Superficial dyspareunia

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1 Superficial dyspareunia is a common complaint that affects women's health and relationships with partners

The prevalence of superficial dyspareunia — pain at the vaginal opening during intercourse — is unclear.[1] Women with superficial dyspareunia are prone to body image and self-esteem issues, depression and anxiety.[1,2] These factors, along with the fear of experiencing/causing pain, can lead to increased sexual dysfunction and feelings of isolation for both partners.[1,2]

2 Treatable causes should be excluded

A cause is usually not found for superficial dyspareunia in premenopausal women.[1] However, an assessment for treatable causes (psychosocial, medical) should be undertaken (Box 1). There may be multiple etiologies requiring treatment.[1–4]

3 Gentle vulvar care and the use of moisturizers and lubricants are encouraged

Proper vulvar cleansing involves gently rinsing the labia with tap water, once daily at the most.[1,3] Irritants (soaps, douches, wipes and panty liners) should be avoided.[1,3] A preservative-free emollient (vegetable or coconut oil) can be used to moisturize.[3,5] Unscented lubricants are recommended during intercourse.[3]

4 First-line pharmacotherapy includes the regular use of topical anesthetics

Treatment evidence is based on clinical experience, descriptive studies and expert committee reports.[5] Lidocaine 5% gel or ointment should be applied directly to the vestibule twice daily.[3] It should also be applied 30 minutes before penetrative vaginal intercourse; the use of condoms is encouraged, to prevent numbness in the partner.[3]

5 An individualized, multidisciplinary approach is essential for treatment

No single therapeutic agent is effective for all women. Mindfulness therapy, sex therapy, couples' counselling and pelvic physiotherapy are important components of treatment. Early therapy and counselling may enhance communication, reduce feelings of guilt or shame, create positive sexual encounters, and help to manage pain.[1,2] Assessment and treatment of the pelvic floor by a pelvic physiotherapist can reduce symptoms and decrease anxiety regarding penetration.[1] Referral to a specialist could be considered if there is no improvement after 6–12 months of therapy.[1]

Box 1: Causes of persistent vulvar pain[1–4]

Origin	Treatable cause
Hormonal	Vulvovaginal atrophy (hypoestrogenic states such as menopause, breastfeeding, use of low-dose birth control)
Infectious	Candidiasis, herpes simplex virus
Inflammatory or dermatoses	Dermatitis, lichen sclerosis, lichen planus, immunobullous disorders
Muscular	Vaginismus, myofascial pain
Neurologic	Herpes neuralgia, pudendal neuralgia, spinal nerve compression or injury, neuroma
Anatomic	Clitoral adhesions, narrowing of the vaginal opening
Neoplastic	Paget disease, squamous cell carcinoma
Iatrogenic	Postoperative, chemotherapy, pelvic radiation
Trauma	Female genital cutting, obstetrical

Resources for patients and physicians

- Further information on vulvar pain is available from the International Society for the Study of Vulvar Disease (http://issvd.org/), National Vulvodynia Association (www.nva.org) and the Vulvar Pain Foundation (www.vulvarpainfoundation.org)
- A useful printout for vulvar hygiene recommendations from the International Society for the Study of Vulvar Disease is available at: http://3b64we1rtwev2ibv6q12s4dd.wpengine.netdna-cdn.com/wp-content/uploads/2016/04/GenitalCare-2013-final.pdf

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