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# Presentation of 03 Case Reports that Help Gynecologists Understand the Deep Dyspareunia

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**Abstract**

**Background:** Many women have low quality of sexual life because they have deep dyspareunia, which is not solved due to the lack of knowledge of the professionals who assist them.

**Case:** Three cases of women complaining of chronic pelvic pain and deep dyspareunia have been described. They was assisted by several gynecologists who did not solve the problem and therefore maintained low quality of sexual life and marital relationship. The diagnosis of the relative short vagina syndrome with consequent clinical approach and behavior change and sexual practices restored self-esteem and confidence with improved quality of life.

**Conclusion: :** Gynecologists need to know how to address deep dyspareunia that should be understood as a medical condition related exclusively to the sexual act.

**Keywords:** Deep dyspareunia; Pelvic pain; Painful sex; Coitus; Quality of sexual life

**Abbreviations:** CDD: Deep Dyspareunia; PP: Pelvic Pain; TVU: Transvaginal Ultrasonography; RSVS: Relative Short Vagina Syndrome

## In Brief

The understanding of deep dyspareunia with it consequent correct approach allows the gynecologist to improve the quality of life of women with this condition.

## Case Report

We described 03 case reports that help gynecologists understand the deep dyspareunia. The first shows a woman, 27-year-old, Brazilian, white, childless, who was married for 3 years reported lower abdominal pain that began 3 years ago, after her wedding [1].

She reported pain during intercourse and unbearable pain in particular positions. She reports having performed previous gynecological exams each year, with no pain relief. The patient was questioned about sexual relations, and the patient responded with disgust and stated that she tries to avoid sex. She states that she is tired or has a headache to avoid sex. The patient denies urological and intestinal complaints. The patient denies previous surgeries and genital infections [2].

The gynecological examination revealed a normal vulva. Speculum examination showed smooth walls of the vagina and a centred cervix, jec=0. The vagina, measured by speculum examination, was 11.5cm; the vagina was measured in its fully extended state without trauma by Matthes vaginometer and was 13cm, revealing a flexibility of 1.5cm [3].

Gynecological exam showed a wide elastic vaginal orifice, a vaginal wall without tumours and a large, stretchy vaginal canal. The cervix was cartilaginous, and painful mobilization revealed a positive Matthes sign. After pelvic examination, the patient was asked about the penis size of her partner, and she responded that her partner was black and had a very long penis, which was negatively affecting their relationship, and said:" I hate it. It hurts. It hurts. It hurts". She stated that her marriage was not healthy because her husband always complained that the patient was always avoiding intercourse [4].

An ultrasound was ordered to rule out possible pathologies not detected by the gynecological exam. The patient was diagnosed with RSVS and was advised to avoid vaginal penetration for 20 days. She was instructed to take anti-inflammatory medication at a dose of 2 tablets a day for 20 days. After this period, she could have intercourse but was instructed to adopt sexual positions that prevented complete penetration of the penis. A paper mold the size of the vagina was made for comparison with the penis and guides the partner to know the extent of which the penis could penetrate the vagina without causing traumatic stretching of the ligaments [5].

The patient returned 3 months later and reported that the treatment was effective and that she uses the recommended sexual positions. She reported no more pain in the lower abdomen and that their married life had improved. The ultrasound was normal. The diagnosis of RSVS was confirmed [6].

The second shows a 53-year-old, Brazilian white woman, G5P4A1, who had been in menopause for 2 years, came into the clinic. She reports that she has been sexually active for over 30 years and that her first sexual encounter was at age 19. She reports 4 marriages and multiple sexual partners; her last sexual encounter was 3 months ago [7].

The patient reports pain during intercourse and lower abdominal pain, in addition to vaginal discharge and dysuria, for 2 years. The patient reports seeing many gynecologists to solve her problem but with no improvement. The patient was questioned about her recent sexual relations, and she responded with disgust and stated she tries to avoid sex. She states she is tired or has a headache to avoid sex. She states that her marriage is not healthy because her husband always complains that the patient is avoiding the relationship.

The patient brought a transvaginal ultrasound that showed no gynecological pathology. Her last Papanicolaou was 5 months ago and was normal. The patient reports recurrent urinary tract infections and denies intestinal complaints.

The gynecological examination showed hypertrophic vulva. The speculum examination showed smooth walls of the vagina and shortened and centred cervix, jec=0. The vagina measured 8.2cm, and using a Matthes vaginometer, the vagina measured in its fully extended state without trauma, 12 centimetres, which revealed a flexibility of 3.8cm.

The gynecological exam showed a wide elastic vaginal orifice, a vaginal wall without tumors and a large, stretchy vaginal canal. The cervix was cartilaginous and painful mobilization revealed a positive Matthes sign. After the pelvic examination, we asked about the penis size of her partner, and she stated that her partner is black and has a very long penis, which was negatively affecting the relationship.

