

## Case Report

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# Management of sexual dysfunction following poorly healed episiotomy in a multipara in low-income setting

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### Abstract

**Background:** Episiotomy describes an incision made on the perineum to widen the vaginal orifice so as to aid delivery of the baby. Though not routinely recommended, it is a common during delivery. Despite the intended positive outcomes, complications like sexual dysfunction, urinary incontinence, chronic pelvic pain, perineal infection do occur following it. When sexual dysfunction occurs as sequelae as a result of poor episiotomy repair technique or poor healing, it can affect sexual intercourse and lead to marital disharmony especially in societies that tend to lean towards patriarchy.

**Case presentation:** A 31-year-old Nigerian multiparous lady with three living children presented on account of complaints of lax introitus and lack of sexual satisfaction by the partner. She had poorly healed bilateral episiotomy scar following her last delivery. She has been practicing Kegel's exercise with no improvement. There was associated threat to their relationship by her partner. Perineoplasty and vaginoplasty was done. She had successful recovery and improvement in the quality of sex.

**Conclusion:** This is a rare case of a woman in our clime visiting the clinic to request for perineal reconstruction following complaints by her partner and threat to their relationship. Obstetricians should pay attention to any complaint or worry following episiotomy and offer appropriate care to meet the sexuality needs of the parous following childbirth.

**Keywords:** episiotomy; Kegel's exercise; perineoplasty; vaginoplasty.

### Introduction

Sexual function is an important aspect of the health and life of a woman irrespective of her age [1,2]. Pregnancy and delivery cause many changes which may affect the quality of life and sexual function. Generally, there is a decline in sexual function during pregnancy and this return after delivery but not to the baseline level. Sadly, healthcare practitioners tend to neglect this despite its significant impact on life. Postpartum sexual dys-

function is common and varies from 41% to 83% at 2-3 months postpartum to 64% at 6 months postpartum [2,3]. This is compared to the prepregnancy prevalence of 38% [2]. Female sexual dysfunction is a term that covers several aspects of sexual health and has been classified by the American Psychiatric Association into distinct disorders of desire, arousal, orgasm, and pain [1].

Perineal trauma including episiotomy has been suggested as one of the causes of sexual dysfunction [2,4]. Episiotomy is a surgical incision made on the perineum to widen it during delivery and prevent untoward injury to the baby and the mother. It is classified as a second degree perineal tear. Episiotomy is so common that it has been described as the commonest performed obstetric surgical procedure [5-7]. If properly and carefully performed, especially when indicated as in cases of fetal macrosomia, breech delivery, shoulder dystocia, or operative vaginal delivery, it facilitates smooth delivery, and protects women from urogenital complications [5].

It is given only when needed and not offered routinely. Research has shown that about half of women that deliver vaginally have episiotomy [4]. Midline, mediolateral, and the lateral episiotomies are the most practiced episiotomy methods<sup>7</sup>. The benefits of episiotomy is controversial, and many studies produce contradictory results. Some studies have shown that episiotomy negatively affects pelvic floor function and is related to the occurrence of perineal pain, painful intercourse, and vaginal dryness, all of which can lead to impaired sexual performance and reduced sexual desire [8,9].

Women's morale and sexuality can be altered by perineal injury from episiotomy [4]. Contrary to other studies that suggested reduced sexual desire following delivery; a study reported no significant drop in women that had episiotomy after 3 months [10]. Prolonged sexual dysfunction impacts negatively on sexual partnership of women [9].

We report here a rare case of a young woman in our clime visiting the clinic to request for perineal reconstruction following complaints by her partner and threat to their relationship. We discuss the challenges of the case and management.

### Case presentation

She was a 31-year-old P4+0A3 Nigerian woman who presented at the gynecological outpatient clinic on account of complaints of lax introitus and lack of sexual satisfaction by the partner following her last confinement. She delivered a macrosomic baby in the last confinement and had bilateral episiotomy which healed poorly. She has been practicing Kegel's exercise with no improvement.

