



DSM-V CLASSIFICATION GENITO-PELVIC PAIN/PENETRATION DISORDERS VULVARVESTIBULITIS - SEXUOLOGICAL DIAGNOSTICS IN A GYNECOLOGIST'S PRACTICE

Beata R. Wróbel

Individual Practice for Women's Health, Dąbrowa Górnicza, Poland.

ABSTRACT

Nowadays, women's sexual disorders are included in three classifications of diseases:

1. by the World Health Organization: International Statistical Classification of Diseases and Related Problems (ICD – 10),
2. by the American Foundation for Urological Disease (AFUD), and
3. by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V).

The diversity of the classifications arises from the absence of an unambiguous definition of a sexual disorder.

Up to the present times, the woman's painful sexual intercourse and sexual dysfunctions have not been associated with the physiopathology of the female genitals. At present, the situation seems to be changing due to the DSM-V Classification published in 2013. Dyspareunia and vaginismus are jointly classified there and described as: Genito- Pelvic Pain/ Penetration Disorders. DSM – V opens a new direction of diagnostics and therapy of pain-related sexual disorders in women. This requires collaboration of gynecologist, psychologist and a physiotherapist. Such a situation needs new procedures to be implemented. [1,2,3,4].

The paper presents a suggestion of the Sexological Examination Model (SexEM) as prepared for the use of a gynecologist. The model is based upon an interview and bimanual gynecological examination towards a diagnosis of the sexual problem.

The purpose of such an examination is to confirm or exclude the presence of an organic factor which causes the women's sexual disorder in vulvodynia and in diseases of the vulva which accompany other ailments and diseases classified as nonvulvodynia.

KEY WORDS: Genito-pelvic pain / Penetration Disorders, DSM – V, Vulvarvestibulitis, Sexological examination in gynecology.

Introduction

The history of observation of sexual pain is more than 150 years long. In 1861, Marion Sims an American physician delivered a speech to the Obstetrical Society of London 'On *Vaginismus*'. He was the first to describe in the speech five women with the 'syndrome' of symptoms to form a separate disease, horrible as for the extent of the misery caused by it, not only physical but also social and moral misery'. The 'moral misery' pertained to the fact that such women remained virgins even with years of being married. Sims distinguished two types of painful sexual intercourse, i.e. inflammation of the vestibule of the vagina (vestibulitis) and involuntary contraction of muscles around the vagina opening vaginismus. He used the term 'vaginismus' to describe both of the disorders.

For the next fifty years Sims' theory was not accepted by the environment of medicine. Woman's painful sexual intercourse was left beyond the scope of medicine. When S. Freud introduced his psychoanalytical theories into the environment of physicians, they were more favorably received of medicine and sexual issues were classified as neuroses and hysterias, i.e. exclusively psychiatric problems. The aspect of pain in the surface of vestibule of the vagina, so well described by Sims, was ignored till the end of the 20th century. Women used to be referred to psychotherapists whose standard procedures did not include a physical gynecological examination, and without it was impossible to find and define the ailment. Thus, the medical texts of the years 1929-1974 did not mention any diseases of the vulva. After half century of silence, in 1975, the term vulvodynia was used again by the International Society for the Study of Vulvovaginal Disease (ISSVD) [5].

DSM – V. Genito-Pelvic Pain/ Penetration Disorders

Nowadays, according to the DSM - V Classification, four types of women's sexual disorders are recognized:

1. Female Orgasmic Disorder,
2. Female Sexual Interest/Arousal Disorder,
3. Genito-Pelvic Pain / Penetration Disorder, and
4. Substance/Medication-Induced Sexual Dysfunction.

The third item of the Classification includes pain-related sexual disorders. According to R. Basson's understanding of the course of woman's sexual response cycle, disorders of desire, excitement, orgasm and disorders of penetration co-exist and they function as psychosexual *continuum*. However, it seems

that in the syndrome of genito-pelvic pain / penetration disorders which develops at presence of co-existent vulvodynia, vestibulodynia or vulvarvestibulitis, the causative factor is of organic nature. Differential diagnostics of the organic factor plays the crucial role in the process of proper therapeutic proceedings, and differential diagnostics may be carried out by a gynecologist only. Effects of therapy may too be assessed by a gynecologist in the course of a gynecological examination [1, 2, 3, 4, 6].

