WHAT IS PROVOKED VULVODYNIA AND HOW CAN IT BE CURED?

An explanation of diagnosis
and treatment by Dr. Anna Ghizzani,
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What is PVD?

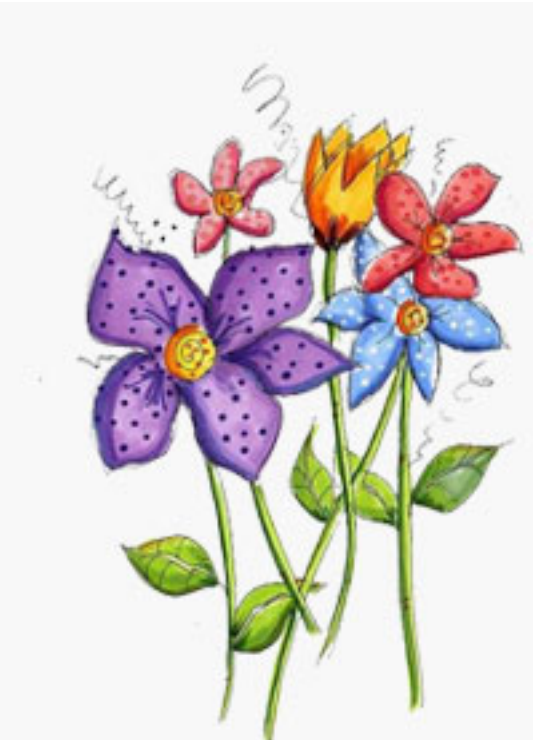
PVD is a medical condition that results in distressing pain in the area around the vagina, brought on by touching. It's a type of Vulvodynia, which is simply Latin for "pain in the external female genitals". PVD stands for Provoked Vestibulodynia, and is one of the most common forms of this type of pain. The "provoked" part of PVD means the pain comes as a result of physical contact, even very light touching. (The unprovoked type is called Dysesthetic Vulvodynia.)

PVD is still poorly understood, and it's a tricky disease to identify. Many medical professionals, even gynecologists who specialize in genital health, are not trained to look for PVD and fail to recognize it. For the same reasons, patients often feel they are inventing this very real condition. The intention here is to educate people about the syptoms and causes of PVD so they can seek the right treatment.

Let me be clear. There's no question that PVD exists. There's also no question that it can be cured.

What we know so far is that PVD is a chronic disease – meaning it lasts a long time or comes back frequently. You can recognize it by a burning pain in response to light pressure around the "vestibule" of the vagina (the region between the inner lips of the vagina, which includes the opening of the urinary tract, the vagina and some glands). The characteristic burning sensation is what was first observed and led to the definition of the syndrome.

It is very similar to the burning sensation a woman experiences during childbirth when her vagina is stretched by the crowning of the baby's head; something I often hear about in the delivery room. As a consistent symptom of PVD, it's the burning sensation that an expert will be looking for, specifically, when making a diagnosis of PVD. All cases of PVD involve this tell-tale symptom, so when I see a patient for the first time, I will ask a lot of questions about the specific sensations and types of discomfort she experiences, because I need to know exactly what type of pain is present.



I also want to know about the onset and pattern of the disease – in other words, what was going on in a patient's life when the pain first announced itself, and how often and when it occurs. Bear in mind, however, that the pain may not necessarily be limited to the vulvar vestibule, and may involve the wider area of the external genitalia.

PVD Appears For No Obvious Reason

The frustrating thing for someone suffering from PVD is that this condition, which can be excruciatingly painful and deeply distressing, usually comes on for no apparent reason. The symptoms are all too real, but they don't make sense to the patient or her partner because there's no sign of the usual causes of pain and discomfort in the genitals, such as infection or trauma.

So far, the causes of PVD are hard to trace. Estimates about how common it is range from very rare to ten per cent of the female population. The truth is most likely somewhere in-between. My colleagues and I, working at the Pain Laboratory at the Siena Medical School in Italy, have been investigating PVD for more than five years. Initially, it looked like PVD could be caused by repeated infections or stress, or even genetic history. But, as our research has gone on, we've come to think that there may be no types of woman more prone to PVD than others.

