Painful intercourse (dyspareunia)
INTRODUCTION
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If you feel pain when you have sex, or even when you try to have sex, then you may have a condition called dyspareunia!

Dyspareunia affects 8–22% of women at some point during their lives, making it one of the most common pain problems in gynecologic practice.
DEFINITION

- **Dyspareunia** is painful sexual intercourse due to medical or psychological causes. The pain can primarily be on the external surface of the genitalia, or deeper in the pelvis upon deep pressure against the cervix. It can affect a small portion of the vulva or vagina or be felt all over the surface. Understanding the duration, location, and nature of the pain is important in identifying the causes of the pain.

- There are numerous physical, psychological, and social/relationship causes that can contribute to pain during sexual encounters. Commonly multiple underlying causes contribute to the pain. The pain can be acquired or congenital. Symptoms of dyspareunia may also occur after menopause. Diagnosis is typically by physical examination and a medical history.

- A woman who has dyspareunia often also has vaginismus. This is an involuntary tightening of the vaginal muscles in response to penetration. It can make intercourse painful, or impossible. Millions of women experience pain before, during, or after sexual intercourse—a condition called dyspareunia (from the Greek *dyspareunos*, meaning "badly mated"). This condition not only saps sexual desire and enjoyment, it can also strain relationships and erode quality of life in general. For postmenopausal women, dyspareunia may also raise concerns about aging and body image.
Classification

• Dyspareunia can be categorised as primary or secondary; as well as superficial or deep.

• Primary dyspareunia is characterised by pain associated with intercourse since the onset of sexual activity.

• Secondary dyspareunia is acquired over a patient's sexual lifetime.

• Painful intercourse that is localised to the introital area is characteristic of superficial dyspareunia, due to disorders of the vulva and vestibule.

• Deep symptoms are often related to disorders in the pelvis.
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Dyspareunia is pain that occurs only (or primarily) during sexual intercourse. It is not a disease but rather a symptom of an underlying physical or psychological disorder. The pain, which can be mild or severe, may occur in the genitals, the pelvic region or the lower back.

At least 10 percent of women have experienced chronic pain in the genital area, and that number rises to 29 percent among postmenopausal women. Up to 60 percent of women who have dyspareunia say the pain is so bad they stopped having sex.

• Sexual problems are highly prevalent in women. In the United States, approximately 40 percent of women have sexual concerns and 12 percent report distressing sexual problems. Female sexual dysfunction takes different forms, including lack of sexual desire, impaired arousal, inability to achieve orgasm, or pain with sexual activity.

• Individuals with sexual pain disorders experience genital pain just before, during, or after sexual intercourse. There are many possible etiologies of pain related to sex (table 1A-C). The leading cause in women under the age of 50 has been attributed to localized provoked vulvodynia [1]. In women over the age of 50, urogenital atrophy is the leading cause [2].

• Women often do not bring this complaint to the attention of their health care providers. A study from Sweden reported only 28 percent of women with a history of prolonged and severe pain with sex consulted a physician for their symptoms [3].
Abstract

AIMS:
The principle aim of this study was to investigate the prevalence and incidence of prolonged (>= 6 months) and severe dyspareunia in a non-patient population of women, and to explore the rate of recovery as well as the inclination to seek medical care. Another aim was to compare the use of oral contraceptives among women who had ever had dyspareunia and those who had not.

METHODS:
A total of 3,017 women aged 20-60 participating in a screening program for cervical cancer answered a questionnaire about possible painful coitus.

RESULTS:
The prevalence was 9.3% for the whole group and 13% for women aged 20-29 and 6.5% for the women aged 50-60, with a risk ratio of 2.0 (95% CI 1.4-2.8) for the youngest age group compared with the oldest. The incidence risk ratio was 9.3 (95% CI 2.8-30.9) for the youngest age group compared with the oldest. Using age-specific incidence rates, a rising incidence of dyspareunia in young women was demonstrated. Of the women who had ever had prolonged and severe dyspareunia 28% had consulted a physician for their symptoms; 20% recovered after treatment, while 31% recovered spontaneously. No differences were found in the use of oral contraceptives between the women who had had dyspareunia and those who had not.