Since 1975, many various terms have been used to describe the two common subtypes of vulvodynia: generalized and localized (topical). Confusion and misunderstandings in the scientific and medical jargons, and in communication with the patient are common.

The term **vulvodynia** was first used in a medical text in 1880, and in 1888, S. A. Skene wrote about *'particular hypersensitivity of the vulva with no visible rubefaction or other visible diseases manifested externally. When the examining finger touches the hypersensitive part, the patient complains about pain which is sometimes so strong that it causes weeping. Sexual intercourse is as painful, irritating and impossible in such cases'*.

Vestibulodynia is perceived by 18% of the population of women as chronic pain or discomfort characterized as the sensation of burning, piercing or irritation of the vestibule of the vagina at absence of symptoms of infection or disease of the cutis of the vulva or vagina. The type and intensity of the symptoms are fairly individualized. The pain may occur periodically or permanently.

Vulvarvestibulitis is a condition whose causes may be complex, and they may arise from nerve injury, from genetic factors and/or from too dense nerve endings. All the present theories need research and scientific confirmation. The factors of pathophysiology of the vulva and vestibule of the vagina will be probably identified as genetic, environmental or perhaps hormonal or neurotransmission in their nature [7].

The term vulvarvestibulitis is convenient for the purpose of diagnosing the presence of an organic factor in pain-related sexual disorders in women. It defines joint occurrence of vestibulitis and vulvitis [8, 9].

Society for the Study of Vulvovaginal Disease (ISSVD) suggests a classification of vulva-derived ailments which is very practical from the point of view of diagnosing the organic factor in the course of gynecological examination.

Each pain related with specific diseases is defined as 'nonvulvodynia', and it includes the following:

1. Infection (candidiasis, bacterial vaginosis, etc.);
2. Inflammatory diseases (contact dermatitis, etc.);
3. Neoplastic conditions (Paget's disease, squamous cell carcinoma, etc.);
4. Neurologic conditions (pudendal nerve irritation, spinal nerve compression, etc.); and

Proper vulvodynia which is divided into generalized and topical vulvodynia.

Table 1. Division of proper vulvodynia

Generalized Vulvodynia (numerous lesions on the vulva):	Topical vulvodynia in a single place of the vulva (e.g. clitorodynia, hemivulvodynia):
1. Provoked vulvodynia (sexual, extra-sexual vulvodynia or both types)	1. Provoked vulvodynia (sexual, extra-sexual vulvodynia or both types)
2. Unprovoked (generalized) vulvodynia	2. Provoked vulvodynia limited to the vestibule of the vagina - vestibulodynia (formerly "Vulvar Vestibulitis Syndrome")
3. Mixed vulvodynia (provoked and unprovoked)	3. Unprovoked vulvodynia
	4. Mixed vulvodynia

Sexological Examination Model (SexEM)

For the purpose of diagnosing the organic factor in pain-related sexual disorders, questions concerning sexual activity shall be introduced to the gynecological interview.

Each woman visiting a gynecologist shall be asked the questions about: pain in the vulva (vulvodynia and nonvulvodynia), experiencing painful sexual intercourse (genito-pelvic pain / penetration disorders) or remaining in non-consumed relation (long life vaginismus) [10]. The test of four questions may be used for this purpose.

1. Test of four questions whether the patient suffers from:

- "genital pain";
- "burning in the vulva", "genital burning";
- pain in the course of vaginal pack introduction, sexual intercourse or gynecological examination;
- deliberate avoiding sexual contacts due to pain.

2. In case of at least one affirmative answer, the patient should be asked whether:

- the condition occurred suddenly;
- the condition has been remaining for a longer time;
- the condition is caused by absence of sexual initiation in the relation.

