Unconsummated Marriage: Relationship between Honeymoon Impotence and Vaginismus

SHERIF GHAZI, M.D.* and AMANY SHALTOUT, M.D.**

The Departments of Andrology* and Obstetrics & Gynaecology**, Cairo University.

Abstract
Unconsummated marriage is a common problem in the andrology clinics in eastern communities. The aetiology of this problem is attributed to factors like erectile dysfunction, premature ejaculation and vaginismus. The aim of this study is to examine the role of vaginismus in erectile dysfunction of newly married men refractory to conventional treatment. 40 men were included in this study. All had erectile dysfunction dating since marriage with history of normal erectile function before marriage and failure of PDE5 inhibitors treatment as well as intracorporal injection home therapy. Twenty-five female partners were diagnosed for vaginismus. Following treatment all but two women (drop outs) were improved. However when women were ready for intercourse 12 men were still having erectile dysfunction and needed to use Tadalafil for a short term before having normal erectile function. We concluded that vaginismus is an important etiological factor in unconsummated marriage and it should be considered when treating men presenting with honeymoon erectile dysfunction.

Key Words: Erectile dysfunction – Vaginismus – PDE5 inhibitors.

Introduction
UNCONSUMMATED marriage is a common medical and social problem in andrology clinics in conservative communities. However, its etiological factors remain unclear. Many authors tried to investigate the etiological factors of unconsummated marriage. However, there were different cultural and social factors that influenced their work. Unconsummated marriage in the conservative middle east societies may be frequently present in the Andrology clinics as honeymoon impotence, which is quiet common complain. It could be defined as the inability to be successfully involved in sexual intercourse at the beginning of marriage, particularly in the first few nights. The incidence in the middle East conservative societies ranged from 8%-17% [1-3].

Unconsummated marriage may arise due to a role of the female partner, male partner or both. Previous reports from Eastern societies indicate higher incidences of premature ejaculation and vaginismus than the Western world, which underline a strong cultural influence in the background of these disorders. Psychological causes, a lack of sexual education, the social circumstances in which partners are obliged to initiate and complete coitus, erectile dysfunction (ED), premature ejaculation (PE), performance anxiety, vaginismus, hypo desire disorder, not knowing the coital technique, men who have sex with men (MSM), hypogonadism, request by bride to delay coitus and thick hymen (more than one factor involved in many cases) [1,4-6].

Before the introduction of phosphodiesterase-5 inhibitors, men with honeymoon impotence were offered behavioral sex therapy or intracavernosal injection. Later on reports about the successful use of PDE5-I in the treatment of honeymoon impotence. The successful use of Sildenafil on demand was reported. Patients who failed to respond to PDE-5 I were offered ICI [1-4].

Vaginismus, which is the recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration, which causes personal distress. It represents one of the causes of sexual pain disorders. Clinical diagnosis could be done after taking a detailed history taking and conducting a clinical examination. There are several reports that, after successful treatment, these women could have the abilities to reach orgasm and sexual desire in a way that is not different than that among normal women. And, there was a correlation between duration of unconsummated marriage and success rate and also between severity of vaginismus, treatment sessions and success rate. However, the
assessment of sexual functions of males who have vaginismic partners should be an integral part of the management procedure of vaginismus for optimal outcome [6-8].

The aim of this study is to investigate the causal relationship between honeymoon erectile dysfunction and vaginismus.

**Patients and Methods**

Forty couples complaining of unconsummated marriage were recruited from the sexual health clinic. The selection criteria were: 1- Presence of normal erectile function prior to marriage 2- Failure of medical treatment including PDE5 inhibitors and intracorporal self-injection to overcome the ED.

Men fulfilling the criteria were counselled about the importance of assessment of their female partners and their involvement in the therapy.

The male partners were subjected to thorough medical and sexual history taking (this included previous sexual experience and the risk factors for ED e.g. smoking, diabetes, hypertension: etc). General examination was done regarding body weight, height, blood pressure and secondary sexual characters. Local genital examination was done with special concern to the penile size and testicular size. The international index of erectile dysfunction could not be used because no vaginal penetration occurred yet. Laboratory investigations were done including serum testosterone, prolactin, fasting blood sugar and glycosylated haemoglobin and lipid profile. Penile duplex was done for all patients to evaluate vascular condition. This was done with the use of intracavernosal injections of PGE1. Penile biothesiometry was done also for all patients.