CONCLUSIONS:
Prolonged and severe dyspareunia is a great health problem among all women and especially young women, for whom a rising incidence of dyspareunia is suggested and discussed. Surprisingly few women have consulted a physician, raising the question of why this is the case and what can be done about i
WHO IS MOSTLY AFFECTED

- Both men and women can experience dyspareunia. But the condition is more common in women. Dyspareunia is one of the most common problems of postmenopausal women, and a majority of women have painful intercourse at some time (FDA).
- You are at an increased risk if you:
  - take medications that cause vaginal dryness
  - have a viral or bacterial infection
  - are postmenopausal
- Dyspareunia is recurrent or persistent pain with sexual activity that causes marked distress or interpersonal conflict. It affects approximately 10% to 20% of U.S. women. Dyspareunia can have a significant impact on a woman's mental and physical health, body image, relationships with partners, and efforts to conceive. The patient history should be taken in a nonjudgmental way and progress from a general medical history to a focused sexual history. An educational pelvic examination allows the patient to participate by holding a mirror while the physician explains normal and abnormal findings. This examination can increase the patient's perception of control, improve self-image, and clarify findings and how they relate to discomfort.

- Eisenhower Army Medical Center, Fort Gordon, Georgia 2014 Oct 1;
TRENDING STATISTICS

• 1. About 30% of women said they felt pain the most recent time they had vaginal sex, compared to just 7% of men. 30%! That’s basically one in three!
• 2. For the women who felt pain during P-in-V sex, about 3/4 of them said they felt it inside the vagina, or around the vaginal entrance.
• 3. Most of the other women who had painful P-in-V sex said they felt pain deep inside, around the cervix.
• 4. 43.9% of the men who felt pain during vaginal sex said it hurt their penis; and about one in five guys said it hurt in and around their scrotum.
• 5. 72% of women said they felt pain during their most recent anal sex experience, compared to 15% of men.
• 6. The men who reported pain during anal sex mostly said they felt pain in their penises and/or around the ball region.
• 75% of people said that vaginal intercourse pain lasted less than 5 minutes. 3% of men and 2% of women said that it lasted for longer than a day, though.
• 53% of the men who experienced pain during anal said it lasted less than 5 minutes, and so did 63% of the women. But an alarming number of women who experienced painful anal sex said it lasted a really long time: 25.5% said it stayed painful for more than an hour, and 14.5% said the pain lasted longer than a day.
• According to the study, about 2/3 of men and 43% of women said they didn’t speak up about their pain.

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BREAKING NEWS

• In 2015, research published in the the *British Journal of Obstetrics & Gynaecology* revealed that **women who have had an 'operative' childbirth are much more likely to suffer subsequent pain during sex.**

• Pain during intercourse is one of the most common complaints in gynecologic practice. Together with chronic pelvic pain, it is **also one of the more difficult clinical problems to assess and successfully treat.**-W.H.O
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Because dyspareunia can be distressing and emotional, the physician should first establish that the patient is ready to discuss the problem in depth. The history should be obtained in a nonjudgmental way, beginning with a general medical and surgical history before progressing to a gynecologic and obstetric history, followed by a comprehensive sexual history.\textsuperscript{5}

Details of the pain can help identify the cause. If the dyspareunia is classified as secondary, the physician should ask about specific events, such as psychosocial trauma or exposure to infection, that might have triggered the pain. A description of the patient's sensations during sexual activity also can help determine the underlying cause. If penetration is difficult to achieve, the cause may be vulvodynia or accompanying vaginismus. Lack of arousal may be an ongoing reaction to pain. Lack of lubrication can occur secondary to sexual arousal disorders or vaginal atrophy. If the pain is positional, pelvic structural problems, such as uterine retroversion, may be present.\textsuperscript{6} Additional historical features pointing to specific diagnoses are outlined in \textit{Table 1}.

