

Dyspareunia

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Dyspareunia is pain during attempted or completed vaginal penetration.

Dyspareunia may occur at the moment of penetration (superficial or introital), with deeper entry, with penile movement, or postcoitally. Some pelvic muscle hypertonicity, manifested as both voluntary guarding and involuntary high muscle tension, is common in all types of chronic dyspareunia.

Etiology

Causes may involve psychologic and physical factors (see [Overview of Female Sexual Function and Dysfunction : Etiology](#)). Superficial dyspareunia may result from provoked vestibulodynia (PVD), atrophic vaginitis, vulvar disorders (eg, lichen sclerosus, vulvar dystrophies), congenital malformations, genital herpes simplex, radiation fibrosis, postsurgical introital narrowing, or recurrent tearing of the posterior fourchette.

Deep dyspareunia may result from pelvic muscle hypertonicity or uterine or ovarian disorders (eg, fibroids, chronic pelvic inflammatory disease, endometriosis).

Penile size and depth of penetration influence presence and severity of symptoms.

Women with dyspareunia due to PVD (see [Provoked Vestibulodynia \(Vulvar Vestibulitis; PVD\)](#)) tend to have high self-expectations, fear of negative evaluation by other people, increased somatization, catastrophizing (gross exaggeration of possible consequences), low pain thresholds in general, hypervigilance to pain, and often other chronic pain syndromes (eg, irritable bowel syndrome, temporomandibular joint disorder, interstitial cystitis).

Diagnosis

Clinical evaluation

Diagnosis is based on symptoms and a pelvic examination.

For superficial dyspareunia, evaluation focuses on inspecting all the vulvar skin, including the creases between the labia minora and majora (eg, for fissures typical of chronic candidiasis), and the clitoral hood, urethral meatus, hymen, and openings of major vestibular gland ducts (for atrophy, signs of inflammation, and abnormal skin lesions requiring biopsy). PVD can be diagnosed using a cotton swab to elicit allodynia (pain caused by a nonnoxious stimulus); nonpainful external areas are touched before moving to more typically painful areas (ie, outer edge of the hymenal ring, clefts adjacent to the urethral meatus). Pelvic muscle hypertonicity may be suspected if pain similar to the pain that occurs during intercourse can be elicited by palpating the deep levator ani muscles, particularly around the ischial spines. Palpating the urethra and bladder may identify abnormal tenderness.

For deep dyspareunia, evaluation requires a careful bimanual examination to determine whether cervical motion or uterine or adnexal palpation causes pain and to check for nodules in the cul-de-sac or vaginal fornices. A rectovaginal examination is usually indicated to check the rectovaginal septum and posterior surface of the uterus and adnexa. Suspected uterine and ovarian disorders are evaluated with imaging studies as clinically indicated.

Treatment

Treatment of cause when possible (eg, topical estrogen for atrophic vaginitis, pelvic physical therapy for pelvic muscle hypertonicity)

Education about chronic pain and its effects on sexuality

Psychologic therapies

Management frequently includes the following:

Encouraging and teaching the couple to develop satisfying forms of nonpenetrative sex

Discussing psychologic issues contributing to and caused by the chronic pain

When possible, treating the primarily physical abnormality that contributes to pain (eg, endometriosis, lichen sclerosus, vulvar dystrophies, vaginal infections, congenital malformations, radiation fibrosis—see elsewhere in [THE MANUAL](#)).

Treating coexisting pelvic muscle hypertonicity

Treating comorbid sexual desire/interest or arousal disorders

Topical estrogen is helpful for atrophic vaginitis (see [Menopause : Hormone Therapy](#)) and recurrent posterior fourchette tearing. A topical anesthetic or sitz baths may help relieve superficial dyspareunia.

Psychologic therapies such as cognitive-behavioral therapy, mindfulness, and mindfulness-based cognitive therapy (see [Treatment](#)) can often help.

Women with pelvic muscle hypertonicity, including some with PVD, may benefit from pelvic physical therapy using pelvic floor muscle training, possibly with biofeedback, to teach pelvic muscle relaxation.



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