In patients who suffer from this condition, the history of pregnancy or other gynecological events is totally normal, and we don't see any greater history of promiscuity or risk-taking behavior. Additionally, women who suffer from PVD don't seem to get genital infections more often than women who don't. The only exception worth noting in this context is the "association" of PVD, which is a syndrome of chronic pelvic pain, with other syndromes of chronic pain such as Interstitial Cystitis and Fibromyalgia.

So PVD is an unpredictable enemy. The first attack can happen at any age. We have seen girls in their teens experience PVD pain the first time they try to have sexual intercourse, but we also treat women who got PVD for the first time after menopause.

I recently treated a 24-year old patient, who was engaged but “unfortunately still a virgin” (her words). She had experienced intense pain all over her body since when she could remember. A pinch from her brother would make her cry; a spank from Mother would sting until the next day. Often, she was too tired to go out and play with the other children. Her Mother scolded her, saying she complained too much and the girl believed her. “How did I know what other girls felt?” she said. “I just thought I was a complainer; just too sensitive!” Only when she began adulthood did she realize that her experiences were not normal, prompting her to look for answers. Luckily, she was referred to our Pain Lab and, not surprisingly, she was diagnosed with Fibromyalgia. Learning more about the syndromes of chronic pain, she felt encouraged to seek counseling for pain during attempted intercourse. She came to see me and was diagnosed with PVD. As a positive person, she felt it was a good opportunity to get better, and so far has embraced the recommended treatment enthusiastically.

In some cases of PVD, there’s a history of repeated inflammation of the vagina, mostly because of yeast infections, but this is not by any means always the story. Sometimes the pain of PVD builds slowly; in others cases, it comes on suddenly. Sometimes it seems to be triggered by pregnancy.

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Painful sex makes relationships difficult

One of the main problems with PVD is that it makes sexual intercourse difficult to bear.

This direct and distressing effect makes it a lot harder to treat than something like joint pain or limb injury. There is a mental and emotional aspect that absolutely must be included in any PVD treatment if it is to be effective. Otherwise, patients become trapped in a vicious cycle - anticipating pain during sex, which leads to avoidance, which in turn leads to discord between sexual partners. This, of course, produces anxiety, which results in stress, which in turn tends to trigger more emotional discomfort, added on top of the pain caused purely by the PVD.

PVD's physical-mental intertwining can produce a tight knot to untangle. Most women have no idea why sexual contact causes genital pain. Their partners, fearing rejection or even feeling responsible, often become emotionally detached, creating an unhealthy downward spiral in the relationship. Like pretty much any problem involving sexual function, this condition must be treated in a way that includes the psychological health of the relationship involved. We'll talk more about that below, but let's look at the physical aspects of PVD.

First, a little history. Genital pain without an obviously recognizable cause was first referred to as "Burning Vulva" when it was formally identified by the International Society for the Study of Vulvovaginal Disease (ISSVD) in 1970. It is not an itch, and it does not bring spasms or sensations of pressure. It is a feeling of burning, as reported by all the women who experience it.

In 1987, Dr. Eduard G. Friedrich, affiliated with the University of Florida, College of Medicine, at Gainesville, described in finer detail the condition of painful sensations localized at the vulvar vestibule. Pain came in response to light pressure; something he called Vulvo Vestibular Syndrome, which we now call PVD. The patients who were first investigated reported genital pain that consisted mostly of burning sensations when their exterior genitals were exposed to light pressure typical of touching or sexual intercourse. Apparently, the pressure was such that non-affected women would not consider it harmful.

Dr. Friedrich's observations led him to establish the criteria according to which the diagnosis of PVD can be made, when the vestibular mucosa around the entrance to the vagina demonstrates:

- Increased sensitivity to pain (hyperalgesia)

- Redness (erythema)

- Swelling (oedema)

Since then, the different causes of PVD have been investigated by many scientists and clinicians, and a great deal of new information has come to light to help in effectively treating this puzzling condition.