\textbf{Epidemiology} The prevalence of dyspareunia varies widely depending on the population being sampled and how it is defined. Retrospective studies have cited a range from 1.5\% to 70\%. A survey of women at primary care clinics reported that 46\% of women had experienced painful intercourse, whereas another survey of university alumni who had participated in a sexually transmitted infection study during college found a lifetime prevalence of 61\%.
HOW DOES IT HAPPEN

• **Vaginismus**. This is a common condition. It involves an involuntary spasm in the vaginal muscles, mainly caused by fear of being hurt.

• **Vaginal infections**. These conditions are common and include **yeast infections**.

• **Problems with the cervix (opening to the uterus)**. In this case, the **penis** can reach the cervix at maximum penetration. So problems with the cervix (such as infections) can **cause pain** during deep penetration.

• **Problems with the uterus**. These problems may include **fibroids** that can cause deep intercourse pain.

• **Endometriosis**. This is a condition in which the tissue that lines the uterus grows outside the uterus.

• **Problems with the ovaries**. Problems might include cysts on the ovaries.

• **Pelvic inflammatory disease (PID)**. With PID, the tissues deep inside become badly inflamed and the pressure of intercourse causes deep pain.

• **Ectopic pregnancy**. This is a **pregnancy** in which a fertilized egg develops outside the uterus.

• **Menopause**. With **menopause**, the vaginal lining can lose its normal moisture and become dry.

• **Intercourse too soon after surgery or childbirth**.

• **Sexually transmitted diseases**. These may include **genital warts**, **herpes** sores, or other **STDs**.

• **Injury to the vulva or vagina**. These injuries may include a tear from **childbirth** or from a cut (episiotomy) made in the area of **skin** between the **vagina** and **anus** during labor.

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SYMPTOMS

- Symptoms include a burning, ripping, tearing, or aching sensation associated with penetration. The pain can be at the vaginal opening, deep in the pelvis, or anywhere between. It may also be felt throughout the entire pelvic area and the sexual organs and may occur only with deep thrusting.
- Dyspareunia pain can vary. Pain may occur:
  - in the vagina, urethra, or bladder=
  - during penetration
  - during or after intercourse
  - deep in the pelvis during intercourse
  - after pain-free intercourse
  - only with specific partners or circumstances
  - with tampon use
  - along with burning, itching, or aching
  - with a feeling of stabbing pain, similar to menstrual cramps
CAUSES

• Any part of the genitals can cause pain during sex. Some conditions affect the skin around the vagina. The pain from these conditions is usually felt when a tampon or penis is inserted into the vagina, but pain can also occur even when sitting or wearing pants.

  Inflammation or infection may be the cause; such as a yeast infection, urinary tract infection or inflammation of the vagina. Injury to the vagina and the surrounding area can also cause pain. If a diaphragm or cervical cap not fit correctly, sex may also be painful.

• Several conditions can cause dyspareunia. For some women, it is a sign of a physical problem. Other women may experience pain as a result of emotional factors.

  • Common physical causes of dyspareunia include:
    • vaginal dryness from menopause, childbirth, breastfeeding, medications, or too little arousal before intercourse
    • skin disorders that cause ulcers, cracks, itching, or burning
    • infections, such as yeast or urinary tract infections
    • injury or trauma from childbirth, an accident, an episiotomy, a hysterectomy, or pelvic surgery
    • pain centered in the vulva area (vulvodynia)
    • inflammation of the vagina (vaginitis)
    • a spontaneous tightening of the muscles of the vaginal wall (vaginismus)
    • endometriosis
    • cystitis
    • pelvic inflammatory disease
    • uterine fibroids
    • irritable bowel syndrome
    • radiation and chemotherapy
    • In many cases, a woman can experience painful sex if there is not sufficient vaginal lubrication. When this occurs, the pain can be resolved if the female becomes more relaxed, if the amount of foreplay is increased, or if the couple uses a sexual lubricant.
CAUS IN WOMEN