All female partners had complete medical, sexual and psychosocial history and thorough physical and gynaecological examination.

If the diagnosis of vaginismus is established, couples will receive few sessions for sex education covering the anatomy and physiology of the genital organs, the normal sex cycle and the role of both partners. The nature of the vaginismus, the methods of treatment and the expected outcome was also discussed. Issues of cultural concern was addressed especially the loss of virginity during vaginal dilatation sessions. A patient support group including previously treated patients were also available for reassurance and support.

The couple a program of gradual exposure including mutual non-genital stimulation in the first stage followed by genital stimulation in later sessions. This was aiming to reduce anxiety, improve non-verbal communication and enhance sexual skill in both partners.

Female partners start a series of vaginal dilatation sessions, first in the clinic followed thereafter at home. Size of dilators used is gradually increased. The rate of progression depended on the acceptance of the patient.

When the woman feels comfortable with insertion of the dilators in the vaginal, coitus is allowed with the women in control (e.g. female up position). Whenever successful couple is asked to have sex on their leisure. A follow-up visit is scheduled to monitor for any possible relapse. Female sexual function index (FSFI) [9] was recorded both before and after treatment.

If men still experience ED and not able to achieve or maintain erection they are re evaluated using the internal index for erectile function (IIEF) and are prescribed Tadalafil 20mg per demand.

**Results**

25 women were diagnosed to have vaginismus through history and examination. Mean age for women was 24.3±5.2 years and for their male partners 33.4±6.3 years. The mean duration of the complaint was 2.4±2 years the range was 2 month to 12 years.

All couples have stable marital relationship. All female partners had no sexual activities prior to marriage and had no history of sexual abuse. Only 3 men had sporadic previous sexual experience. All couples have history of male partner visiting clinics of different speciality seeking treatment for ED. In no case the possible diagnosis of vaginismus was discussed. Seven women’s consulted gynaecologists for their condition. The diagnosis of vaginismus was not discussed with the patient and in one case a surgical procedure was done for surgical incision of the hymen visiting.

Serum level of testosterone and prolactin was normal in 23 men. Mean serum testosterone was 14.4±nmol/L 2.2 and mean serum prolactin was 9.6ng/ml±1.4 In two men serum testosterone was slightly lower than normal (7.7nmol/L and 8.5nmol/L) and in one of these two patients serum prolactin was also elevated (22ng/ml).

Penile vascular study was normal in all men. Full penile rigidity following intracorporal injection was achieved in all men. It was of note that although examining physician judged penile rigidity as
normal, still 15 of the patients considered it sub-optimal. Eight men reported that they still have similar quality of erection during foreplay but they lose it as they fail to penetrate. The remaining 17 described penile rigidity at time of coitus as less or much less than that obtained following intracorporal injection. However most of them reported rigid erection in the first few days following marriage.

The degree of vaginismus was evaluated using Lamont's (1978) classification, accordingly: 5 patients (20%) had second degree vaginismus; 15 patients (60%) had third degree; 5 patients (20%) had fourth degree, while none of the patients had first degree vaginismus.

Patients with vaginismus had lower score in all domains of FSFI which was significantly improved following therapy (Table 1). The mean number of vaginal dilatation sessions was 8±2. Women with longer duration of vaginismus, had to go through more number of sessions.

All but 3 patients (dropouts) responded favourably to the therapy and were able to achieve vaginal penetration

Patients with prolonged period of the complaint had the lowest desire before treatment, while those with the severer degree experienced some form of pain in the first trials of vaginal penetration, which, however, improved by time and repeated trials of intercourse.

Table (1): Different domains of FSFI before and after treatment of vaginismus.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre-treatment</th>
<th>Post-treatment</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desire</td>
<td>2.9±1.8</td>
<td>4.6±1.2</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Arousal</td>
<td>3.6±1.8</td>
<td>5.0±1.2</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Lubrication</td>
<td>4.2±1.7</td>
<td>5.5±0.3</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>2.9±0.7</td>
<td>5.0±0.9</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Pain</td>
<td>0 (no intercourse)</td>
<td>4.9±1.6</td>
<td></td>
</tr>
</tbody>
</table>

When sexual intercourse was allowed, 10 (43%) of male partners were still complaining of ED (mean IIEF score: 14±1.4) and needed short course of oral therapy (Tadalafil) before they resumed normal sexual function (mean no of tablets used was 6 tablets).

Follow-up in the first 6 months following treatment showed normal sexual activity with no sign of relapse.