We now know that the pain can be highly localized around the vaginal entrance or vestibule, or can spread to the vulva (the generalized term for the external female genitals) and to the perineum (the area between the vagina and the anus).

We also know that genital pain can come on spontaneously, without any touching or other provocation, or as a result of light pressure (the "provoked" part of PVD). Another puzzling characteristic is that this condition can emerge during the first incidence of sexual intercourse, but can suddenly appear after a long period of normal sexual functioning, and any time in between. In other words, there's no way to predict when this condition might manifest itself in the arc of an individual's sexual history. In addition, it is now accepted that, although it's often possible for an expert eye to identify tell-tale redness and tenderness in the mucosa around the vaginal entrance, symptoms of PVD may exist without any apparent visual signs, making it all the harder to diagnose and treat.

Diagnosis Can Be Tricky

One firm rule has emerged for diagnosis: symptoms must be present for at least three months to warrant a diagnosis of PVD. PVD is always accompanied by pain during sex In any event, it's important for the healthcare provider treating someone with PVD to look for the presence of tension in the pelvic floor muscles, which can make pain during sex much worse and must be evaluated and treated separately. – at penetration, or during or after intercourse.

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There are several other causes of genital pain in women, apart from PVD, and it's important to rule them out before proceeding with treatment.

These include dryness of the vagina, thinning of the vaginal walls for different reasons, reactions to some types of medication, scarring from childbirth, and skin conditions. All these can get worse during or after a gynecological examination, inserting a tampon, and vigorous sexual intercourse. Feeling pain during sex often happens during and after menopause, as the walls of the vagina get thinner and more sensitive, but younger women with low levels of the hormone estrogen are likely to experience similar symptoms. The estrogen hormone group plays a key role in vaginal health; low levels can cause increased sensitivity, and therefore discomfort. All of these sources of pain have predictable and often distressing consequences for the frequency and enjoyment of sex. More causes are discussed below. The doctor will have to rule out all other potential causes of genital pain before making a diagnosis of PVD.

Other potential causes

Once these plain physical causes have been ruled out, the doctor needs to consider other types of sexual dysfunction, which have symptoms very similar to PVD and are often difficult to separate. PVD is a lot like a condition called Vaginismus, and also like HSDD, or Hypoactive Sexual Desire Disorder: the medical term for loss of sexual interest. But a good doctor will be able to tell them apart because the symptoms occur in different patterns that allow for an accurate diagnosis.

With PVD, sex is painful without any identifiable cause, and penetration is difficult, if not impossible. The patient is typically worried and frustrated, and experiences an understandable loss of sexual desire, which in turn causes the relationship with her sexual partner to suffer.

In Vaginismus, involuntary muscle spasms make sex near-impossible and, if penetration is forced, it's very painful. Again, this brings on loss of desire and inevitable relationship problems.

HSDD patients, by contrast, lose desire mostly in response to stressful situations or relationship problems. They no longer find erotic stimulation arousing, and their vaginas do not get lubricated, which, again, makes it difficult and painful to have sex, and in turn causes greater conflict and stress.
Because the causes of these three conditions are very different, they require dramatically different treatments. It is therefore very important for the doctor to get a clear history of the patient's medical and sexual background, as well as the onset of the pain, and for the patients to be very honest about their experiences so far.
Patients who suffer from genital pain with no recognizable origin need to be evaluated carefully, because they often suffer from more than one condition; something we call "association". It means that painful conditions with no obvious physical cause accumulate either in one patient or – even more strangely - in family clusters, following a hereditary pattern.

In my work with PVD over the years, I have observed many women with signs of this type of association, or who had close relatives like mothers and sisters affected by similar illnesses that are not related to sexual function.

These conditions can include:

- Fibromyalgia - long-term, body-wide pain and tenderness in the joints, muscles, tendons, and other soft tissues, which is also commonly linked to fatigue, sleep problems, headaches, depression, and anxiety.

- Chronic Fatigue Syndrome - severe, continued tiredness that is not relieved by rest and is not directly caused by other medical conditions.

- Interstitial cystitis, which brings severe urgency and painful urination.