Vaginal examination showed a poorly healed right and left mediolateral episiotomy scar. Rest of pelvic exam showed normal findings. Following counseling and basic blood investigations, she had successful perineoplasty and vaginoplasty (Figure 1). The scar tissues at the poorly repaired previous episiotomy sites were excised. The remaining adjoining healthy tissues were apposed in layers with Vicryl 0 for the perineal muscle and vicryl 2/0 for the vaginal mucosa and perineal skin.

Post operatively, she was placed on intravenous antibiotics (ceftriaxone and metronidazole) and analgesics (pentazocine and rectal diclofenac). Urethral catheter was left in-situ for 24 hours after which her medications were converted to oral medications. Recovery was uneventful.

Following discharge, the patient was seen after a week at the outpatient clinic. Incision site has healed properly and she was advised to leave 4 weeks before resumption of coitus.



**Figure 1:** The genital tract of the patient that had successful perineoplasty and vaginoplasty procedure.

### Discussion

This is a case of reduced sexual satisfaction following poorly healed episiotomy in the partner. Pregnancy, labor and delivery may cause anatomical and functional changes in the pelvic floor muscles as well as the pelvic organs in the mother leading to fatigue, perineal pain, urinary incontinence, depression with consequent changes in their sexual function [11]. Postpartum sexual problems may manifest in delayed resumption of sexual intercourse, loss of desire, dyspareunia, lack of lubrication, pain, and decreased ability to achieve orgasm [1]. Postpartum sexual dysfunction have been attributed to several factors. During vaginal delivery, pressure from the fetal head and/or forceps may cause injury to the pudendal nerve, which is responsible for transmitting sensory and motor impulses to/from female external genitalia through dorsal nerve of the clitoris and perineal nerve [1]. Further, vaginal laxity due to stretching during labor and hypotonia of the muscles of the vagina can lead to decreased orgasm [11]. In addition, scarring of repaired tears and anal sphincter injury could lead to pain and dyspareunia [1].

Desirable sexual function has an important role in strengthening marital life. Post-partum sexual health is often not discussed during prenatal or postpartum care and had received little attention from clinicians and researchers [11]. It is not common to find women presenting to clinic on account of reduced sexual sensation because of the perception by not just the populace but health workers also. In this case, it was dissatisfaction and complaints by her partner which has led to a considerable degree of stretch on the cord holding the relationship. Reduced sexual performance and interest has been shown by research to be among the complications of episiotomy [11]. Nearly half of postpartum women showed signs of sexual dysfunction following episiotomy [5]. Predisposition to sexual dysfunction by episiotomy is controversial. Ejegard et al showed that women that underwent episiotomy reported higher frequency of dyspareunia and insufficient lubrication than women without episiotomy [12].

Management of postpartum sexual dysfunction can be challenging, first because of the little attention it gets from the patient, partner and care giver. It is so common that many persons consider it to be normal. Pelvic floor muscle training is first-line treatment for all types of urinary incontinence and mild pelvic organ prolapse and can improve some aspects of a woman's sexual life. Pelvic floor muscle training have been suggested to improve sexual function postnatally [13,14].

Sexual dysfunction in our patient can be attributed to vaginal laxity which is known to lead to reduced sensation during sexual intercourse and decreased ability to achieve orgasm [1,11]. Again, scar tissues at the sites of the repaired tears as noted in our patient may add to the occurrence of pain [1]. Both the vaginal laxity and scar formation can be attributed to poor repair and healing of the episiotomy. She had surgery with the aim of restoring anatomy. The scar tissues on both sides of the introitus were excised and the edges of the wound apposed. The introitus was narrowed during the surgery. The patient's symptoms improved following surgery.

There are lots of complications that may arise after episiotomy which include urinary incontinence, reduced sexual desire and satisfaction, fistula formation, dyspareunia etc. Disturbance of sexual pleasure after delivery has significant impact among partners. Many women in Africa are usually not forthcoming to present with complains relating to sexual dysfunction. It is important that episiotomy repair should be done with the aim of ensuring that optimal sexual life obtainable prior to delivery and not just ensuring hemostasis.

### Conclusion

This is a rare case of a woman in our clime visiting the clinic to request for perineal reconstruction following complaints by her partner and threat to their relationship. Obstetricians should pay attention to any complaint or worry following episiotomy and offer appropriate care to meet the sexuality needs of the parous following childbirth.

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