To the Editors:

In reply:

Couple characteristics and outcome of therapy in vaginismus [1]

Professor Goonewardene's contention in his letter (pages 148–149) that we "appear to have confused dyspareunia with vaginismus" is without foundation in fact. We have clearly defined vaginismus in our article as "a psychosomatic disorder," and our management involved no drugs or an operation under general anaesthesia. [1]. He may have been misled to believe that we were confused on this matter by our sentence, "Avoidable causes of secondary vaginismus include vaginal trauma, infection or surgery as in poor obstetric practices at delivery" [1].

Regarding vaginismus occurring secondary to organic causes we are on solid ground. Here are a few relevant excerpts.

1. "On occasion, therefore, it (vaginismus) may be secondary to organic disease" [2].
2. "Secondary vaginismus cases may be the result of unpleasant experiences or trauma" [3].
3. Vaginismus, like other disturbances of sexual functioning may be described as primary or secondary, and as situational or complete …" [4]. In this article too, "vaginitis and other organic factors" are causally linked to secondary vaginismus.

Goonewardene describes in his letter our management of vaginismus as "extremely laborious and time consuming and not very satisfactory (80% success as reported by them)" [5]. In our series, neither the therapists nor the couples found the management "laborious", for hardly any labour was involved. As for the time spent, a given couple expended at most 2 h for 4 or 5 interactions of 15–30 min each. All treatments for vaginismus have distinct failure rates, and our experience [1] of the various methods used by others (Table 1) is no different from that of reported series. To a large extent success rates depend on duration and quality of follow up. And failures tend to end up with another therapist, and are not often counted as failures by the initial therapist.

Goonawardene says that the technique he uses for the treatment of this psychosomatic disorder is to insert a "mould or a large dilator into the vagina" under a general anaesthetic, when both the psyche and the soma are unconscious. The insertion may take only a couple of minutes of the operator's time, which is valuable in every sense of that word. But what about the couples' time? The hapless spouse has to hang about for a *minimum* of 24 h [5], making a minimum total of 48 man/woman hours of *their* time, which is presumably of little value. In addition, the couple has to spend for a stay in a private hospital (for males cannot stay in government hospital female wards), plus theatre charges and fees for the operator and the anaesthetist.

Above all, general anaesthesia of itself carries small but definite risks of mortality and morbidity even in elective minor operations. Every couple has a legally recognised right to be told of this risk, however small it might be, before obtaining consent for the procedure described [5].

References

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2. Scholl GM. Prognostic variables in treating vaginismus. *Obstetrics and Gynaecology* 1988; **72**: 231–5.
3. Freeman H, Pullen T, Stein G, Wilkinson G. Dyspareunia and Vaginismus: Seminars in Psychosexual Disorders. Royal College of Psychiatrists, London, 1998. p. 188.
4. Steege JF. Dyspareunia and vaginismus. *Clinical Obstetrics and Gynaecology* 1984; **27**: 750–9.
5. Goonewardene IMR. Couple characteristics and outcome of therapy in vaginismus. *Ceylon Medical Journal* 2004; **49**: 148–9.

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