Although the symptoms of PVD seem clear, diagnosis can be confused with these other, more pervasive diseases. In other words, the tell-tale symptoms of PVD might be masked by the symptoms of some other disease, and not be recognized. Again, it's crucial to be very attentive when gathering the history of how the symptoms first appeared and what happened next. Experienced caregivers are careful to make sure they detect signs of additional conditions such as PVD as early as possible, so they can offer better treatment.

The women themselves had considered pain during sex as simply another aspect of Fibromyalgia instead of a symptom of a separate illness requiring different treatment. Initially, the aim of our project was to better understand chronic pain syndromes, but by the end of the investigation we came to realize that, thanks to our findings, a number of women had an accurate diagnosis that included PVD, and they could now access effective treatment, bringing a huge improvement in the quality of their lives.

Problems Beyond the Physical

Any condition that interferes with sexual function, whether on the part of the woman or the man, brings with it risks of painful penetration and loss of interest in sex. Sexual dysfunction also brings frustration, difficulty in becoming aroused, and, of course, romantic discord.

PVD makes sexual penetration difficult or impossibly painful, and couples have to create new ways to keep each other sexually satisfied – at least until treatment is completed. Most couples are initially reluctant to keep their sex life active when it's no longer something that just happens spontaneously, or if it can't involve "going all the way". Some adapt successfully, and explore lovemaking without penetration, while others feel something crucial is missing and give up.

Make no mistake, PVD is certain to have a strong negative impact on a couple's sex life before they decide to do something about it. We often hear from patients that simply getting the diagnosis of PVD is a relief for both partners, and that it lessens conflict by increasing understanding of the nature of the problem. But patients and partners can become frustrated all over again by the lack of a quick and effective solution, so be prepared for what might be a long and complex journey with this illness.

Treatment and management of PVD must involve both members of the couple, not just the women alone, since the impact of this disease goes well beyond physical discomfort. In my experience, many women who suffer from PVD feel inadequate as sexual companions, and their partners feel rejected and resentful; sometimes even responsible. Gynecologists know all too well how disturbing a simple vaginal infection that is solved with a few days of local ointment can be, and how nervous women and even their partners become around this problem.

So even more sympathy and compassion is needed when it comes to PVD patients, not least because attempts at treatment often have a poor outcome.

The good news, however, is that most couples get closer and develop non-sexual ways to connect with each other to repair or preserve the relationship, while therapy is on-going.

At the clinic, we encourage couples to work to develop a capacity to manage anxiety, stay open to creative erotic activities that do not involve penetration, and be willing to voice needs and not to blame each other.

We have observed that the outcome is greatly improved where there is a well-adjusted relationship and a supportive partner.

Although the illness has an inevitable impact on relationships, most couples can learn to minimize the distress, and support each other to overcome conflicted feelings of anger and rejection. They also learn to build good communication skills, so they can share their reactions and maintain emotional intimacy when sexuality without intercourse feels unnatural and alternative ways are not satisfying. Even better, some couples report increased erotic gratification and grow to value alternatives in their sex life.

A couple in their late twenties came into my clinic – a shy woman and a protective man. They had problems the very first time they tried to make love, and those problems persisted even after their marriage, one year before their visit. All hope that the difficulty would vanish by itself had faded, and they were determined to get help. When I took the medical history, he gushed: “A wonderful thing happened this year. I married her!” I knew instantly that I could count on his support to help his wife through the therapeutic process.

Suffering the physical discomfort and emotional burden of sexual pain is not easy, and it takes courage to follow a treatment that cannot promise a complete cure.

But, overall, PVD couples benefit greatly from behavioral sex therapy as they learn to develop deep, meaningful ways of talking to each other with the therapist’s support, and to experiment with alternative methods of pleasuring each other sexually. Again and again in my clinic, I see how much difference it can make when a women with PVD is married to a man incapable of seeing her discomfort or, instead, when she has a sympathetic and patient partner.

