals with dyspareunia and showed positive effects in reducing dyspareunia caused by tenderness[17] similarly in this case the tenderness was highly prevalent and very painful and was building the anxiety and fear in the individual which was similar to the study done by Payne KA et al.[18] perineal massage helped in reducing the tenderness, pain and the anxiety which was associated with pain which helped in improving penetration.

In a study by Pacik PT et al dilators were used in a case of vaginismus which helped in improving and maintaining the stretch[19] similarly in this case the dilator helped in stretching and maintaining the tone of the pelvic floor muscle which helped in improving the quality of penetration.

In a study conduced by C M Meston on the scoring of the FSFI has the weight to correctly understand the sexual dysfunction and to a guided treatment.[20]

6. Conclusion

The treatment helped in reducing the tone of the pelvic floor, reduced the intensity of trigger points, reduced the anxiety and fear of penetration resulting in improved quality of copulation.

7. Source of Funding

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8. Conflict of Interest

None.

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