

The use of dilators (trainer) for the treatment of vaginismus / painful penetration
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Indications

- Tension of PFM in all quadrants – (tension in just one area is better treated with manual stretching / MFR)
- Paradoxical contraction in response to vaginal penetration
- Patient expresses fear or anxiety about possible negative experience during penetration – gives women a chance to “practice” intercourse
- Vaginal dilators are used in conjunction with other treatments, never as the sole treatment

Method

- External peri anal EMG sensors on, patient in hooklying, on several pillows,
- Record resting base line
- Patient picks a trainer to start with - one that will not cause pain
- Place a sufficient amount of water-soluble lubricant on the tip and sides of the dilator. Lubricant should be non irritating – I use "Slippery Stuff". Can also use pure olive oil
- Patient inserts dilator - Separate the labia with one hand and insert the dilator with the other – do not let a part of the labia fold in on the dilator – explain this for intercourse also. Common source of pain
- Angle the dilator slightly down toward the table; might have to angle up or to the side if PFM is tight, you may need to hold the dilator and assist the patient but never force.
- Keep the pelvic floor muscle relaxed and slowly insert the dilator – watch EMG screen. Remember movement artifact may cause signal to increase during movement of dilator.
- Pause if there is significant pain or resistance; allow the muscle time to relax
- Continue to insert until fully inserted
- If you are unable to insert the dilator to this depth, hold it at the depth you are able to tolerate with slight to moderate pain (usually less than 4/10)
- Allow the dilator to stay in place for up to 10 minutes; remove before 10 minutes if the pain is increasing
- Keep the pelvic floor muscle relaxed
- It may also be helpful to perform sub maximal PFM contractions to enhance relaxation, breathing, toe wiggling, leg moving, change of thinking
- Desensitize skin to sliding - Movement can also be introduced; hold onto the end of the dilator and move it slowly and gently in and out

Other factors

- Home training is usually necessary – patient should buy a set
- Suggest patient and partner work on increasing desire at start of therapy - without intercourse
- May also visualize partner and intercourse during dilator use
- Helpful to use dilator before intercourse
- Also consider use of lidocane with dilators for very painful conditions
- Excessive lubrication after several dilator insertions may bridge electrodes making EMG signal unreliable

Brief highlights from the literature

McCullagh WMH, Vaginal dilators. April 23, 1949 BMJ, pg 723.

- Describes new metal vaginal dilator with small groove for urethra and handles.
- References previously used glass dilators and some of their troubles.

Fuchs K. Therapy of vaginismus by hypnotic desensitization. Am J Obstet Gynecol 1980;137(1):1-7.

- Basis is avoidance of anxiety producing situation
- Start – insertion of patient's finger – end intercourse in the female superior position
- 71 women (no control) 18 = hypnosis, 54 = dilators
- "good results" 88% in hypnosis group, 98% of dilator group
- Follow up 2 to 5 years with no relapse reported

Idama TO, Pring DW. Vaginal dilator therapy-an outpatient gynecological option in the management of dyspareunia. J Obstet Gynecol 2000;20(3):303-305.

- 18 women received instruction with glass dilators
- 77.8% "successful"
- 16.7% (3 women) required additional treatment – psychotherapy or surgery

Murina F, Bernorio R, Palmiotto R. The use of Amielle vaginal trainers as adjuvant in the treatment of vestibulodynia: an observational multicentric study. Medscape J Med 2008;10(1):23.

- Prevailing theory of vestibulodynia – neuropathic disorder involving abnormal pain perception and PFM dysfunction
- No single treatment is right for all and it may take many months to determine correct treatment
- 15 patients used vaginal dilators by specific protocol (dilators and instructions available at <http://www.vaginismus.com>)
- Marinoff dyspareunia scale – initial 2.2, end 1.1 (0.001)
- FSFI – initial 16.3, end 25.3 (0.001) (26.5 is the cut off for differentiating sexual dysfunction)

McGuire H, Hawton KKE. Interventions for vaginismus. Cochrane Database of systematic reviews 2009.

- Worldwide prevalence rates 5% to 17% (Irish women 42%)
- Treatment approaches
 - Systemic desensitization – Imagined / hypnosis and / or graded dilators
 - Sex therapy – couple and individual
 - Cognitive therapy
 - Education
 - Relaxation therapy
 - Flooding – subjects watches in mirror as therapist then patient inserts finger into vagina
 - Pharmacotherapy – benzodiazepines
 - Botox injection
- Successful outcome = ability to complete sexual intercourse and have a speculum examination
- 3 studies "eligible"
 - One not randomized – success 89.7% (desensitization) and 100% (hypnosis)
 - One compared doctor inserted dilator and verbal instruction only
 - No statistical difference - Therapy every 2 weeks
 - Home program – 10 to 15 minutes of dilator use 5 times per week
- Conclusion – not enough data