One of my patients in her early thirties had married at 18 while still a virgin. She most likely suffered PVD right from the beginning, but in any case found it difficult to have sex. Her husband, not understanding her “frailty”, simply forced her to have sex, and the resulting resentment and bitterness spread through every corner of their ten-year marriage. At some point, she was diagnosed with PVD, but did not feel she had the strength to pursue therapy. It took her a long time to build up the courage to divorce her husband, but she finally did. She resumed a career in teaching and, enjoying her new-found independence, decided it was time to solve her sexual problem, so she came to see me for treatment. Just at that time, she met a nice man to whom she felt she could open up emotionally, and they started a romantic relationship. He was gentle, he understood her need for a slow pace, and the relationship flourished while therapy continued smoothly. As a result, they were able to have a normal, satisfying sex life.
A year later, when I called to check on her, she thanked me and said I had changed her life, but I think she owes the changes to the kindness of her partner and her own determination to open up to him.

Diet and Hygiene Can Help

Simple genital hygiene can play a part in PVD. In the hope of lessening pain, patients often wash their genitals with increased frequency. But soaps and detergents are irritants, and potentially harmful, as they change the natural balance of bacteria, leaving the area vulnerable to invasion by harmful ones that may make the symptoms worse or even bring new ones into the picture. Although it is very clear that PVD is not an infectious disease, you don’t want to complicate the situation with related infections.

Good genital hygiene includes wearing all-cotton underwear, because synthetic fibers are a potential irritant, and should be avoided by people with sensitive genitals. Often, also, patients with this sensitivity can benefit from modifying their diet to include foods low in oxalate, such as boiled pasta, chicken, lamb, white fish, avocados and melon, and avoiding hot peppers, eggplants, tomatoes, dried fruits, coffee and sugar. You can easily find out more about this on the Internet.

Treatment of PVD

Because PVD's causes are not well understood, treatment has been developed by focusing on what works and discarding what doesn't. For that reason, the outcome is generally considered poor. However, I have seen many women completely cured of PVD, and it is most certainly worth exploring treatment, even if it gives only partial relief. The British Society for the Study of Vulval Disease encourages the practice of combining medication, physical therapy, psychotherapy, dietary changes and surgery, as the most effective way to tackle PVD pain, with the deployment of each one tailored to the individual case.

Most often, treatment starts by combining anti-depressants with ointment applied directly where the pain occurs, at the vestibule of the vagina. We then move on to a more active method of re-training the vagina to accept sexual stimulation and penetration.
Usually, a doctor will gradually increase the dose of anti-depressants, according to the individual patient's needs, until the pain is under control. However, some patients abandon this medication because of its side effects, which can include, ironically, lowered sexual appetite. Other drugs are sometimes helpful for those who do not respond to anti-depressants, such as gabapentin, used to control seizures, and pregabalin, used to soothe pain in damaged nerves.

After the pain is under control, you will typically start with the first kind of physical treatment. This is minimally invasive, and involves gently rubbing creams containing corticosteroid or estrogen directly onto the entrance to the vagina to reduce inflammation, and to help reinforce the defense mechanisms of the vestibular mucosa. Estrogen supplements can also help, as a low level of estrogen - as mentioned above - is a trigger for PVD pain.

The vast majority of PVD patients also have chronic tension in the pelvic floor muscles, which adds discomfort to an already painful condition. This muscle tension is usually in response to pain, and can be treated with different types of physical therapy including external and internal massage, trigger-point pressure and biofeedback, all of which aim at desensitizing the pelvic floor area. Behavioral therapy is usually a good idea for PVD patients, as it works to relax the muscles and gradually ease the muscle tension. Kegel exercises, which involve rhythmic squeezing and releasing of the pelvic muscles, are easy for patients to learn simply by stopping the flow of urine mid-flow.

The next phase involves using dilation-based “trainers”. These are small plastic cylinders of gradually increasing sizes, a bit like the tube that allows you to insert a tampon. They are used in gynecological surgery to stabilize the reconstruction of a vagina or the creation of a new vagina.