The patient was diagnosed with RSVS, advised to avoid vaginal penetration for 20 days and instructed to take 2 tablets of an anti-inflammatory medication a day for 20 days. After this period, she was allowed to have vaginal intercourse but was instructed to adopt sexual positions that prevented complete penetration of the penis. A paper mold with the size of the vagina was made to guide the partner to know the extent of which the penis could penetrate inside the vagina without causing traumatic stretching of the ligaments of the vagina.

The patient returned 4 months later and reported the treatment was effective, she actually denies deep dyspareunia and pelvic pain and she reported her marriage had improved. Thes diagnosis of RSVS was confirmed These 2 case reports that was without diagnostic elucidation, even having consulted several gynecologists was diagnosticated with the relative short vagina syndrome due a primary deep dyspareunia, which is the pain felt deep down in the vagina due to the incompatibility of the larger penis size with the distended vagina.

The last case shows a 34 years old, black woman, 1.59 centimeters, 52kg, from Ribeirão Preto, G1P1C1, on use combined contraceptive pill. He made the first appointment at the Gynecology Department of the Eletro Bonini Hospital of the Medical School of the University of Ribeirão Preto, in October 2010, with complaint of deep dyspareunia (DD) and pelvic pain (PP) in the left iliac fossa; low intensity, but which worsens in sexual intercourse.

The gynecological examination showed and vaginal cytology confirmed bacterial vaginosis, which was treated with metronidazole. In May 2011, the patient returns reporting persistence of pain in the left iliac fossa that aggravates sexual intercourse, causing a deep dyspareunia. The patient was referred to the Pelvic Pain Outpatient Clinic. In July 2011, he performed transvaginal ultrasonography (TVU), which was within the normal range.

The patient maintained complaints of pelvic pain and dyspareunia, and a laparoscopy was requested, which was performed in February 2012. The surgical finding revealed pelvic adhesions and absence of signs of endometriosis and other pelvic alterations. Adhesion lysis was performed. After surgery, the patient reported worsening of pelvic pain that now radiated throughout the lower abdomen and was therefore referred to the Orthopedic Service that excluded orthopedic causes for this pain.

Without improvement of the complaints of PP and DD, she was referred to the Sexuality Outpatient Clinic in August 2013. In the initial complaint, the patient complains of the same symptomatology: PP associated with intense PD, with sporadic episodes of sinusorrhagia. She has been reporting sexual life for 12 years with first relation to 22 years. He reports that he has had 03 partners and has been with the current one for 5 years. Maintains 01 sexual intercourse 02 times a week and always presents DD. He had the last relationship for 2 days presenting the same symptomatology.

In the gynecological examination it was found diffuse pain in all lower abdomen and in the gynecological touch it was verified the presence of mass in the region of cervical isthmus to the left, painful to the pressure and Matthes signal positive to the examination, with which it was verified secondary dyspareunia, organic cause of Relative Short Vagina Syndrome (RSVS).

It was requested TVU and oriented to do sexual abstinence for 20 days and use of anti-inflammatory: piroxicam 20mg, 02 times a day, for 20 days. She was also instructed, after the period of sexual abstinence, to adopt sexual positions that would prevent full penetration of the penis into the vaginal canal. He was also asked to measure the penis from the base of the pubis at the end of the glans penis.


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Patient returns in November 2013, with TVU whose report reveals the presence of intramural myoma in isthmic region, retroperitoneal, measuring 1.3x0.9x1.4cm. It reports that the penis of the companion measured 15 centimeters. It reports a marked improvement of the pelvic pain and absence of the DD with the change of the sexual practices adopted. The vagina was measured during speculum examination with a ruler placed at 0cm at the D-point of POP-Q20 and the end point was measured at the outside of the vaginal orifice measuring 11.5cm and using the Matthes vaginometer, the vagina was measured in its completely stretched state, without trauma, from the perineum to the maximum of the stretch, without mentioning discomfort, which measured 13.7cm, showing a flexibility of 2.2cm.

The guidelines made in the previous consultation were reinforced and a 12cm size paper template was given to the patient to guide the companion to penetrate the penis as far as the mold so as not to cause traumatic stretching of the ligaments. Clinical treatment for myoma with GnRH analogue was also prescribed for 6 months. The patient returns annually in the Outpatient Clinic of Sexology and in her last one, in April of 2017, brought TVU that did not verify the presence of myoma. She is asymptomatic and refers to good quality of life.

In this case report, we describe the relative short vagina syndrome due a secondary dyspareunia, that has an organic cause, that was without diagnostic elucidation, even with the help of invasive diagnostic tests. After presenting another possible differential diagnosis for chronic pelvic pain, performed in 2012 with the description of SVCR, a new approach was possible for the patient, with confirmation of this diagnosis and treatment, which brought improved quality of life for the patient. In addition, we can see in this case the importance of performing the measurement of the vaginal canal of patients with complaints of pelvic pain and dyspareunia, since through this simple measure, we can direct our diagnostic suspicion and provide appropriate treatment for cases that, before that, would be sub treated.

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