DYSPAREUNIA FOLLOWING VAGINAL OPERATIONS

by

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In recent times, vaginal operations are getting more common as the surgical technique is rapidly advancing. A detailed and a thorough follow-up is necessary to find if dyspareunia is present, following any of these operations. The interest has increased as some cases have been reported where dyspareunia has become incurable and ruined their entire marital happiness.

Foul discharge or bleeding can be easily noted by the patient. Improper healing can be made out by speculum examination but difficulties in cohabitation cannot be made out unless specifically inquired for. Women themselves very rarely complain about it unless a direct question is asked for.

Causation of Dyspareunia

Uneven apposition and non-obliteration of spaces lead to collection of serum and blood under the repaired mucosa. Collection of blood forms hematoma which leads to easy infection and dysruption of apposed surfaces. Infected areas cause delayed healing and give rise to uneven fibrous tissue formation which become painful on stretching.

Perineal repair is a common procedure after labour. In the absence of prophylactic episiotomy, irregular and ragged lacerations of perineum take place which prolong the healing process and give a painful scar even though proper repair is done with sufficient care.

Often wide mucosa is excised to narrow the upper, lower and lateral vaginal walls for repair of cystocele and rectocele. This subsequently narrows the introitus and several times results in dyspareunia.

Pedical stumps in vaginal hysterectomy are joined together to form a large size lump at the vault, which narrows the top and causes painful cohabitation.

The posterior commisure or the fourchette is the most vulnerable site for tenderness. Improper repair of mucosa there without specific subcuticular lock suture (Te Linde) continued to the perineum gives painful and unhealthy scar formation.

Comments

Vaginal wall needs extra care during repair as it has to undergo frequent stretching and straining during cohabitation.

Subcuticular repair of perineum brings smooth healing and prevents pain while sitting and squatting. Proper repair of posterior commissure with a subcuticular lock suture would not cause dyspareunia.

For cases of prolapse of uterus, thought should be given to every individual for selecting the correct method of repair or the type of operation (Brutar). During marital life defective operative trauma to the

vagina may bring untold miseries to the couple, if proper care is not taken.

Making very narrow introitus during plastic vaginal repair and allowing only one finger to be introduced inside to give a nulliparous feeling during cohabitation is an incorrect technique and would give rise to dyspareunia. The introitus should always allow two fingers to be introduced inside. Sometimes underlying psychogenic focus may flare up due to operative trauma.

The pubococcygeus muscle is essential for sexual function and satisfaction during cohabitation. And that function can be improved only by correct suturing of torn and lacerated muscles and fascia and not by shortening the mucosa and narrowing the introitus. It is now a known fact that the pubococcygeus muscle maintains the tone and the active functions of all the lower pelvic viscera situated in pelvic cellular tissues. The supportive function of the musculo-fascial tissue is acquired by the time the child assumes erect posture, while the sexual perception centred in the peri-vaginal tissues is developed during adult or married life. This sensory perception of vagina undergoes rapid and marked changes due to psychic factors, repair surgery, child-birth, etc. (Adatia), and unless proper care is taken to prepare a correct pubococygeus sling, the function would not be satisfactory.

In vaginal hysterectomy, the vaginal vault should be sufficiently lifted up by preparing a sling of neatly isolated uterosacral and ovarian ligaments and stitched at the outer angles of the peritoneal opening. Vagina should not be completely closed by continuous suturing but should be repaired by interrupted sutures which would allow satisfactory drainage and avoid collection of blood in the retroperitoneal space, that would form tender areas afterwards.

In the older age group, for treatment of complete prolapse of uterus along with vaginal hysterectomy often partial colpocleisis is done to prevent vault prolapse. This would result in painful cohabitation and dissatisfy them in sexual life.

Recent interest in geriatrics has shown that in women even after the age of 70 years sexual interest has been maintained in several cases (Newman & Nichols). Undertaking a Leforte's operation even with the present modification of keeping a lateral gutter would not minimize the difficulties of cohabitation.

Clinical Impression

It is difficult to get accurate figures as complete follow-up and inquiry for cohabitation was not made with every one. But the general impression is that at least 2 to 3 out of 10 patients complained of pain and tenderness after vaginal operations.

Perineal repair was understood as a frightful procedure by several women as they feared pain while squatting and during cohabitation. Some had developed definite tender nodules, which required local hyalase and Novocaine injections for relief. Linen threads used for vaginal operations often caused sepsis and extreme tenderness at the site of sinus formation.

Post-partum dyspareunia was very commonly observed, particularly when perineal or lateral vaginal trauma was repaired.

It is true, many women believe that after delivery it is inevitable to have pain as well as loss of sexual appreciation and therefore very few complained about it unless directly asked for.

Four cases were terribly worried for the pain during cohabitation and did not allow the husband to come near. The husbands complained that, after delivery, sex life has completely ended and asked for a remedy to make them happy. Estrogenic suppository or cream, analgesic creams and vaginal dilators had to be used to relieve them.

In the beginning of the practice, vaginal plastic repair for prolapse of uterus was done with enthusiasm, particularly to narrow the introitus to a greater extent which subsequently caused dyspareunia. Cohabitation could not be resorted to by some, till the introitus was satisfactorily dilated with glass or metal dilators and perineal exercises were done with Kegel's perineometer.

In few cases of total hysterectomy, the vault of vagina became narrow and was drooping down as the sling was not properly taken during operation. Hematoma and blood collection were also observed in some cases, which needed satisfactory drainage and occasionally resuturing.

One case of artificial vagina, constructed by taking whole skin graft from the thigh on a mould, gave rise to several ulcerations in the newly constructed wall. Foul smelling discharge continued till about eight weeks and cohabitation was painful for about 16 weeks. The other case of large bowel graft gave similar trouble due to fistula formation and took a long time to heal.

Repair of rectovaginal and vesicovaginal fistulae was a surgical success in several cases. But three of them continued getting dyspareunia for a period of more than six months.

Summary

A plea is made by the author to become extra careful while undertaking any surgical procedure in the vaginal walls. Proper and correct apposition and suturing of muscle walls and fascia is essential.

Pedicles should be properly isolated, bleeding points carefully checked and vault correctly lifted and apposed to the sling formed of the pedicles.

Wide excision of vaginal mucosa should be avoided.

References

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