The cause of the pain may be anatomic or physiologic, including but not limited to lesions of the vagina, retroversion of the uterus, urinary tract infection, lack of lubrication, scar tissue, or abnormal growths. More commonly the cause may be psychosomatic, which can include fear of pain or injury, feelings of guilt or shame, ignorance of sexual anatomy and physiology, and fear of pregnancy.[6]

- In women, common causes for discomfort during sex include
  - Infections. Infections that mostly affect the labia, vagina, or lower urinary tract like yeast infections, chlamydia, trichomoniasis, urinary tract infections, or herpes tend to cause more superficial pain. Infections of the cervix, or fallopian tubes like pelvic inflammatory disease[7] tend to cause deeper pain.
  - Tissue Injury. Pain after trauma to the pelvis from injury, surgery or birth.
  - Hormonal Causes:
    - endometriosis[9] and adenomyosis
    - Estrogen deficiency is a particularly common cause of sexual pain complaints related to vaginal atrophy among postmenopausal women and may be a result of similar changes in menstruating women on hormonal birth control.[10] Estrogen deficiency is associated with lubrication inadequacy, which can lead to painful friction during intercourse. Vaginal dryness is often reported by lactating women as well.[11] Women undergoing radiation therapy for pelvic malignancy often experience severe dyspareunia due to the atrophy of the vaginal walls and their susceptibility to trauma.
  - Presence of objects that take up space in the pelvic like ovarian cysts[12] tumors[13] and uterine fibroids can cause deep pain[7]
In men, as in women, there are a number of physical factors that may cause sexual discomfort. Pain is sometimes experienced in the testicular or glans area of the penis immediately after ejaculation. Infections of the prostate, bladder, or seminal vesicles can lead to intense burning or itching sensations following ejaculation. Men suffering from interstitial cystitis may experience intense pain at the moment of ejaculation. Gonorrheal infections are sometimes associated with burning or sharp penile pains during ejaculation. Urethritis or prostatitis can make genital stimulation painful or uncomfortable. Anatomic deformities of the penis, such as exist in Peyronie's disease, may also result in pain during coitus. One cause of painful intercourse is due to the painful retraction of a too-tight foreskin, occurring either during the first attempt at intercourse or subsequent to tightening or scarring following inflammation or local infection. Another cause of painful intercourse is due tension in a short and slender frenulum, frenulum breve, as the foreskin retracts on entry to the vagina irrespective of lubrication. In one study frenulum breve was found in 50% of patients who presented with dyspareunia. During vigorous or deep or tight intercourse or masturbation, small tears may occur in the frenum of the foreskin and can bleed and be very painful and induce anxiety which can become chronic if left unresolved. If stretching fails to ease the condition, and uncomfortable levels of tension remain, a frenuloplasty procedure may be recommended. Frenuloplasty is an effective procedure, with a high chance of avoiding circumcision, giving good functional results and patient satisfaction. The psychological effects of these conditions, while little understood, are real, and are visible in literature and art.
RISK FACTORS

- Factors that reduce sexual desire or affect a person’s ability to become aroused can also cause dyspareunia. These factors include:
  - stress, which can result in tightened muscles of the pelvic floor
  - fear, guilt, or shame related to sex
  - self-image or body issues
  - medications such as birth control pills
  - relationship problems
  - cancer, arthritis, diabetes, and thyroid disease
  - history of sexual abuse or rape

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COMPLICATIONS

• Complications and sequelae of Dyspareunia from the Diseases Database include:
  
• **Female infertility**

• **Cancer**

• This is a very rare cause of intercourse pain, but it must be borne in mind for a woman who develops this kind of pain for the first time after the age of 40.
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6. Motivational seminars
7. Medical Coverage at Events/ Functions