Dilators are typically prescribed for Vaginismus, for example, to promote muscle control and to achieve a systematic desensitization in order to diminish or completely prevent involuntary reactions. Similarly, in the treatment of PVD, dilators can be used to make the vagina and surrounding area much less sensitive and reactive. They are used in sequence: the first tube is so narrow that it can be inserted without causing much pain. After practicing with that size and getting comfortable with it, you can then move on to the next size up, beginning a process of gradually accepting broader dilators comfortably. We’ve found that mastery of pain in this way increases the patient’s confidence and makes for a favorable therapeutic outcome.

The second type of physical therapy we like to use when treating PVD is called Sensate Focus. It is a practice widely used to help couples regain the physical confidence lost because of a sexual problem. You and your partner are asked to touch each other according to a very structured pattern of progression. The idea is to focus on the feelings of intimacy that you get simply from touching each other, without worrying about sexual performance. In this phase, in order to keep you focused, you’re actually banned from having intercourse. Sensate Focus is designed to help couples become comfortable with each other’s bodies before moving to penetration. In the case of PVD, we ask patients to engage in Sensate Focus at the same time as using the dilator tubes.

This helps build confidence with each other after what is often a period of physical estrangement; regain physical intimacy, share the emotional load and overcome the uneasiness of the vaginal exercises. We’ve found this approach allows the patient to take control of vaginal pain while getting emotionally closer to her partner.

Alternative treatments for women who show no response to initial treatment for PVD include acupuncture and injections of various combinations of drugs (methylprednisolone acetate, lidocaine, and betamethasone) directly into the affected site.

As a last resort, surgery involving removal of the vaginal vestibule may be considered for women who do not respond to other treatment. Although it is highly effective in curing PVD, it is an extreme measure, and only suitable for a minority of well-motivated patients.

A Combined Approach Works Best

Because I am qualified as an MD, a gynecologist and a sex therapist, I have a good understanding of how the female genital equipment works. Crucially, this combination of expertise means I can tailor treatment to emphasize physical therapy, the use of drugs or behavioral sex therapy, as I see fit in each individual case. This greatly improves the outcome, as each case of PVD is unique, and requires a fine-tuned approach using every available methodology.

Adding behavioral sex therapy to physical treatment brings a powerful weapon into the battle with PVD. Little attention has been given so far to the benefits of different types of psychotherapy in couples affected by PVD, but, as mentioned above, the positive impact of couples' therapy in solving romantic discord is clear. It can go a long way toward curing one of the main side-effects of PVD – problems with intimacy. Talk therapy also works wonders on a woman's individual distress and anxiety, which is otherwise bound to affect her physically and must be taken very seriously.

Over the years of treating PVD patients, I have determined that the most effective approach is a combination of pharmacological, physical and psychosexual treatment, with surgery regarded as an absolute last resort. Generally, the best approach is Cognitive Behavioral Therapy that is focused on sexual symptoms, as this directly addresses constantly recurring behavioral patterns or "ruts". Most humans are prone to reacting to a particular emotional or physical stimulus in exactly the way they reacted before. In the case of anxiety and tensing up around sexual activity, it's important to break this pattern, and Behavioral Sex Therapy is designed to quickly and effectively do just that.

Overall, women who suffer from PVD should take heart. While treatment is still in the early stages of development, there is good evidence that a combination of drugs, physical therapy and psychotherapy will alleviate and even completely resolve the problem.

When does therapy end?

Traditionally, therapy ends when the patient is healed and can resume a satisfactory sex life. When this happens, our goal is accomplished, but the bond between patient and doctor often continues. Something very heartening happened to me not too long ago. A patient who had finished PVD treatment a few months before called for a consultation. I worried she might have had a relapse. On the contrary!

She was very well and happy. In answer to my question: “What can I do for you?” she smiled and said: “I don’t need anything, doctor, but you are the one who gave me my life back, and a I feel a bond with you, so I’d like to keep coming back from time to time.” She had gone eight years without sex, and could not picture herself ever having orgasms again. She had been on the point of finishing her relationship and yet, in a few months, she was normal again, married, and enjoying sex.

