

The Genito Urinary Syndrome of Menopause Presents Sexual Symptoms that can be Best Explained by the Relative Short Vagina Syndrome

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Abstract

The authors comment Genito Urinary Syndrome of Menopausal (GUSM) calling attention to the topic of sexual dysfunction that can be associated with the syndrome, but the specific point: deep dyspareunia (DD) is better accounted for by another syndrome, which also affects women who are not menopausal and which have in common the vagina that is short relative to the penis that penetrates it and therefore has a deep dyspareunia, which causes Relative Short Vagina Syndrome (RSVS).

One of the causes of the short vagina is the hypoestrogenism that some women have, for various reasons, but in the premenopausal and menopausal women is, mainly, the decrease in hormones steroids by ovarian failure. There is a medical condition called deep dyspareunia (DD) that affects some climacteric and menopausal women with or without GSM, as well as women of any age.

The DD does not occur, exclusively, during menopause, but is a source of discomfort at any age and is better explained by another diagnosis, the RSVS that presents chronic pelvic pain (CPP). The repeated deep dyspareunia leads to pelvic pain due two situations: 1- by primary dyspareunia - during intercourse, a bigger penis than the vagina can lead to injury of the vaginal tissue, 2- by secondary dyspareunia - there is an organic cause, as endometriosis or other, and just a penis touch this tissue, the patient fill pain.

The goal is to show that many causes of chronic pelvic pain treated as a psychological cause, is concerned the RSVS. The ultimate aim is to improve the quality of sexual life of women.

Keywords: Chronic pelvic pain; Deep dyspareunia; Coitus; Intercourse; Genito-urinary pain syndromes

Under the supervision and sponsorship of the Administrative Council of the International Society for the Study of Women's Sexual Health (ISSWSH) and of the Curators' Council of the North American Menopause Society (NAMS), both societies co-sponsored a consensus conference held in May 2013 and established the current terminology for genitourinary symptoms related to menopause, which were defined as Genitourinary Syndrome of Menopause (GUSM) [1].

GSM is defined as a collection of symptoms and signs associated with a decrease in estrogen and other sex steroids involving changes to the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra and bladder. The syndrome may include but is not limited to genital symptoms of dryness, burning, and irritation; sexual symptoms of lack of lubrication, discomfort or pain, and impaired function; and urinary symptoms of urgency, dysuria and recurrent urinary tract infections. Women may present with some or all of the signs and symptoms, which must be bothersome and should not be better accounted for by another diagnosis" [1].

There is a medical condition called depth dyspareunia (DD) that affects some climacteric and menopausal women with or without GUSM, as well as women of any age. The condition does not exclusively occur during menopause but is a source of discomfort at any age and is better explained by another diagnosis, i.e., Relative Short Vagina Syndrome (RSVS) [2].

Specifically, only women who are sexually active with vaginal penetration and who feel pain in the vaginal fundus during intercourse can have DD and can develop RSVS after repeated and/or traumatic episodes of DD that causes chronic pelvic pain (CPP).

The CPP is highly prevalent also debilitating, with great impact on the quality of life and productivity along with significant costs to the health services [3]. The objective of this paper is to show to doctors in general and especially to the gynecologists a prevalent cause of chronic pelvic pain due the deep dyspareunia because during intercourse, a bigger penis than the vagina can lead to injury of the vaginal tissue.

In contrast to GUSM, which is associated with a decrease in estrogen and other sex steroids involving changes to the genitalia, this decrease is not the cause of the signs and symptoms of DD, which are rather due to sexual penetration of a vagina that is not compatible with the size of the penis that penetrates it.

Many women with GUSM who have no sexual relations will never develop RSVS despite having low sex steroid levels. This is a determinant factor causing the vagina to be less trophic, less elastic and less flexible. However, if the vagina is not penetrated, there will be no sexual complaints. An identical situation is observed in women on antiestrogen therapy for breast cancer who are not menopausal but who have the same problems, complaints, signs and symptoms as

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women with GUSM. However, if these women have no sexual relations they will not develop DD or any other sexual complaints.