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MANAGEMENT

• Taking regular oestrogen, i.e. the Pill (e.g. Microgynon /Loestrin /etc) – having consulted a doctor
• Taking an extra oestrogen supplement as a pessary, e.g. Vagifem (prescription only)
• Using a specialist intimate moisturiser, e.g. Yes
• Eating live yoghurt – which helps the vagina keep its proper pH (see my links for further ideas on good vaginal pH management)
• Drinking cranberry juice – good for avoiding cystitis (in extreme cases, drink a glass of water with 1tsp bicarbonate of soda stirred into it. Sounds disgusting – tastes disgusting – works brilliantly every time)

• Therapy
• Different types of therapy may be helpful, including:
  • Desensitization therapy. During this therapy, you learn vaginal relaxation exercises that can decrease pain. Your therapist may recommend pelvic floor exercises (Kegel exercises) or other techniques to decrease pain with intercourse.
  • Counseling or sex therapy. If sex has been painful for a long time, you may experience a negative emotional response to sexual stimulation even after treatment. If you and your partner have avoided intimacy because of painful intercourse, you may also need help improving communication with your partner and restoring sexual intimacy. Talking to a counselor or sex therapist can help resolve these issues.
• Cognitive behavioral therapy also can be helpful in changing negative thought patterns and behaviors.
Figure 1.
External female genitalia. The physician should observe for any abnormalities. The vaginal and vulvar mucosa in particular should be examined for abnormal plaques or areas of erythema. A cotton swab can be used gently to attempt to identify any focal areas of tenderness.
DIAGNOSIS

• **A thorough medical history.** Your doctor may ask when your pain began, exactly where it hurts, how it feels, and if it happens with every sexual partner and every sexual position. Your doctor may also inquire about your sexual history, surgical history and previous childbirth experiences.

• Don't let embarrassment stop you from giving candid answers. These questions provide clues to the cause of your pain.

• **A pelvic exam.** During a pelvic exam, your doctor can check for signs of skin irritation, infection or anatomical problems. He or she may also try to identify the location of your pain by applying gentle pressure to your genitals and pelvic muscles.

• A visual exam of your vagina, using an instrument called a speculum to separate the vaginal walls, may be performed as well. Some women who experience painful intercourse are also uncomfortable during a pelvic exam, no matter how gentle the doctor is. You can ask to stop the exam at any time if it's too painful.

• **Other tests.** If your doctor suspects certain causes of painful intercourse, he or she might also recommend a pelvic ultrasound.

• **A pelvic examination is also common in diagnosis.** During this procedure, a doctor will look at the external and internal pelvic area for signs of:
  - Dryness
  - Inflammation or infection
  - Anatomical problems
  - Genital warts
  - Scarring
  - Abnormal masses
  - Endometriosis
  - Tenderness

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Differential Diagnosis

Although the differential diagnosis of dyspareunia is large, several features of the history and physical examination can help narrow the possibilities (e.g., type of pain, patient age). For example, vulvodynia is typically most painful with entry dyspareunia, and vaginal atrophy typically occurs in postmenopausal women. Pain that can be localized to the vagina and supporting structures may indicate vulvodynia or vaginitis. Pain that localizes to the bladder, ovaries, or colon points to pathology within those structures. Several of the most common causes of dyspareunia are described here; Table 1 provides a more comprehensive list of diagnostic possibilities.

VAGINISMUS

Vaginismus is involuntary contraction of the pelvic floor muscles that inhibits entry into the vagina. The relative roles of pain, muscular dysfunction, and psychological factors in vaginismus are controversial. Whether vaginismus is a primary cause of dyspareunia or develops in response to another physical or psychosexual condition, there is significant clinical overlap between vaginismus and dyspareunia.\(^8\) The Diagnostic and Statistical Manual of Mental Disorders, 5th ed., (DSM-5) now addresses dyspareunia and vaginismus as one entity, characterized by pain, anxiety, problems with penetration, or a combination of these, rather than as separate conditions. In addition, DSM-5 amends its earlier criteria by stating that difficulties must be present for at least six months.\(^8\) Therapy typically focuses on treating underlying causes of pain in combination with pelvic floor physical therapy. Cognitive behavior therapy or psychotherapy may be included in the treatment regimen.\(^9\) OnabotulinumtoxinA (Botox) injections are a promising new therapy for vaginismus, but are not within the purview of the primary care physician.\(^11\)

