INTRODUCTION

Endometriosis affects 10% of reproductive-age women, and approximately half of women with endometriosis have deep dyspareunia (pelvic pain with intercourse).¹⁻³ The consequences of deep dyspareunia have been demonstrated in multiple studies, including negative effects on sexual function, relationships, and quality of life.¹⁻⁷ Deep dyspareunia is differentiated from superficial dyspareunia (introital pain with intercourse),⁶ which is due primarily to vulvodynia.

There has been a call for more research into the pathophysiology of deep dyspareunia.²,⁸ Endometriosis of the cul-de-sac or uterosacral ligaments, especially deep (infiltrating) endometriosis of this region, is a known risk factor for deep dyspareunia.⁹⁻¹¹ Treatment trials also have shown that management of endometriosis can alleviate deep dyspareunia in some patients.⁶,¹⁻²,¹⁴
However, there is still phenotypic variability in deep dyspareunia that cannot be accounted for by the endometriosis alone. For example, clinicians will observe that one patient with cul-de-sac or uterosacral endometriosis might have severe deep dyspareunia, whereas another patient with the same cul-de-sac or uterosacral endometriosis might have minimal pain with intercourse. This was demonstrated in a study of women with cul-de-sac or uterosacral endometriosis: although cul-de-sac or uterosacral endometriosis increases the risk for deep dyspareunia, there was still wide variability in severity of deep dyspareunia reported by this population of women.15

Thus, treatment of cul-de-sac or uterosacral endometriosis, although important, cannot be the sole management approach for deep dyspareunia. That is, there must be other causes of deep dyspareunia in this population of women. In addition to the cul-de-sac or uterosacral ligaments, deep dyspareunia could arise from contact with several other pelvic structures with proximity to the vagina (Figure 1): the bladder, the pelvic floor musculature, the cervix and uterus, and the adnexa. In some women, at least one of these anatomic structures can become tender and contact during deep penetration can lead to pain and deep dyspareunia. However, it is important to empirically validate whether tenderness of each anatomic site is associated with deep dyspareunia, similar to the cul-de-sac or uterosacral ligaments, so that clinicians know whether tenderness of each site can be a contributor to a patient’s deep dyspareunia and thus a potential treatment target. It also is important to provide some insight into the underlying etiologic factors for each tender anatomic site, which in turn would guide management. For example, it is clear that surgical excision of cul-de-sac or uterosacral endometriosis can be a treatment for deep dyspareunia.12 However, what is less clear are the clinical conditions or risk factors that could give rise to tender bladder, pelvic floor, cervix and uterus, or adnexa, which also could be potential therapeutic targets for deep dyspareunia.

Therefore, our primary research question was whether tenderness in other pelvic structures (bladder, pelvic floor, cervix and uterus, and adnexa)—in addition to the known importance of tenderness of the cul-de-sac or uterosacral ligaments in endometriosis—is associated with severity of deep dyspareunia. The clinical importance of this analysis is that it establishes whether tenderness of each anatomic site potentially has an independent contribution to deep dyspareunia. This guides the clinician in formulating a differential diagnosis for the deep dyspareunia. For example, in a given patient, deep dyspareunia could be due to independent contributions from the cul-de-sac or uterosacral ligaments, the bladder, the pelvic floor, and the uterus and cervix, each of which might require specific management, as described below.

Our secondary question was whether there are specific clinical factors associated with tenderness of each pelvic structure to provide insight into possible etiologic mechanisms for the development of tenderness. Endometriosis commonly grows in the cul-de-sac or uterosacral ligaments, and thus we hypothesized that endometriosis would be associated with tenderness of the cul-de-sac or uterosacral ligaments as described earlier. However,
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