Women of any age with normal, reduced or even higher than expected hormone levels and with a common complaint of DD will start to have low abdominal pain when the condition is repeated or traumatic. Next, or even before the occurrence of low abdominal pain, these women will start to have sexual complaints such as loss of libido and sexual aversion, using excuses to reduce or even to avoid sex relations. As a consequence, the marital relationship will be negatively affected with mutual complaints. This may lead to the end of the marital relationship or may attribute the cause of the sexual problem to the woman, who may then experience low self-esteem, depression and anxiety with behavioral or eating disorders causing weight gain or loss.

The characteristics of RSVS depend on the duration of repeated DD, with affected women having only repeated dyspareunia or all the characteristics of the syndrome.

Hypoestrogenism is most commonly found in women who are postmenopausal, have premature ovarian failure, or are suffering from amenorrhea; however, it is also associated with hyperprolactinemia and the use of gonadotropin-releasing hormone (GnRH) analogues in treatment of endometriosis and breast cancer [4]; in all this condition, we can find the RSVS.

In women with GUSM associated with RSVS, the latter condition can be reversed by hormone replacement therapy and changes in sexual attitudes. Sexual activity should be constant and progressive in order to render the vagina accustomed to a gradual adaptation [5]. The ideal goal would be for women not to have RSVS, which could be prevented with knowledge about the syndrome, about the size of the vagina and the size of the partner's penis, with the adoption of positions that will prevent maximum and traumatic penetration [6].

However, women who already have the syndrome, if they have parametrial inflammation [7] should remain in sexual rest for 20 days as soon as the diagnosis is made and during this period they should take anti-inflammatory drugs and local or systemic hormones depending on hormonal indication, or opt for other treatments including ospemifene, fractional microablative laser CO₂, and dehydroepiandrosterone [3]. After this period, the couples should be instructed to consider a change in sexual practice, with clitoris manipulation with little or no vaginal penetration or with progressive and constant penetration over several days until deep vaginal penetration can be performed without pain. The ideal goal would be for a woman to know the capacity of distention of her vagina in order to direct her partner to adopt positions that will prevent a penetration exceeding the capacity of distention of her vagina [6].

Several studies show the clinical relevance of the organic cause, as a relative short vagina as a cause of deep dyspareunia [6,8-12].

As stated by Binik [12], "it seems highly probable that different dyspareunia syndromes exist". The author is correct and RSVS is one of them. The points listed below are key elements for the understanding of this syndrome, with starts with DD:

1-Pain only occurs during sexual relations. The pain a woman feels before and after coitus is considered to be pelvic pain. The concept that dyspareunia includes genital pain immediately before, during or after coitus should be abandoned.

2-Contact pain in the superficial vaginal ostium (superficial dyspareunia) should be distinguished from DD. There are reports of pain when the penis contacts the vaginal entry, often preventing coitus,

or there is pain only in the vaginal fundus or both kinds of pain (entry and depth) can be present.

3- Primary dyspareunia is defined as pain during coitus without an organic case, with pain occurring exclusively owing to incompatibility between penis size and vagina size. If the pain is due to an organic cause, then dyspareunia is secondary. The concept that primary dyspareunia is the first occurrence of pain and secondary dyspareunia is recurrence of pain after a pain-free period should be abandoned since pain during sexual relations is always related to the compatibility of the penis and the vagina. To clarify, for example, if a widow who has experienced dyspareunia marries again after five years and still feels pain during the sexual relation, she should be diagnosed as having primary dyspareunia if the only cause of pain is incompatibility of the penis with the vagina.

4- There are limits to the capacity of distention of the vagina. The concept that during vaginal orgasm the vagina reaches more than double its length to accommodate the penis is incorrect and should be abandoned. The vagina only extends from 0.5 to 5.5 cm, as determined with the use of the Matthes gynometer.

The understanding of RSVS opens up an enormous field of research, and further studies should be conducted to expand our knowledge about the size and maximum flexibility of the vagina; for example, in women before and after hysterectomy. Longitudinal work is also required to understand the changes in vaginal flexibility that may occur in premenopausal and menopausal women, as well as racial variations. This work could offer significant benefits to the 30% of women who experience DD and CPP and reduced enjoyment of sexual activity, although further studies are needed to investigate relative short vagina syndrome.

Conflict of Interest

The authors have no conflicts of interest to declare.

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