VULVODYNIA

Vulvodynia is defined by the International Society for the Study of Vulvovaginal Disease as vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder.\(^12\) Vulvodynia is classified as provoked, unprovoked, or mixed. In unprovoked vulvodynia, the pain is more or less continuous. In provoked vulvodynia, the pain is triggered by touch, as with tampon insertion or intercourse. Vulvodynia can also be categorized as generalized or localized, depending on the distribution of the pain.\(^12\) There is an association between vulvodynia and psychiatric disorders. Women with depression or anxiety are at increased risk of vulvodynia, and women with vulvodynia are at increased risk of depression and anxiety.\(^13\)

Physical examination reveals a normal or erythematous vulva. In provoked vulvodynia, light touch with a moist cotton swab reveals areas of intense pain, often highly localized. These areas are commonly on the posterior portion of the vestibule. Testing, such as cultures or biopsies, should focus on ruling out other potential causes of vulvar pain, such as infections or dermatologic conditions (e.g., lichen planus, psoriasis).\(^14\) A multidisciplinary team approach is needed to treat vulvodynia, and combining multiple therapies is often required.\(^15\) A variety of therapies have been used, most without solid supporting evidence.\(^15\) Amitriptyline and lidocaine ointment have been evaluated in small trials.\(^17\)\(^18\) Patients with provoked vulvodynia that is unresponsive to conservative management may be offered surgical excision of painful areas, which is effective up to 80% of the time.\(^19\)
• **INADEQUATE LUBRICATION**

Inadequate lubrication of the vagina leads to friction and microtrauma of vulvar and vaginal epithelium. It may be caused by a sexual arousal disorder or chronic vaginal dryness.\(^\text{10}\)

Female sexual arousal disorder is defined as the inability to attain or maintain an adequate lubrication-swelling response from sexual excitement.\(^\text{1}\) This may be multifactorial, but important historical clues include satisfaction with current sexual relationships, negative body image, fear of pain during sex, history of sexual trauma or abuse, and restrictive personal beliefs about sexuality. Sexual arousal disorder often requires treatment by a physician with experience treating female sexual dysfunction.\(^\text{10}\)

Chronic vaginal dryness may suggest an underlying medical disorder with a hormonal (e.g., hypothalamic-pituitary dysfunction, premature ovarian failure, menopause), vascular (e.g., peripheral atherosclerosis, anemia), neurologic (e.g., diabetic neuropathy, spinal cord injury or surgery), or iatrogenic (e.g., hormonal contraceptive use, chemotherapy, radiation) cause.\(^\text{10}\) Treatment of underlying disorders and vaginal lubricants are the mainstays of therapy.\(^\text{20}\)

• **VAGINAL ATROPHY**

Dyspareunia is a common presenting symptom in women with vaginal atrophy.\(^\text{24,25}\) Vaginal atrophy affects approximately 50% of postmenopausal women because of decreasing levels of estrogen.\(^\text{24}\) It is important to inquire about vaginal symptoms in postmenopausal women. Fewer than one-half of women with vaginal atrophy have discussed it with their physician because of embarrassment, belief that nothing can be done, or that such symptoms are expected with advancing age.\(^\text{26}\) In early vaginal atrophy, the physical examination may be unremarkable. Later, the vaginal mucosa becomes thinner, paler, drier, and less elastic. Vaginal rugae are lost, the mucosa may appear irritated and friable, and the vagina shortens and narrows. Lubricants can help treat vaginal atrophy, but the most effective treatment is estrogen replacement. A 2006 Cochrane review of 19 trials involving more than 4,000 women found that estrogen preparations—cream, ring, or tablet—were associated with a statistically significant reduction in symptoms of vaginal atrophy compared with placebo or nonhormonal gels.\(^\text{27}\) In 2013, the U.S. Food and Drug Administration approved ospemifene (Osphena), a novel selective estrogen receptor modulator that increases vaginal epithelial cells and decreases vaginal pH, for the treatment of postmenopausal dyspareunia.\(^\text{28}\)
TREATMENT