Discussion

Vaginismus is a common problem among couples complaining of honeymoon erectile dysfunction. Lack of sexual knowledge and the misconcepts about the role of both partners in the sexual relation make the couple present with erectile dysfunction rather than vaginismus. In the current therapy was effective in all female partners with successful vaginal penetration and significant improvement of other sexual domains. However many male partners needed further medical treatment before resuming normal sexual function.

The relationship between female sexual dysfunction and erectile dysfunction is extensively studied [11-15]. In most of the cases female sexual dysfunction is looked at as a sequel of erectile dysfunction. Rosen et al. [14] reported that female partners of men suffering from erectile dysfunction have a higher incidence of depressed libido, arousal’s problems and failure to reach orgasm. Following treatment with Sildenafil all domains were significantly improved. The incidence of vaginismus and other pain related female sexual disorders was significantly low in all studies examining the effect of erectile dysfunction occurring later on in the couple relationship.

Speckens et al. [16] reported increased incidence of vaginismus and dyspareunia and relationship distress in female partners of men suffering from psychogenic erectile dysfunction with no organic etiology detected. He also reported that the onset of the vaginismus preceded the onset of ED suggesting a causal relationship. He interestingly reported increased sexual interest in these group of women. He concluded that the relationship problems and the female sexual dysfunction contribute to the onset, exacerbation and maintenance of erectile dysfunction.

In contrary to what was reported before that female partners tends to attribute more responsibility for erectile dysfunction to themselves when they believed it was psychogenic [17], our current study shows that although female partners believed that the ED problem of their husbands is psychological problem, still they were insisting that this have nothing to do with themselves and that they are not contributing to the etiology by any mean. Female partners in the unconsummated marriage usually resist being involved in the therapy or attending the clinic for assessment. This negative attitude might be attributed to several cultural factors. Lack of sexual experience and absence of proper sexual education is associated with wrong
stereotype about the role of male in the sexual relationship and a false believe that a normal male should be able to enforce his penis inside the vagina. They perceive pain during penetration attempt as natural and expected part of the first time coitus. In addition some female will stop short of admitting having any problem fearing of social sequels including possible divorce, social humiliation and decrease chance to remarry. Even if they have the feeling or knowledge that they have a problem still the male partner and the close family would not consider this possible due to lack of knowledge and cultural heritage. Naturally not knowing about possible treatment will make things more difficult. Not only the couple or the public are suffering from the lack of information but many of the gynecologist seems to share them the same problem. Eleven women in the current study tried medical consultation with their gynecologist and received no treatment or referral. Unfortunately one underwent surgical incision of the hymen with anticipation that this will make vaginal penetration easier and possible. This bizarre procedure was reported elsewhere in the literature [18]. Although not widely reported in literature, the negative psychological impact of such procedure on the women warrants a serious review of this practice.

One of the finding of this study that warrant attention is that all women diagnosed with vaginismus suffers from moderate to very severe form of pelvic muscle contraction (grades 2,3 and 4 vaginismus). The absence of patients with mild grade of vaginismus raises the question: Whether these women are able to have pleasurable intercourse or they are suffering from dyspareunia and not seeking medical advice. This matter still needs to be examined.

Although vaginismus was stated in many cases as one of the possible etiologies for unconsummated marriage, many studies failed to do so. In a study of Zargoshi (2000) [8] he reported the successful use of intracorporeal injection of papaverine / phentolamine in treatment of 70% of male patients complaining of unconsummated marriage. In the rest of cases, intercourse was not possible. The author failed to recognize vaginismus as a potential etiology of unconsummated marriage or a potential factor for failure of the treatment.

Patient believed that they need a more rigid erection than what they have following intracorporeal injection to be able to have intercourse. A unique reaction shaped by the negative psychological impact of failure to penetrate their wives together with the sex ignorance and wrong cultural believes. The psychological effect is so profound in men that even after the gradual sexual exposure and in presence of accepting female partner almost half of men failed to achieve erection and needed medical help using Tadalafil. However the usage was short term and all men reported normal erectile function.

In conclusion, vaginismus is overlooked etiology for unconsummated marriage in the Middle East. It is related mainly to lack of sexual knowledge and unhealthy cultural myths about sexual intercourse. Sex education and public awareness is important to help young couple to enjoy healthy sexual life. Primary care physicians, gynecologists and urologists should be more aware about vaginismus as a possible cause of unconsummated marriage.

References


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