One patient was making very slow progress and, though she was making some headway, I thought she and her husband of five years didn’t seem very motivated. She also had the discouraging habit of calling off sessions at the last minute. After four or five sessions, she and her husband simply stopped coming to see me. I doubted they would complete treatment or even stay together as a couple. But one day, out of the blue, she called to announce happily that she was pregnant.
It showed me that their slow pace was still effective. When I hear a patient tell me she’s pregnant, then I know I’ve done my job!

In less favorable instances, it may be difficult to know if my work is finished because the behavioral difficulties are solved, but the couple has not returned to a satisfying sex life. This can be the case when sexual pain is preceded by marital discord or another sexual problem. In more severe cases, it is unwise to overlook fundamental interactive issues between partners. On the whole, however, in my experience, when a couple has a genuine desire to be together, simple behavioral interventions may be enough to reinforce the romantic bond. Furthermore, when sexual pain or discomfort develops after one or both partners experience a loss of desire, the therapist faces the risk that behavioral change will not last once therapy ends because it is not sustained by the couple’s loving interaction.
I’m glad to say, however, that often the cure is quite clear. I treated a 20-year old woman who came in holding a baby of only a few months. She told me she had unexpected sexual pain after delivery. It did not make sense to her that sex had turned to be unbearably painful, and she most certainly did not want it to stay that way. Her gynecologist sent her to me. When she walked in, I was struck by how beautiful she was, and how happy with her husband and her baby. She attentively took in all I said without question.

She even jumped ahead of the suggested dilator progression sequence because she felt confident enough to move at her own pace. She was completely cured in three sessions. I check up on her periodically, and I’m happy to report that three years later she is still doing well.

Pregnancy and Provoked Vulvodynia

When women with PVD become pregnant, they are understandably worried about the impact the new condition will have on their genital pain. Their worst fears are that they will not be able to give birth naturally, and that anatomical changes brought about by labor will worsen their symptoms forever. Based on the clinical experience of Ob-Gyn professionals who have an interest in the management of genital pain, there are no changes in the intensity or occurrence of PVD-related pain during pregnancy, nor changes in the characteristics of pain afterwards. Clinical data on this matter is sparse, however one author reports that 30% of women report improvement against 40% who report no change during and after pregnancy. Certainly, genital pain does not interfere with or prevent natural childbirth. It is also worth remembering that most medications used to treat PVD are not considered risky during pregnancy, and there is no need to interrupt a treatment that's already working.

On the other hand, women with PVD who become pregnant, like every other pregnant woman, have to deal with changes in their bodies that can trigger genital pain. For instance, as the baby grows, the weight forces the lower spine into an unnatural position to compensate. The growing fetus will also put additional pressure on the muscles of the pelvic floor.

In both cases, back pain and pelvic pressure may not necessarily trigger PVD, but may have a negative effect by adding overall discomfort and pain. It is important for patients to learn about safe painkillers or other forms of relief such as physical therapy or yoga, which can be of great help.

During pregnancy, it is common to develop varicose veins on the legs, and by the third trimester these may appear on the external genitalia. They are not harmful and usually resolve spontaneously after childbirth, but they do provoke swelling, a sense of heaviness and fatigue while walking. To ease the discomfort of varicose veins, patients should wear support stockings, underwear, or belts that are specially designed to help pregnant mothers, and should also learn techniques such as resting with the legs elevated, taking long, easy walks and remaining within weight-gain limits.

Labor and delivery must be handled according to the advice of the attending obstetrician. About one month after giving birth, which is the time genitals need to go back to their pre-pregnancy state, women with painful sexual intercourse should resume the Kegel exercises to strengthen the muscles, provide adequate support to the uterus and avoid spasms.
It's important to remember that pregnancy is a very special state, both emotionally and physically, and even couples who have been together a long time may change the way they interact or respond to one another sexually.

For these reasons, it is wise to closely monitor sexual pain or discomfort, loss of sex drive, increased conflict between partners, and noticeable mood swings. But, on the whole it is best to wait until the pregnancy has concluded before making diagnosis or taking action. Usually, things revert to normal fairly quickly – at least in terms of genitals! However, if symptoms of genital/sexual pain persist beyond three months, it is time to investigate for possible PVD.

Dr. Anna Ghizzani