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Re: Painful sex (dyspareunia) in women: prevalence and associated factors in a British population probability survey

Dyspareunia is a global public health problem!

Sir,

BJOG published a study by Mitchell et al.1 that discusses very important articles about dyspareunia, an old and well-known female health problem. The study shows that one in ten British women has this condition, which implies a low quality of life for women from both sexual and social viewpoints. This subject has been discussed for more than 100 years, although apparently without a solution.

The importance of the study is to call the attention of health managers and professionals involved in women’s care because this medical condition is associated with chronic pelvic pain, a real public health problem.

A study2 on patients submitted to laparoscopy due to suspected endometriosis revealed the concomitant presence of chronic pelvic pain and dyspareunia in 56.8% and 54.7% of patients, respectively, implying public healthcare costs that could be minimised in about 50% of cases if the problem of dyspareunia were solved.

Mitchell et al.1 have reported a relatively high, 7.5%, prevalence of pain during sexual relations among sexually active women; however, this prevalence may be underestimated because the inclusion criteria for sexually active women comprised women that might be having sexual relations exclusively without vaginal penetration. This fact may represent a bias regarding the prevalence of depth dyspareunia and consequently how sexual pain is understood as a whole.

Hence, the study in question may have minimised the true prevalence of sexual pelvic pain because it did not differentiate between superficial sexual pain and deep sexual pain, entities with different aetiologies for the cause of pain that require different approaches for the diagnosis and treatment of each condition.

There is no depth dyspareunia when nothing penetrates the vagina; hence, this condition necessarily implies penetration of the vagina by the penis, which may cause pain in the vaginal fundus due to size incompatibility.

It is easy to understand the incompatibility between the penis and the vagina since, according to Veale et al.3, the mean size of the erect male sex organ is 13.12 cm. According to a Brazilian study4, the stretched vagina measures 13 ± 3 cm, a size that must correspond to that of any woman in the world. Hence, there is a group of women whose vagina measures 10–13 cm, and for them sexual contact with a penis longer than 13.2 cm causes pain due to maximum extension of their vagina. In addition, there is trauma that causes petechiae, microhaematomas, tissue rupture and ligament distension, as is the case for any person practicing sports who suffers injury to muscles and ligaments.

As the types and causes of dyspareunia are different, we suggest that the authors of this important study for the sexual health of women should conduct a further study focusing on the different types of sexual pain and the different sexual practices.

References

Angelo do Carmo Silva Matthes*a & Gustavo Zucca-Matthesb
*aUniversidade de Ribeirão Preto-UNAERP, Ribeirão Preto, SP, Brazil bHospital de Câncer de Barretos, Barretos, SP, Brazil

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Authors’ reply

Sir,

We thank Matthes and Zucca-Matthes for their comments on our paper1,2 and agree with them that this is a neglected aspect of women’s health that requires greater focus on clinical outcomes through robust research. The aim of our prevalence study was to outline the
scale of the problem at a population level. The data come from the National
Survey of Sexual Attitudes and Life-
styles; they are broad in scope and do
not permit detailed investigation of
clinical subgroups. Obtaining clinically
sufficient information in the context of
a population survey is rarely feasible due
to small numbers in subgroups and the
complexity of information required. In
addition we cannot make the assump-
tion that the deep and superficial dys-
pareunia framework correlates to different pathologies as the experience of
painful sex is complex and is depend-
ent on a variety of physical reasons
(e.g. lubrication, menopausal state, skin
disease) as well as psychosexual factors.
Matthes and Zucca-Matthes suggest that
we may have underestimated the preva-
ience of painful sex by including women
who might be having sex exclusively
without vaginal penetration. They sug-
gest that disproportion between penis
and vagina size may be relevant and that
this may be true for selected subgroups
of patients (e.g. post-hysterectomy or
women receiving vaginal radiotherapy)
where there is limited capacity and
compromised function. However, for the
majority of women without organic
pathology, it remains unclear whether
there is a correlation between penis size,
vaginal capacity and overall experience.
Having highlighted the problem of pain-
ful sex in our paper, we would welcome
clinical teams to support research focus-
ing on defining and improving clinical
outcomes for these women.

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Johnson, i & Catherine H Mercer i
Centre for Sexual and Reproductive Health
Research, Department of Social and
Environmental Health Research, London
School of Hygiene and Tropical Medicine,
London, UK jMRC/CSO Social and Public
Health Sciences Unit, University of Glasgow,
Glasgow, UK kCentre for Sexual Health and
HIV Research, Research Department of
Infection & Population Health, University
College London, London, UK lCentre for
Sexual Health Research, Department of
Psychology, University of Southampton,
Southampton, UK mDepartment of
Gynaecology, Nottingham University
Hospitals NHS Trust, Nottingham, UK n
Department of Psychiatry, University of
Oxford, Oxford, UK
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Re: Dilute versus concentrated vasopressin administration during
laparoscopic myomectomy: a randomised controlled trial

Sir,

I read with interest the article titled
‘Dilute versus concentrated vasopressin
administration during laparoscopic
myomectomy: a randomised controlled
trial’ published recently. I congratulate
the authors for addressing this very rele-
vant question in the perioperative man-
agement of myomectomy. I would like to
add my comments from an anaesthesiol-
ist’s perspective to improve patient
safety. As affirmed by the authors, cur-
rently there is no consensus regarding the
dose, dilution, and technique of admin-
istration. But largely, it is assumed that a
dilute concentration of vasopressin will
reduce complications related to intravas-
cular injection.

Even the diluted vasopressin may
cause a transient increase in pulse rate
and blood pressure. The authors did not
define the adverse effects and also
specifically did not mention any haemo-
dynamic changes immediately after
vasopressin injection. The significant
(more than 20% of the pre-injection
value) but transient elevation in haemo-
dynamic parameters would not have
been reported by the anaesthesiologist.
However, the concerned anaesthesiolo-
gist would have alerted the surgical team
if there were any catastrophic compli-
cations such as bradycardia, severe
hypertension, or tachycardia. This study
would have been further thought-pro-
voking if it had addressed haemody-
namic parameters in detail.

Several reports have documented dis-
astrous complications even when
diluted concentrations were injected. In
this study, patients with cardiovas-
cular and pulmonary diseases were
excluded. In this population, even a
transient increase in haemodynamic
parameters could be disadvantageous.
In our centre, a dilute concentration is
injected in small aliquots, pausing for
10–20 seconds between injections. The
amount varies depending upon the
operating surgeon, myoma size, and
the patient’s comorbidities. Hence, one
should aim to avoid transient haemo-
dynamic changes by choosing a dilute
centration of vasopressin injected
frequently at short intervals.

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