3. Question concerning occurrence of fear

Prior to a bimanual gynecological examination, the patient should be asked whether she feels any fear of sexual activity.

If the patient's sexual history shows that she has experienced pain related to sexual intercourse, each further attempt of sexual intercourse will be accompanied by fear of pain. Fear also of pain experienced or expected during the gynecological examination. Presence of pain is the key element which determines the further stage of the gynecological examination. In case the pain is so intensive that it may be defined as 'claustrophobic', the patient 'pushes' the doctor away and she does not allow the examination while already on the gynecological chair, the doctor shall give up attempting the gynecological examination. In such a case, it is necessary to refer the patient to a psychologist or sexologist-gynecologist and to prepare her for a gynecological examination in the form of a therapy [8,9,11,12]. In case of less intensive fear, the sequence and necessity of consecutive actions shall be explained to the patient, and further stages of the examination shall be carried out.

4. External examination

Inspection of the mucosa and cutis of the vulva. The examiner shall pay attention to occurrence of reddening/congestions, injuries related to cosmetics of the vulva. The topical condition shall be described with reference to pain intensity.

'Cotton swab' examination is an examination of the vulva and the vestibule of the vagina with a cotton swab, which consists in touching the greater pudendal lips, the groove between the lesser and greater pudendal lips, clitoris together with its prepuce, crotch, places within the area of the vestibule of the vagina. On each touch, the patient shall be asked about any feeling of pain.

Examination of neurosensitivity of the vulva is the next part of the examination which consists in tactile examining of the internal surface of the thigh and knee. The examiner asks the patient about the difference in the sensation of pain and her feeling in each of the examined places.

5. Internal examination

Examination of the muscles of the pelvic floor is the stage at which fingers of the examiner shall be introduced into the vagina. **The patient must accept** this activity, and she should try to cooperate with the doctor. No examining movement shall be made without the patient's consent. The examination may be interrupted at any time so to not intensify the woman's trauma. In case there are favorable conditions to conduct the examination, we examine the pelvis with a circular clockwise motion, and we pay attention to painfulness of the soft and bone tissues and of the ligaments.

6. Supplement to history taking

Assessment of the co-existing factors which may affect the sensation of painfulness of the vulva, i.e. mental and somatic diseases and problems, sleep disorders, evaluation of life quality. Such information is necessary to formulate the appropriate diagnosis.

NOTE

Nowadays, the common wrong procedure of treatment of the joint occurrence of vulvovaginitis and painful sexual intercourse is the inappropriate commencement of treatment of vulvovaginitis prior to the therapy of painful sexual intercourse. Contraction of the orbicular muscles of the opening of the vagina and sensitivity of the other muscles of the pelvis may be the cause of mechanical damage of the mucosa and occurrence of secondary pain during sexual intercourse. Such a condition is one of the causes of such sexual dysfunction in a woman as persisting and new desire disorders, subjective and genital excitement, sexual pain on preparing for and during sexual intercourse.

The author's therapeutic experience shows that psychological therapy should be carried out prior to treatment of vulvovaginitis. Initiating therapeutic meetings pertaining to vaginismus and painful sexual intercourse (genito-pelvic pain / penetration disorders) is primarily of the educational nature, and it prepares for the actual understanding of the problem, attitude towards the therapy which sometimes takes up to a few years. It should be taken into account that current understanding of painful sexual intercourse requires collaboration of a gynecologist, physiotherapist and psychologist [8, 9, 13].

7. Female Sexual Function Index (FSFI)

The SexEM examination is an intimate one which includes questions about psychogenic factors, bounds in the relationship, also the sexual one. It is often difficult for the patient and also for the gynecologist. In order to simplify the, often, difficult diagnostic dialog between the physician and the patient, the Female Sexual Function Index Questionnaire (FSFI) should be used as it is often used in sexual disorder screening surveys. It does not serve diagnostics as it does not include any specificity as for the cause of the disorder [14, 15].

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