- Dyspareunia treatments are based on the cause of the condition. If your pain is caused by an underlying infection or condition, your doctor may treat it with:
  - antibiotics or antifungal medicines
  - topical or injectable corticosteroids
- Treatment depends on the cause of dyspareunia:
  - If vaginal dryness is the problem, you can ease penetration and sexual intercourse with increased clitoral stimulation before intercourse or lubrication with an over-the-counter lubricant such as K-Y jelly, Replens or Astroglide.
  - For vaginal yeast infections, you will be given antifungal medication.
  - Antibiotics will be prescribed for urinary tract infections or sexually transmitted diseases
  - To relieve painful inflammation, try sitz baths, which are warm-water baths in a sitting position.
  - For skin diseases affecting the vaginal area, the treatment will vary depending on the disease. For example, lichen sclerosus and lichen planus often improve with steroid creams.
  - For vulvar vestibulitis, typical therapies include topical estrogen cream, low-dose pain medications, and physical therapy with biofeedback to lower the muscle tension in the pelvic floor.
  - For atrophic vaginitis, estrogen therapy will be prescribed, either as a vaginal formulation or as a pill.
  - If endometriosis is causing your dyspareunia, you may be prescribed medication or you may need surgical procedures to control or remove abnormal growths of uterine tissue.
  - For dyspareunia that has no apparent physical cause or has lasted for months or years, you may need psychological counseling to address stress or anxiety regarding sexual intercourse.
THE COST OF THIS CHALLENGE FINANCIALLY OR OTHERWISE

• Dyspareunia can have a negative impact on a woman's mental and physical health, body image, relationships with partners, and efforts to conceive. It can lead to, or be associated with, other female sexual dysfunction disorders, including decreased libido, decreased arousal, and anorgasmia.

• Significant risk factors and predictors for dyspareunia include younger age, education level below a college degree, urinary tract symptoms, poor to fair health, emotional problems or stress, and a decrease in household income greater than 20%.

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Although some causes of dyspareunia, such as a history of sexual abuse or trauma, can't be avoided, other causes can be prevented:

To decrease your risk of yeast infection, avoid tight clothing, wear cotton underpants and practice good hygiene. Change your underclothes after prolonged sweating. Bathe or shower daily, and change into dry clothing promptly after swimming.

To avoid bladder infections, wipe from front to back after using the toilet, and urinate after sexual intercourse.

To avoid sexually transmitted diseases, avoid sex or practice safe sex by maintaining a relationship with just one person, or using condoms to protect against sexually transmitted diseases.

To prevent vaginal dryness, use a lubricant, or seek treatment if the dryness is due to atrophic vaginitis.

If you have endometriosis, avoid very deep penetration, or have sex during the week or two after menstruation (before ovulation), when the condition tends to be less painful.

After childbirth, wait at least six weeks before resuming sexual intercourse.

Use a water-soluble lubricant when vaginal dryness is an issue.

Use proper hygiene.

Get proper routine medical care.

Prevent sexually transmitted diseases (STDs) with safe sex.

Encourage natural vaginal lubrication with enough time for foreplay and stimulation.

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About 30% to 40% of all women who seek help from a sexual counselor for dyspareunia turn out to have a medical problem that is causing their pain.

A full medical examination is necessary to rule out a possible medical cause. This includes a pelvic exam and may also include an ultrasound, as well as other diagnostic tests. Examples of possible physical causes are infections, sexually transmitted diseases (STDs), estrogen deficiencies, and vulvar vestibulitis.

SO GET TESTED NOW! BE SURE! KNOW YOURSELF!

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